STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225549	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brigham Health and Rehabilitation Center	77 High Street Newburyport, MA 01950

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to electronically submit direct care staffing data to the Centers for Medicare and Medicaid Services (CMS) for the entire reporting period, Fiscal Year (FY) Quarter 2, 2025 (January 1 - March 31), in accordance with the schedule specified by CMS. Findings include: Review of the Payroll Based Journal (PBJ) Staffing Report, CASPER Report 1705D, FY Quarter 2 2025 (January 1 - March 31), indicated the facility triggered for:-Failed to Submit Data for the Quarter (No Data Submitted for Quarter)-One Star Staffing Rating (Staffing Rating Equals 1) During an interview on 9/16/25 at 8:55 A.M., the Director of Nurses said that while she is not responsible for the reporting of the PBJ data, she would expect the facility to submit it as required. During an interview on 9/16/25 at 9:02 A.M., The Regional Nurse Consultant said that she is aware of the PBJ reporting concerns and said that the expectation is that the data is submitted as required. During an interview on 9/16/24 at 10:30 A.M., the Director of Operations said that the PBJ staffing had not been submitted for the quarter and has since been submitted as required. The expectation is that data is submitted as required.

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

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure an intervention used to prevent and manage a pressure ulcer was effectively implemented for one Resident (#8), out of a total sample of 14 residents. Specifically, the facility failed to identify, intervene and ensure proper function when Resident #8's air mattress alert feature was illuminated and flashing, indicating a potential problem with the air mattress function. Findings include: Review of the document titled [NAME] Relief, Alternating Pressure with Low Air Loss System, Operation Manual, not dated, included but not limited to the following: Indications, this alternating pressure system with low air loss is designed to treat and prevent wounds by facilitating blood circulation and decreasing pressure of each tissue's contact area. Features: Designed to aid in the prevention and treatment of Stage 1-IV pressure ulcers. Visual/audible low-pressure alert (a diagram of a triangle with an exclamation point), 12.0 Troubleshooting 3. Problem: Alarm LED is lit during operation, Inspection Procedure: Check if there is leakage in the air tubes or air cells, Problem Solutions: Please contact (vendor) For assistance. Resident #8 was admitted to the facility in June 2020 and has diagnoses that include but are not limited to Alzheimer's disease, and pressure ulcer of the sacral (area at the base of the spine) region, stage 4. Review of the most recent Minimum Data Set (MDS), assessment dated [DATE], indicated Resident #8 scored zero out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having severe cognitive impairment. Further the MDS indicated Resident #8 was dependent on staff for all aspects of daily care and had a stage 4 pressure ulcer. During an observation on 9/15/25 at 7:50 A.M., Resident #8 was in his/her bed. Resident #8 did not respond to the surveyor's greeting and was unable to participate in an interview. The control unit for the air mattress affixed to the footboard of Resident #8's bed was observed flashing an orange light - a triangle symbol with an exclamation point. Review of Resident #8's medical record indicated the following: Physician's' orders: -Left medial buttocks: cleanse with normal saline, pat dry, apply Santyl and then collagen powder then cover with superabsorbent silicone bordered gauze dressing, every day shift for wound care, date 9/10/25. -May have Alternating Pressure Air Mattress to-set for comfort range 150-200lbs (pounds)-check placement/setting/function every shift, date 7/16/25. -A Kardex (a document used by Certified Nursing Assistants (CNA) that indicates special instructions specific for a resident's care and needs), Skin, May have Alternating Pressure Air Mattress to-set for comfort range 150-200lbs (pounds)-check placement/setting/function every shift. -A care plan, date initiated 6/10/2020, My skin: I am at risk for pressure ulcer development/impaired skin integrity related to decreased mobility, bowel and bladder incontinence. Interventions/Tasks include but are not limited to, May have Alternating Pressure Air Mattress to-set for comfort range 150-200lbs (pounds)-check placement/setting/function every shift, dated 7/7/2024. On 9/15/25 and 9/16/25 the surveyors made the following observations: On 9/15/25 at 4:11 P.M., Resident #8 was lying in his/her bed. The air mattress alert indicator was illuminated orange and flashing. On 9/16/2025 at 7:47 A.M., Resident #8 was lying in his/her bed. The air mattress alert indicator was illuminated orange and was flashing. -At 7:50 A.M. the alert indicator continued to be flashing orange light. -At 8:14 A.M., Resident #8 was sitting up in his/her bed and the air mattress alert indicator light was off. -At 8:22 A.M., Resident #8 was sitting up in bed with the over bed tray table in front of him/her. The alert indicator on the air mattress control was lit and flashing orange. - At 8:40 A.M., Resident #8 was sitting up in bed. A rehabilitation staff member entered the room and provided Resident #8 his/her breakfast. The alert indicator, which