STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225557	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Rehabilitation and Healthcare Center	255 Central Avenue Chelsea, MA 02150

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to ensure staff provided care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life and recognizing resident individuality for two sampled Residents (#68 and #119) out of a total of 33 sampled residents. Specifically, the facility failed to ensure staff regularly communicated with Resident #68 and Resident #119 in a language they understand. Findings include: Review of the facility's Interpreter Services policy dated February 2022 indicated: -The facility shall ensure that Limited English Proficient (LEP) residents and their families are able to effectively provide facility staff with a clear statement of their medical condition and history and understand the healthcare provider's assessment of their medical condition and treatment options. This is essential to the provision of quality resident care. -The facility shall provide language assistance services, including bilingual staff and interpreter services as no cost to each resident/consumer with limited English proficiency at all points of contact in a timely manner during al hours of operations, thus ensuring that LEP residents have available translators to assist in understanding the activities of staff members on their behalf and ensure the residents'/families' involvement in planning care, treatment and services. -LEP residents hall have services provided to them in their primary language or have interpreter services provided to them during the delivery of all significant healthcare services. 1. Resident #68 was admitted to the facility in October 2018 with diagnoses including dementia, aphasia and anxiety disorder. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #68 required a translater to communicate as his/her primary language was Korean. On 3/31/25 8:36 A.M., the surveyor observed Resident #68 resting in bed. Resident #68 could not engage in an interview or respond to questions. Review of Resident #68's care plans indicated: (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: Risk for impaired communication secondary to Resident being non-English speaking. Primary language is Korean, dated 12/4/23. Interventions: Provide resident with communication/picture board if available. Use gestures i.e. pointing to items whenever possible. Utilize language translating hotline or interpreter as needed. Focus: Resident is at risk for social isolation secondary to being Korean speaking only (understands some English). Resident attends activity programs in day room daily. He/she needs encouragement to initiate participation, dated 1/14/2025. Interventions: Korean communication card Utilize Korean speaking translators, family members and staff to obtain interests and support daily routine. Assist and support communication with family and friends via social media. During observations of Resident #68's room on 3/31/25 and 4/1/25, the surveyor was unable to locate communication cards or picture boards. Review of the progress notes indicated: 3/10/2025: Met with Resident #68 for a wellness check after the incident with another resident who became inappropriate with him/her. Resident #68 has a dementia diagnosis, is aphasia and is Korean, he/she does understand basic questions, but during this interview he/she was unable to respond. When asked if he/she is okay and feels safe, he/she nodded yes and grabbed my hand. That was his/her only response to any of the questions. SS (Social Service) department will continue to follow up with Resident #68 and a referral to be seen by psych services has been completed. 3/11/2025: This writer met with resident in his/her room. No observable signs of trauma or stress. Limited English, but able to say he/she is doing ok. Due to cognitive deficits he/she is unable to relate to this writer the events of the previous day. Social service will continue to monitor. The progress notes failed to indicate staff utilized a translator to meet with Resident #68. On 4/1/25 at 7:33 A.M., the surveyor observed Certified Nursing Aid (CNA) #8 serve Resident #68 his/her breakfast. The CNA did not speak to or attempt to engage with Resident #68 as she arranged the breakfast tray. CNA #8 said that Resident #68 can speak some English but that he/she needs an interpreter. When asked how to obtain an interpreter, CNA #8 said that she would tell the activities lady. During an interview on 4/1/25 at 7:54 A.M., Nurse #4 said no residents on the unit speak Korean. On 4/1/25 at 7:58 A.M., the surveyor observed Resident #68 calling out and reaching his/her arms up and wave to staff passing by his/her room. Resident #68 became increasingly upset and threw his/her bed control off the bed. Nurse #6 entered the room to assist. Nurse #6 said that Resident #68 is unable to explain to staff in English what he/she wants. Nurse #6 said that staff could call an interpreter service. Nurse #6 continued to remain the room and