could be viewed on the foot board, illuminated orange and was flashing. -At 8:49 A.M., Resident #9 was assisted to eat breakfast by the rehabilitation staff member. The air mattress alert indicator continued to be illuminated and flashing orange. -At 10:01 A.M., Nurse #2 entered Resident #8's room and administered his/her medication. The air mattress alert indicator was illuminated and flashing at this time. -10:54 A.M., Resident #8 was in bed. He/she had two drink cups in front of (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	him/her on the over bed table. The alert indicator on the air mattress was illuminated and flashing orange. On 9/16/25 at 12:27 P.M., Resident #8 was up in a chair in the dining room for the lunch meal. During an interview on 9/16/25 at approximately 1:00 P.M., CNA #1 said Resident #8 stays up for only a short time because of the wound. CNA #1 said the Resident will be assisted back to bed before the end of the shift (3:00 P.M.) On 9/16/2025 at 3:22 P.M., Resident #8 was in bed. The alert indicator on the air mattress was illuminated orange and flashing. Review of the Treatment Administration Record (TAR) dated 9/1/25-9/30/25 indicated, May have Alternating Pressure Air Mattress to-set for comfort-range 150-200lbs-check placement, setting/function every shift as documented with a check mark and initials of the nurse on the day shift on 9/16/25. During an interview and observation on 9/16/25 at 3:41 P.M., Nurse #2 said the air mattress on Resident #8's bed is used because he/she has a pressure wound and that he/she has had the air mattress for a long time. Nurse #2 and the surveyor went to Resident #8's room and the alert indicator light was not flashing. Nurse #2 touched the air mattress control unit, and the alert indicator began flashing. Nurse #2 touched the mattress and said it was still inflated but the flashing light looked like a warning that the mattress was not working properly. The surveyor shared the observations made over the last 2 days, which included three different shifts and during the medication pass when Nurse #2 administered medication to Resident #8. Nurse #8 said he signed off on the TAR (Treatment Administration Record) today (9/16/25) that the air mattress was functioning. Nurse #2 said he did see it blinking during the medication pass. During an interview on 9/16/2025 at 4:01 P.M., and at 5:00 P.M., the Director of Nursing said if an air mattress is flashing it means there is a problem. The DON said it does not mean it is failing but that something needs to be addressed. The DON and surveyor went to Resident #8's room and the alert indicator was illuminated and flashing on Resident #8's air mattress. The DON said if she saw the light flashing, she would check to see if the parts are securely in the pump and she would expect the nursing staff to do the same thing. The DON pushed in the side tubes, and the flashing stopped. The DON said if that does not work, they would call the rental company that provides the air mattress. The DON said the nursing staff should have seen or been alerted by any staff who go into Resident #8's room, about the flashing light and to let her know. The DON said the nurses are to document on the TAR that the air mattress is functioning. During an interview on 9/17/25 at 9:43 A.M., Nurse #6 said Resident #8 has a pressure ulcer on his/her sacrum. Nurse #6 said interventions for treating the pressure ulcer are dressing changes, repositioning, providing incontinent care, and the use of the air mattress. Nurse #6 said the air mattress relieves pressure to the wound. Nurse #6 said the nursing staff make sure it is set correctly and functioning. Nurse #6 said if the alert signal is flashing it means the air mattress has something wrong with it and needs to be addressed. Nurse #6 said that any staff who provide care or enter the room should be alerting the nurse if the alert signal is flashing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review and interviews, the facility failed to ensure the environment remained free of accidents and hazards and was safe for all residents and, one Resident (#1), out of a total sample of 14 residents. Specifically, the facility failed to ensure:1. Safe practices in preparing food in the facility kitchen, which has the potential to affect all residents, when [NAME] #1 left a large double pot boiling over two gas burners, with the back burner spewing large flames shooting upwards and left unattended and,2. For Resident #1, the facility failed to implement interventions in the Resident's care plan to keep in supervised area, common areas for increased supervision when out of bed. Findings include: 1. Review of the facility's policy titled 'Safety', revised 9/2017 indicated, The kitchen and associated equipment will be properly maintained and that all Dining Services staff follow safe operating practices. On 9/15/25 at 6:48 A.M., in the facility kitchen, the surveyor observed a large rectangle hotel pan on the gas stove, covering the front and back gas burners, with a pot inside with vigorous boiling water, and large flames coming from the back gas burner. The flames varied in height and extended approximately 12 inches vertically and observed to be a concern. There were no staff in the kitchen at the time of the observation. There were no staff located nearby, in the adjacent hallway outside of the kitchen. -At 6:54 A.M., [NAME] #1 exited the elevator and entered the kitchen. [NAME] #1 immediately turned off the burner and said he put the burner on about 20 minutes ago. [NAME] #1 said the pot contained eggs. [NAME] #1 said he left the kitchen to go upstairs and should not have left the pan unattended on the burner. During an interview on 9/15/25 at 8:45 A.M., the Food Service Director said kitchen staff should never leave food cooking on the stove unattended. During an interview on 9/16/25 at 9:05 A.M., the Regional Food Service Director said the double boiler with the flames coming from the back should not have been unattended by kitchen staff. The Regional Food Service Director said ironically the staff had an in-service last week on fire safety. 