adjust Resident #68 in bed without attempting to speak with the Resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/25 at 8:02 A.M., CNA #4 said that she was not sure how he/she would obtain an interpreter and she would ask the nurse. On 4/1/25 at 8:09 A.M., the surveyor observed an interpreter hotline number posted at the nurses station. Three staff members were in Resident #68's room discussing what he/she could possibly want (i.e. get up, get dressed, etc) as he/she continued to call out from the bed. During an interview on 4/1/25 at 12:25 P.M., Social Worker #1 said that Resident #68's family member can assist with translating and that staff can also use an interpreter hotline. During an interview on 4/2/25 at 9:07 A.M. the Director of Nursing (DON) said that she would expect staff to communicate with residents whose primary language is not English through an interpreter service. 2. Resident #119 was admitted to the facility in October 2024 with diagnoses including dementia and diabetes. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #119 required the use of a translator to communicate as his/her primary language was Vietnamese. During an interview on 3/31/25 at 8:15 A.M., Resident #119 was smiling but unable to engage in a conversation with the surveyor. The surveyor observed a worn communication sheet on the wall with pictures for water, pain, medication and other basic needs. Review of Resident #119's care plans indicated: Focus: Resident has impaired communication due to language barrier. Preferred language is Vietnamese, dated 1/28/25. Interventions: Enlist use of communication devices as needed communication board, sign language. Utilize language translating hotline or interpreter as needed. Focus: Resident is at risk for social isolation secondary to being Vietnamese speaking only, understands some English, dated 11/8/24. Interventions: Utilize Vietnamese speaking translators, family members and staff to obtain interests and support daily routine. Assist and support communication with family and friends via social media. During an interview on 4/1/25 at 7:41 A.M., Resident #119 was observed eating breakfast in his/her room. When asked in English how the food tasted, Resident #119 responded thank you. Review of the nurse progress notes indicated: 3/13/2025: Resident was found by CNA on the right side of the bed. Resident had difficulty to give the description of the fall due to language barrier. Resident c/o (complained of) pain prn (as needed) Tylenol given with effect, new order from on call clean area with ns bacitracin daily until Healed, Neuro checks. Safety maintained. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/10/2025: Resident was found on the floor by CNA after dinner. Due to language barrier resident was unable to give a description of the fall. Resident sustained a small cut on the right side of his forehead, assessment completed resident was able to move all upper and lower extremities PRN Tylenol 650mg was given for discomfort with + effect. The fall was immediately reported to the On call, new order to clean area with normal saline apply bacitracin daily until healed, Neuro checks. Healthcare proxy son also notified of the fall. Safety maintained. The progress notes failed to indicate staff utilized a translator when speaking with Resident #119 after his/her falls to determine the possible cause. During an interview on 4/1/25 at 7:44 A.M., Certified Nursing Aid (CNA) #3 said Resident #119 doesn't speak English but he/she could follow directions when staff speak with him/her. CNA #3 said that Resident #119 cannot express his/her needs in English and he did not know how to get an interpreter to communicate with Resident #119. CNA #3 said he did not know what Resident #119's primary language is. During an interview on 4/1/25 at 7:54 A.M., Nurse #4 said Resident #119 can understand English and follow directions, but could not speak English. Nurse #4 was unable to articulate how to locate an interpreter to speak with residents whose primary language is not English. During an interview on 4/1/25 at 8:02 A.M., CNA #4 said that she was unsure how to get obtain an interpreter and would ask the nurse. During an interview on 4/1/25 at 12:25 P.M., Social Worker #1 said that staff can interpret for Resident #119 and staff could also utilize an interpreter hotline. During an interview on 4/2/25 at 9:07 A.M., the Director of Nursing said she would expect staff to be aware of the primary language of Resident's and utilize an interpreter service to communicate with them.