2. Review of facility policy titled Fall Prevention Program, dated as reviewed and revised 3/4/24, indicated the following: -Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls Resident #1 was admitted to the facility in June 2025 with diagnoses that included dementia, pneumonia and hypertension. Review of the most recent Minimum Data Set (MDS) Assessment, dated 8/27/25 indicated a Brief Interview for Mental Status score (BIMS) of 1 out of a possible 15, indicating that the Resident has severe cognitive impairment. The MDS further indicated that the Resident had two or more falls since admission or the prior assessment, and no falls with injury. Review of Resident #1's active risk for falls care plan indicated that the Resident is high risk for falls related to advanced dementia, poor safety awareness and poor balance, created on 6/4/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions include the following: keep in supervised area, common area for increased supervision when out of bed, dated as initiated on 6/25/25. Review of Resident #1's Kardex (a document that provides information about the level of assistance a resident requires, as well as information about the resident's plan of care) indicated the following: -Safety: Keep in supervised area, common areas for increased supervision when out of bed. During an observation on 9/16/25 at 10:00 A.M., Resident #1 was observed up in his/her wheelchair in the dining room. There were no staff present in the dining room to supervise residents. Review of the CSC Fall risk evaluation, dated 6/3/25, indicated a fall risk score of 26, which according to the assessment places the Resident at risk for falls. Review of the CSC fall risk evaluation, dated 9/4/25, indicated a fall risk score of 15, which according to the assessment places the Resident at risk for falls. Review of Resident #1's fall incident reports and investigations indicated that the Resident sustained unwitnessed falls out of his/her wheelchair in the dining room on 7/13/25, 7/15/25 and 7/19/25. Review of the incident report/ investigation, dated 7/13/25 at 8:00 P.M., indicated the following: -The Resident was found on floor on his/her right side. -Nursing description: resident was found laying in the dining room floor, on [his/her] right side, no apparent injuries noted, able to move all extremities, neuros WNL (within normal limits), VSS (vital signs stable). (sic) -Was this incident witnessed?: No Review of the nursing progress note, dated 7/13/25, indicated the following in part: -Resident was found laying on the dining floor, on [his/her] right side. no apparent injuries note, Able to move his/her extremities, neuros WNL, VSS. Resident is alert and oriented x1 could not explain what caused the fall. Assessment was done. No apparent injuries observed. Assisted back to his/her chair with hoyer. NP (Nurse Practitioner) and HCP (Healthcare proxy) were notified. Neuro sign assessment were initiated. (sic) Review of the incident report/investigation, dated 7/15/25 at 2:09 P.M., indicated the following: -The Nurse was called because the Resident had slide out of [his/her] chair into the floor. As observed resident had his/her had (head) up against rim of the wall. sic) -Was this incident witnessed?: No -Other info: The resident was in the living room/ dining room watching TV with other residents. Review of witness statements as part of the investigation indicated that the Resident was last observed by staff at 1:00 P.M. by one staff member, 15 minutes prior to the incident by one staff (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	member, and five minutes prior to the incident by another staff member. Review of the nursing progress note, dated 7/15/25, indicated the following: -This nurse was called because the resident had slid out of [his/her] chair onto the floor. As observed, the resident had [his/her] head against the wall's rim. The resident states that [he/she] slid out of the wheelchair onto the floor. Denies pain or any other discomfort. Moving all extremities, neurological assessment was within normal limits. Review of the incident report/ investigation, dated 7/19/25 at 7:15 P.M., indicated the following: -Aide came and reported to this nurse that the resident was in the dining room on the floor. -Was the incident witnessed?: No Review of the witness statements as part of the investigation indicated the Resident was last seen five minutes prior to the incident, but it was not witnessed. Review of the nursing progress note, dated 7/20/25, indicated the following in part: -Received in report that resident was found on floor yesterday without injuries. During an interview on 9/17/25 at 7:50 A.M., the Director of Nursing (DON) said that Certified Nurse's Aides (CNAs) utilize the electronic kardex that generates in the electronic medical record from the care plan in order to provide assistance necessary for residents. During an interview on 9/17/25 at 8:04 A.M., Nurse #4 said that she was assigned to Resident #1 on 7/15/25 when he/she fell. She said that staff walked into the dining room and found him/her on the floor, and she was called to assess the Resident. She said the fall was unwitnessed, and if a fall is unwitnessed, it means that the Resident was not being supervised as per the plan of care. She said that Resident #1 is a high fall risk and should be supervised when out of bed. She further said that there should always be a staff member in the dining room supervising the residents that are in there. She said that falls can happen quickly, even if stepping out of the dining room quickly. During an interview and observation on 9/17/24 from 8:33 A.M. to 8:39 A.M., the dining room was unsupervised with residents in there. At 8:39 A.M., CNA #2 entered the dining room to get linen from the linen closet that was located in the dining room. She then proceeded to leave the dining room. Nurse #4 stopped her and said that someone needed to stay in the dining room. The CNA told the surveyor that there is not usually continual supervision in the dining room and said, this is the first I've been told this. She said she was not aware of the need to supervise residents in the dining room and was not aware of any residents on the unit that specifically required supervision when out of bed. During an interview on 9/17/25 at 9:32 A.M., CNA #3 said that Resident #1 requires supervision because he/she is a high fall risk. He said staff should be supervising him/her whenever they are out of bed. During an interview on 9/17/25 at 9:23 A.M., the Director of Nurses said that she expects a resident's care plan to be followed to maintain safety. She said that she agrees with the surveyor's concern. She said that if Resident #1 was in the dining room specifically, then it should be supervised. She said (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that based on the investigation, indicating unwitnessed falls, Resident #1 was not being supervised when he/she was up in their wheelchair.

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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 resident interviews and test tray results, the facility failed to ensure food provided to the residents was prepared by methods that conserve palatability and are at appetizing temperatures on two of two units.Findings include:During the resident screening process on 9/15/25 beginning at 7:10 A.M., multiple residents on the first-floor unit expressed concerns regarding the meals to the surveyors, including not having enough food, running out of staples, the meals not being good and meals being cold. During the Resident Group attended by 17 residents, residents said the following: -A few participants said the facility runs out of inventory and staple foods like coffee, eggs butter, and bread. -One resident said they do not get their diet as ordered like heart healthy, and, -Many of the active participants had mixed reports about the food including no variety of food, the temperature of the hot food is not always hot, and a dislike of the food in general. As a result of the residents' reports about the meals on 9/16/25, the surveyors conducted test tray audits for the lunch meals for both units of the facility, the results were as follows: On 9/16/25 at 11:23 A.M., [NAME] #2 recorded the following temperatures of the food on the steam table: -pureed cream corn, 154.2 degrees Fahrenheit -marinated chicken thighs, 179.8 degrees Fahrenheit -roasted potatoes, 156.7 degrees Fahrenheit -dysphagia advanced potatoes (no skins on the potato) 163.9 degrees Fahrenheit - corn, 171.1 degrees Fahrenheit -gravy, 174.4 degrees Fahrenheit -ground chicken, 173 degrees Fahrenheit -mashed potatoes, 162.5 degrees Fahrenheit - puree chicken, 163 degrees Fahrenheit -puree corn 166.5 degrees Fahrenheit -milk in a cup, 42.6 degrees Fahrenheit -apple juice in a cup, 43.5 Fahrenheit. The regional Food Service Director said he will throw the milk and juice on ice because the holding temperature should be 41 degrees or below. On 9/16/25 at 11:53 A.M., the food truck left the kitchen and was delivered to the second floor. This truck contained a test tray and arrived at the second floor at 11:56 A.M., the surveyor received the test tray at 12:06 P.M. The following was recorded with facility staff present. -Marinated chicken thigh, 109 degrees Fahrenheit, had flavor, was warm not hot to taste. -Roasted Potatoes, 109 degrees Fahrenheit, warm not hot to taste. -Corn, 113 degrees Fahrenheit, tasted buttery, warm not hot to taste. -Apple Juice 53 degrees Fahrenheit, tasted warm not cold to taste. The staff present tasted the food with the surveyor and said the food was not hot enough. On 9/16/25 at 11:57 A.M., the food truck left the kitchen and was delivered to the first-floor unit. This truck contained a test tray and arrived at the second floor at 12:00 P.M., the surveyor received the test tray at 12:07 P.M. The following was recorded with the Regional Food Service Director present: -Marinated chicken thigh, 142 degrees Fahrenheit, had flavor, was hot to taste. -Roasted Potatoes, 113 degrees Fahrenheit, warm not hot to taste, and had a hard texture. -Corn, 116 degrees Fahrenheit, tasted warm not hot to taste. -Milk, 48.3 degrees Fahrenheit, was cool, not cold to taste. -Coffee, 167.2 degrees Fahrenheit, hot to taste. The Regional Food Service Director said he would like to see the corn and potatoes served at a hot palatable temperature. During an observation of the dining room on 9/16/25 at 12:10 P.M., four out of four residents sitting at one table had not consumed any of their potatoes and had large amounts of uneaten food on their plates. During an interview on 9/16/25 at 12:15 P.M. the test tray temperatures were reviewed with the Regional Food Service Director. He said ideally, they aim for cold beverages to be served under 50 degrees to be cold. The Regional Food Service Director said the hot foods should be served at a hot temperature.