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on interviews and observations, the facility failed to provide three Residents (#84, #7 and #67) of 33 sampled residents with the choice of an alternate meal. Findings include: Resident #84 was admitted to the facility in February 2024 and had diagnoses which included depression. Review of his/her Minimum Data Set assessment dated [DATE], indicated a Brief Interview for Mental Status score of 11, signifying moderate cognitive impairment. During an interview on 3/31/25 at 8:00 A.M., Resident #84 said the facility does not provide an alternative meal to what is listed on the daily menu. Resident #84 said the printed menu, located on the wall by the elevators, lists an alternative, but when he/she has asked for the alternative staff always say it is unavailable. Resident #84 said staff do not hand out the menus or ask residents if they would like an alternate meal. Resident #84 said that you get what staff serve you, whether you like it or not. Resident #84 said he/she no longer asks for an alternate meal because it does not seem to exist. Resident #7 was admitted to the facility in November 2024 and has diagnoses which include heart disease. Review of the Resident's Minimum Data Set assessment dated [DATE], indicated a Brief Interview for Mental Status exam score of 15, signifying intact cognition. During an interview on 4/1/25 at 8:08 A.M., Resident #7 said he/she never sees the meal menus because staff do not hand them out. Resident #67 said he/she was unaware the menu was posted by the elevator. Resident #7 said he/she left the bedroom infrequently. Resident #7 said he/she never knows what will be served to him/her, other than for breakfast. Resident #7 said that for breakfast staff serve him/her bagels because the kitchen knows this is his/her preference. Resident #7 said that if he/she does not like lunch or dinner he/she does not eat them and goes without a meal. Resident #7 said that, in the past, when he/she asked staff for an alternate meal they had told him/her it was too late to order. Resident #7 said he/she would like to know in advance what is being served and to be able to order an alternate meal. Resident #67 was admitted to the facility in January 2014 and had diagnoses which included depression. Review of his/her Minimum Data Set assessment dated [DATE], indicated a Brief Interview for Mental Status exam score of 15, signifying intact cognition. During an interview on 3/31/25 at 9:54 A.M., Resident #67 said the staff do not hand out meal menus, so he/she does not know what is being served until the meal is dropped off at his/her room. Resident #67 said that if he/she does not like the meal staff have told him/her to call the kitchen to request another meal. Resident #67 said that staff refuse to take his/her meal order. Resident #67 said he/she used to call the kitchen but because no one ever answers he/she no longer calls. Resident #67 said that sometimes the meal menu is kept by the elevator, but that not all residents leave their bedroom. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/25 at 8:24 A.M., Certified Nurse Aide (CNA) #6 said residents typically find out what is served for their meal when staff give the tray to them. CNA #6 said menus are not handed out. CNA #6 said a menu is sometimes kept at the elevators. CNA #6 said that if a resident does not like the food served to them, they can ask the aide for an alternative and this is sometimes provided. CNA #6 said sometimes residents do not receive an alternate meal because sometimes the kitchen does not answer the phone. During an interview on 4/1/25 at 8:37 A.M., Unit Manager #2 said meal menus are not handed out to residents. Unit Manager #2 said menus are posted by the elevators. Unit Manager #2 said residents should be able to request meal alternatives from nursing staff. Unit Manager #2 said staff should attempt to call the kitchen, and if there is no answer staff should walk to the kitchen to place the order for the alternative meal. During an interview on 4/1/25 at 8:56 A.M., the Food Services Director said the meal menu is located on a wall by the elevator. The Food Service Director said residents who do not leave their bedrooms do not see the menu. The Food Services Director said staff should be able to tell residents what is being served prior to the meal and the alternatives available. The Food Services Director said that either the residents or nursing staff should be able to call the kitchen to place an order. The Food Services Director said she was unaware the kitchen sometimes did not answer the phone. The Food Services Director said the facility does not have a policy regarding the offering of meal alternatives.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review and interview, the facility failed to ensure Advance Directives (written documents that instruct health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) were consistently documented in the medical record for one Resident (#155) out of a total sample of 33 residents. Findings include: Review of the facility policy titled Advanced Directives, dated [DATE], indicated All residents have the right to formulate an advance directive and to request, refuse, and discontinue treatments. Advance directives will be respected in accordance with state law and facility policy. Residents shall be encouraged to communicate their desires in regard to advance directives to their significant others, to allow for guidance by significant others and healthcare providers in following the resident's wishes should the resident become