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure standards of quality of care were provided for one Resident (#8), out of a total sample of 14 residents. Specifically, the facility failed to ensure Resident #8 was provided care and treatment for a skin tear on the back of his/her right hand. Findings include: Resident #8 was admitted to the facility in June 2020 and has diagnoses that include but are not limited to Alzheimer's disease, and pressure ulcer of the sacral (area at the base of the spine) region, stage 4. Review of the most recent Minimum Data Set (MDS), assessment dated [DATE], indicated Resident #8 scored zero out of 15 on the Brief Interview for Mantal Status exam, indicating he/she as having severe cognitive impairment. Further the MDS indicated Resident #8 was dependent on staff for all aspects of daily care. During an observation on 9/15/2025 at 7:50 A.M., Resident #8 was in his/her bed. Resident #8 did not respond to the surveyor's greeting and was unable to participate in an interview. The back of Resident #8's right hand had several steri-strips (narrow adhesive bandages used to close small cuts or minor surgical incisions) covering dark discolored skin. On 9/16/25 the surveyor made the following observations: -At 7:30 A.M., Resident #8 was lying in his/her bed. The back of Resident #8's right hand was covered with several steri-strips, curled on the edges, with dark red skin under the steri-strips. -At 12:27 P.M. Resident #8 was up in his/her wheeled recliner chair. The back of Resident #8's right hand had several steri-strips, curled on the edges revealing dark discolored skin under the steri-strips. Review of Resident #8's clinical record indicated the following: -A Note text: date 8/26/25, At 10:40 P.M., CNAs (Certified Nursing Assistant) discovered a skin tear on Resident's right hand. The Nurse Practitioner was notified and viewed wound. She advised cleaning with NS (normal saline) and steri strips to approximate wound edges best as possible. Sterile gauze pad and bordered sterile bandage was applied. -A SNF (skilled nursing facility) Telehealth note dated 8/26/25 at 10:21 P.M., entered by the Nurse Practitioner. Chief complaint; skin tear R (right) hand. Diagnosis and Plan Ordered: Clean with NS, pat dry, approximate skin and apply steri-strips, cover with dressing and monitor daily. Review of Resident #8's Physician's orders, Medication Administration Record, and Treatment Administration Record, failed to indicate an order for the treatment or monitoring of Resident #8's right hand skin injury. Further review of Resident #8's medical record progress notes indicated the following: -8/31/25 18:54 (6:54 P.M.) Right hand outer bandage removed, gauze soaked off with NS, Steri-strips intact. No Sx (symptoms) infection. Cleaned with NS and dried. Border gauze dressing applied. -9/14/25 21:09 (9:09 P.M.) Complete weekly skin check, Hand wound dry with steri strips intact no s/sx of infection noted. The above notes were written and entered by the same nurse who documented the skin tear on 8/26/25. The progress notes from 8/26/25, with the exception of 8/31/25 and 9/14/25, to 9/16/25, failed to indicate Resident #8's right hand skin tear was monitored. Review of the physician's orders failed to indicate a treatment order or monitoring order of Resident #8's right hand skin tear. During an interview on 9/16/25 at 7:01 A.M., Nurse #5 said if a resident has a new skin tear or any new injury the doctor is called and orders obtained for care and treatment, family is notified, and an incident report is completed. During an interview on 9/16/25 at 1:22 P.M., and 3:39 P.M., Nurse #2 said if a resident has a skin tear the nurse would notify the MD (medical doctor), obtain orders for care and treatment, and an incident report would be completed. Nurse #2 said Resident #8 had a skin tear about two weeks ago. Nurse #2 said skin tears with steri-strips should be monitored at least daily to check that the skin tear is healing, dry and has no signs of infection. Nurse #2 said a physician's order is required to trigger the nurse to document and monitor the skin tear. Nurse #2 said there is no order to monitor Resident #8's right hand skin tear. During an interview on 9/16/25 at 3:20 P.M., the Director of Nursing (DON) said that there was no incident report for Resident #8's right hand skin tear. The DON said incident reports are to be completed by the nurse and entered into the electronic medical record. The DON said she reviews incident reports and without it entered in the medical record she (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would not be aware of the injury to follow up on it. The DON said Resident #8 is at risk for skin tears. The DON said there was no physician's order for the dressing that was applied and there was no physician's order for monitoring the skin tear each shift and there should have been an order in place.

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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 observation, record review and interview, the facility failed to ensure professional standards of practice for the care of a suprapubic urinary catheter (a tube placed through the suprapubic region into the bladder to drain urine) for one Resident (#35) out of a total sample of 14 residents. Specifically, the facility failed to ensure nursing changed Resident #35's catheter drainage bag (a collection pouch that connects to a urinary catheter to collect urine from the bladder) in accordance with physician's orders.Findings include: Resident #35 was admitted to the facility in March 2025 with diagnoses including neuromuscular dysfunction of the bladder. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/26/25, indicated the Resident scored a 13 out of possible 15 on the Brief Interview for Mental Status, indicating he/she was cognitively intact. The MDS indicated Resident #35 had an indwelling catheter. On 9/15/25 at 8:38 A.M., during the initial screening, Resident #35 was observed lying in bed with a catheter drainage bag hanging on the bedframe. The catheter drainage bag was observed unlabeled and undated. Review of Resident #35's active physician's order, dated 3/20/25, indicated:-Change catheter bag weekly, label with date. as needed. Review of Resident #35's Treatment Administration Record (TAR) failed to indicate that nursing had changed the Resident's suprapubic catheter drainage bag for the months of July 2025, August 2025 and September 2025. On 9/15/25 at 2:26 P.M., Resident #35 was observed sitting in his/her wheelchair with the catheter drainage bag hanging underneath his/her wheelchair seat, labeled and dated 9/10/25. During an interview on 9/15/25 at 2:26 P.M., Resident #35 said his/her catheter drainage bag is changed once a month when he/she returns to the facility from his/her urology appointments. Resident #35 said his/her drainage bag is not changed weekly, and the drainage bag was just recently changed shortly prior to the surveyor's interview with Resident. During an interview on 9/16/25 at 12:22 P.M., Nurse #3 said catheter care includes flushing the catheter's access port, changing the catheter drainage bag and cleaning the area daily. Nurse #3 said catheter drainage bags are changed weekly and as needed. Nurse #3 said tasks should be documented in the TAR in the electronic medical record and followed up with a progress note. Nurse #3 said the electronic medical record notifies the nurse when the drainage bag needs to be changed by displaying the order on the date it is due to be changed. Nurse #3 said that she changed Resident #35's drainage bag on 9/15/25 because she noticed the drainage bag needed to be changed but the bag was not scheduled to be changed. Review of the Medication Administration Record (MAR) with Nurse #3 indicated that the physician order was ordered as needed and not routinely scheduled. Review of the Treatment Administration Record (TAR) with Nurse #3 failed to indicate documentation that the drainage bag had been changed. Review of the medical record failed to indicate a progress note reflecting the drainage bag change. During an interview on 9/16/25 at 12:35 P.M., Nurse #3 said the physician's order should have been scheduled routinely instead of as needed. Nurse #3 said because the order was not scheduled routinely, the electronic medical record did not notify the nurse when the drainage bag needed to be changed and that the order was transcribed in error. During an interview on 9/17/25 at 8:34 A.M., the Director of Nursing said drainage bags are supposed to be changed weekly, and physician orders should be carried out.

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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 - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain acceptable parameters of nutritional status for one Resident (#33) out of a total sample of 14 residents. Specifically, the facility failed to obtain weekly weights to monitor the weight for Resident #33 as ordered by the physician resulting in the facility failing to identify a significant weight loss in a timely manner. Findings include: Review of the facility policy titled Weight Assessment and Intervention undated, indicated the following: -The nursing staff will measure resident's weights on admission, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. -Weights will be recorded in each unit's Weight Record chart or notebook and in the individual's medical record.-Any weight change 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing.-The Dietitian will respond within 24 hours of receipt of written notification.-The Dietitian will review the unit Weight Record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether the criteria for significant weight change has been met. - The threshold for significant unplanned and desired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight -actual weight) / (usual weight) x 100:a. 1 month - 5% weight loss is significant; greater than 5% is severe.b. 3 month - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months- 10% weight loss is significant; greater than 10% is severe. Resident #33 was admitted to the facility in May 2025 with diagnoses including chronic obstructive pulmonary disease (COPD), chronic atrial fibrillation and weakness. Review of the Minimum Data Set (MDS) assessment, dated 8/27/25, indicated Resident #33 had moderate cognitive impairment, as evidence by a Brief Interview for Mental Status (BIMS) score of 8 out of a possible score of 15. Further view of the MDS failed to indicate rejection of care.Review of the facility Matrix (a tool used by providers and government surveyors to assess resident needs and track compliance) indicated Resident #33 had an excessive weight loss/gain.Review of the facility Weight Record for Resident #33 indicated the following weight measurements:-5/30/25: 188 lbs. (pounds)-7/31/25: 154.0 lbs.-8/6/25: 153.5 lbs.-8/12/25:157.8 lbs.-8/19/25: 153.7 lbs. -9/13/25: 154.2 lbs. The medical record indicated that from 5/30/25 to 7/31/25, Resident #33 lost 34 pounds resulting in a -18.1% weight loss over two months since admission. Further view of the medical record failed to indicate that any weights were obtained between 5/30/25 and 7/31/25. Review of Resident #33s active physician orders indicated the following:-Diet: Regular diet, regular texture, thin liquids, dated 5/31/25.-Ensure: (a nutritional supplement) two times a day, dated 8/3/25.-Monthly weights: everyday shift, every month: reweigh if +/-3 lbs and notify NP/MD (Nurse Practitioner/ Doctor of Medicine), dated 8/21/25. Review of Resident #33's discontinued physician orders indicated the following: -Weigh weekly x4 weeks: active from 6/2/25 through 6/30/25, dated 5/30/25. -Weekly weights: active from 8/4/25 through 8/21/25, dated 7/31/25. Review of Resident #33's June 2025 Treatment Administration Record (TAR) failed to indicate any documented weights for the entire month. Review of Resident #33's medical record failed to indicate that weekly weights were not obtained between 6/2/25 and 6/30/25 in accordance with the physician's order that was implemented on 5/30/25. Further view of the medical record failed to indicate that Resident #33 had refused weights. Review of Resident #33's Nutritional admission Assessment, dated 6/6/25, completed by the Registered Dietitian (RD) indicated the following: -Resident relates stable weight 185-188-Eating/feeding: independent. -Inadequate energy intake aeb (as evidenced by) diarrhea, fair appetite related to diagnosis of GERD (Gastroesophageal Reflux Disease). -most recent weight 188 on 5/30/25. -goals: maintain weight. Review of a weight change note dated 8/3/25 at 6:47 A.M., written by the Registered Dietitian indicated the following: Resident is [AGE] year-old with PMH (past medical history): Esophagitis, COPD, CHF, diet; Regular. He/She eats (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meals in main dining room. He/She has had a significant weight loss 30# (pounds) over past 2 mo. Appetite is improving per observation and RN/CNA (Registered Nurse/Certified Nurse Aid) team, Resident HCP (healthcare proxy), NP (Nurse Practitioner) will be notified. Resident is not meeting his/her nutritional needs aeb (as evidenced by) weight loss plan; weekly weight serve diet as ordered add Ensure 237 cc (cubic centimeter, each equivalent to one milliliter) twice daily monitor appetite/wt (weight). (sic). Review of a weight change note written by the Registered Dietitian dated 8/7/25 at 2:26 P.M., indicated the following: Resident is 99 y/old with PMH: CHF, CAD. He/She is very HoH (hard of hearing) and has visual impairment. Diet; Regular, regular texture, thin liq (liquids). supplement Ensure 237 cc two times daily. He/She has a fair appetite - eats in main dining room. His/Her weight has trended down since admission. His/her HCP (health care proxy) has been notified of weight tread down. Plan: update food preferences serve diet as ordered monitor wt weekly. Review of Resident #33's Nutritional Quarterly/significant change assessment by the Registered Dietitian (RD) dated 8/26/25, indicated the following:-weight 153.7 dated 8/19/25-eating independently -Adequate energy intake aeb stable weight since admission.-Estimated calorie need: 1540-1550-1540 kcal/day Review of Resident #33's medical record indicated that the Resident was assessed by the Registered Dietitian (RD) on admission and after significant weight loss had been identified. During an interview on 9/16/15 at 1:34 P.M., Certified Nursing Assistant (CNA) #1 said CNAs are responsible obtaining weights and weights are done either weekly or monthly. CNA #1 said residents are weighed on admission or within 48 hours of admission date. CNA #1 said weights are documented on a sheet of paper and the assigned nurse documents the weights in the electronic medical record. During an interview on 9/16/25 at 2:31 P.M., Nurse #2 said residents are weighed on the same day they are admitted , then weekly. Nurse #2 said weights are documented in the electronic medical record under the weights tab. During an interview on 9/17/25 at 10:38 A.M., the Registered Dietitian (RD) said residents that are newly admitted are weighed on admission, then weekly for 4 weeks. The RD said CNAs are given a weekly weight list to obtain the scheduled weights and weights are entered into the electronic medical record by the nurse or director. The RD said she is informed of residents with significant weight changes by looking at weight reports in the electronic medical record, risk meetings and weekly clinical meetings. The RD said she would expect to be notified by staff if a resident has a significant weight loss and would assess the resident within that same week of the weight loss. The RD said she would recommend a reweigh for a 3-pound weight loss or gain. The RD said the risk of weights not being completed timely or as indicated in physician's orders, is further weight loss. She said Resident #33's weight loss would have been detected sooner if the weekly weights had been done. The RD said she would have assessed Resident #33 sooner if the weights were completed. During an interview on 9/17/25 at 10:58 A.M., the Director of Nursing said weights are completed on admission, then weekly for four weeks. The DON said if residents are stable after weekly weights are ordered, then the resident's weight order would be changed to monthly weights. The DON said it is her expectation that weekly weights are obtained as indicated in the physician's orders.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and records reviewed, the facility failed to complete annual Certified Nurse Aide (CNA) performance reviews for two out of two eligible sampled CNAs.Findings include: During review of three CNA employee records, the surveyor was unable to locate annual performance reviews for two out of two eligible CNAs. During an interview on 9/16/25 at 7:59 A.M., the Regional Human Resources (HR) Director (who said she is covering for this facility in the absence of an HR director) reviewed the employee files with the surveyor and said that CNAs should receive an annual performance review. On 9/16/25 at 8:25 A.M., she followed up with the surveyor and said that she could not locate any performance reviews and at this time feels that they had not been completed. During an interview on 9/16/25 at 8:55 A.M., the Director of Nursing said that she has only been in the facility for three months but that performance reviews should be completed annually. During an interview on 9/16/25 10:01 A.M., The Director of Operations said that the expectation in the facility is that annual performance reviews are completed.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation and interview, the facility failed to ensure a gap in the bed was filled to prevent possible entrapment for one Resident (#42) out of a total sample of 14 residents. Findings include:Review of facility policy titled Bed Safety, undated, indicated the following:-2. To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following;b. Review that gaps within the bed system are within the dimensions established by the FDA. Resident #42 was admitted to the facility in July 2024 with diagnoses that included congestive heart failure and lower back pain. Review of Resident #42's most recent Minimum Data Set (MDS) Assessment, dated 9/3/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident's cognition is intact. The MDS further indicated that Resident #42's ability to roll from lying on back to left and right side and return to lying on back on the bed was dependent on staff. On 9/15/25 at 7:41 A.M. the surveyor observed Resident #42 sleeping in bed. There was a large gap between the mattress and the footboard without a gap filler in place. On 9/15/25 at 12:15 P.M., the surveyor observed Resident #42 eating lunch in bed. There was a large gap between the mattress and the footboard without a gap filler in place. On 9/16/25 at 6:59 A.M. and 1:45 P.M., the surveyor observed the Resident in bed. There was a large gap between the mattress and the footboard without a gap filler in place. On 9/17/25 at 7:01 A.M., the surveyor observed Resident #42 sleeping in bed. There was a large gap between the mattress and the footboard without a gap filler in place. The surveyor measured the gap to be approximately six inches. Review of the Bed/Side rail assessment, dated 5/30/25, indicated the following:-Are spacings between the bed rail, mattress and bed surround appropriate to prevent entrapment, in particular, between the end of the bed rail and the headboard; between the mattress and bed rail; and between the mattress and lowest rail of the bed rail when compressed by the bed occupant - the answer was left blank and not indicated in the assessment. During an interview and observation on 9/17/25 at 7:09 A.M., the Director of Nursing (DON) and the surveyor observed the gap at the foot of the bed between the mattress and the footboard. the DON said Resident #42 does not get out of bed per his/her choice and is dependent for bed mobility. She said that she has never seen a gap filler used at the foot of the bed before During a follow up interview on 9/17/25 at 7:33 A.M., the DON said she is asking maintenance to observe the bed and get a gap filler to put in place. During an interview on 9/17/2025 at 9:44 A.M., the Maintenance Director said he has been at the facility for a month and a half. He said that if there is a gap between the mattress and the footboard of the bed, then there should be a gap filler in place. During an interview on 9/17/25 at 9:47 A.M., the Administrator said that he observed Resident #42's bed and agreed that there should be a gap filler in place due to the gap between the mattress and the foot of the bed. 09/17/2025 10:23 AM During a follow up interview with the Maintenance Director he said that he checked all beds and observed that Resident #42's bed had a gap between the mattress and the footboard, he said he measured it to be between five and six inches.