incapacitated, rendering them unable to make decisions. A request of the resident/significant other to provide a copy of the advance directive for medical record entry shall be made by the Admitting Department during the admission process. Resident #155 was admitted to the facility in [DATE] with diagnoses that include cerebral infarction, aphasia, dysphagia and depression. Review of Resident #155's most recent Minimum Date Set (MDS), dated [DATE], indicated he/she was assessed by nursing staff to have moderate cognitive impairments. The MDS indicated the resident was a full code status. Review of Resident #155's Medical Doctor (MD) and Nurse Practitioner (NP) progress notes dated [DATE], [DATE], [DATE], [DATE], and [DATE], indicated Code Status: DNR/DNI (Do Not Resuscitate/ Do Not Intubate). Review of Resident #155's discharge hospital paperwork, dated [DATE], indicated Advanced Care Planning: Code Status at Discharge: DNR/DNI (No CPR/No Intubation). Review of Resident #155's advanced directives care plan, dated [DATE], indicated CODE STATUS: Presumed FULL CODE. Review of Resident #155's social services assessment, dated [DATE], indicated Code Status in Hospital: DNR DNI (No CPR/No intubation). Facility will follow up with verifying that this is still the case with the resident. Review of Resident #155's social services quarterly assessment, dated [DATE] and [DATE], indicated Advanced Directives Reviewed with Resident or Responsible Person? No. Review of Resident #155's medical record indicated a blank MOLST (Medical Orders for Life-Sustaining Treatment) form. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] 7:27 A.M., Nurse #4 said the Resident is a full code and is not sure why the MD/NP is documenting that. During an interview on [DATE] at 9:15 A.M., the Director of Nurses (DON) said advanced directives should be discussed upon admission and quarterly during his/her assessment period. The DON said she is not sure why the MD/NP documents the code status as DNR/DNI for Resident #155. The DON said social services should be discussing advanced directives with the responsible party at least on admission and quarterly. During an interview on [DATE] at 10:03 A.M., the Social Worker said Resident #155 is a full code because they have a guardian and are not allowed to be a DNR. The Social Worker said she has not discussed advanced directives with his/her gaurdian.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 43846 Based on interview, and record review, the facility failed to ensure the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN: notice issued to a resident when a facility determines the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all his/her Medicare benefit days) were issued with the required information for three out of three applicable residents reviewed. Specifically, the facility failed to issue the SNF ABN notice, so the Resident/Resident Representative could decide if they wished to continue receiving skilled services that may not be paid for by Medicare, and were aware of the financial responsibility they may have to assume. Findings include: The SNF ABN (CMS-10055) notice is administered to a Medicare recipient when the facility determines that the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all of the Medicare benefit days for that episode. The SNF ABN provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. The facility was unable to provide three of three requested SNF ABNs. During an interview on 4/1/24 at 8:38 A.M., the Regional Minimum Data Set (MDS) Nurse said the facility has not been providing ABN notices appropriately and they should have been provided.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed accurately complete the Minimum Data Set Assessments (MDS) for two Residents (#68 and #119) out of a total of 33 sampled residents. Specifically, the facility failed to attempt to utilize interpreter services to complete interviews for Resident #68 and Resident #119 to assess for cognition in section C of the MDS. Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, revised October 2024, indicated the following instructions for Section B0700: Makes Self Understood - DEFINITION: MAKES SELF UNDERSTOOD Able to express or communicate requests, needs, opinions, and to conduct social conversation in their primary language, whether in speech, writing, sign language, gestures, or a combination of these. - Steps for Assessment 1. Assess using the resident's preferred language or method of communication. - Code 0, understood: if the resident expresses requests and ideas clearly. - Code 1, usually understood: if the resident has difficulty communicating some words or finishing thoughts but is able if prompted or given time. They may have delayed responses or may require some prompting to make self understood. - Code 2, sometimes understood: if the resident has limited ability but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet). - Code 3, rarely or never understood: if, at best, the resident's understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet) Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, revised October 2024, indicated the following instructions for Section B0800: Ability to Understand Others - DEFINITION: ABILITY TO UNDERSTAND OTHERS Comprehension of direct person-to-person communication whether spoken, written, or in sign language or Braille. Includes the resident's ability to process and understand language. - Steps for Assessment 1. Assess in the resident's preferred language or preferred method of communication. - Code 0, understands: if the resident clearly comprehends the message(s) and demonstrates comprehension by words or actions/behaviors. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Code 1, usually understands: if the resident misses some part or intent of the message but comprehends most of it. The resident may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions. - Code 2, sometimes understands: if the resident demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or instructions. When staff rephrase or simplify the message(s) and/or use gestures, the resident's comprehension is enhanced. - Code 3, rarely/never understands: if the resident demonstrates very limited ability to understand communication. Or, if staff have difficulty determining whether or not the resident comprehends messages, based on verbal and nonverbal responses. Or, the resident can hear sounds but does not understand messages. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, revised October 2024, indicated the following instructions for Section C (Cognitive Patterns): - Steps for Assessment 1. Interact with the resident using their preferred language. Be sure they can hear you and/or have access to their preferred method for communication. If the resident needs or requires an interpreter, complete the interview with an interpreter. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards. - C0100: Should Brief Interview for Mental Status Be Conducted? Coding Instructions - Code 0, no: if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. - Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Review of the facility's Interpreter Services policy dated February 2022 indicated: The facility shall ensure that Limited English Proficient (LEP) residents and their families are able to effectively provide facility staff with a clear statement of their medical condition and history and understand the healthcare provider's assessment of their medical condition and treatment options. This is essential to the provision of quality resident care. The facility shall provide language assistance services, including bilingual staff and interpreter services as no cost to each resident/consumer with limited English proficiency at all points of contact in a timely manner during al hours of operations, thus ensuring that LEP residents have available translators to assist in understanding the activities of staff members on their behalf and ensure the residents'/families' involvement in planning care, treatment and services. LEP residents hall have services provided to them in their primary language or have interpreter services provided to them during the delivery of all significant healthcare services. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #68 was admitted to the facility in October 2018 with diagnoses including dementia, aphasia and anxiety disorder. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #68 required a translator to communicate as his/her primary language was Korean. Additional review of Section C of the MDS indicated that the Brief Interview for Mental Status Exam (BIMS) was not completed because Resident #68 was documented as being rarely/never understood. On 3/31/25 at 8:36 A.M., the surveyor observed Resident #68 resting in bed. Resident #68 could not engage in an interview or respond to questions. On 4/1/25 at 7:33 A.M., the surveyor observed Certified Nursing Aide (CNA) #8 serve Resident #68 his/her breakfast. The CNA did not speak to or attempt to engage with Resident #68 as she arranged the breakfast tray. CNA #8 said that Resident #68 can speak some English but that he/she needs an interpreter. When asked how to obtain an interpreter, CNA #8 said that she would tell the activities lady. During an interview on 4/1/25 at 12:25 P.M., the Social Worker said that she completes section C on the MDS in the facility and she did not utilize an interpreter or attempt to interview Resident #68. The Social Worker said that she did not interview Resident #68 with an interpreter because Resident #68 is cognitively confused and would answer the questions wrong even in his/her own language. The Social Worker said she follows RAI guidelines for the interview process for Section C. 2. Resident #119 was admitted to the facility in October 2024 with diagnoses including dementia and diabetes. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #119 required the use of a translator to communicate as his/her primary language was Vietnamese. Additional review of Section C of the MDS indicated that the Brief Interview for Mental Status Exam (BIMS) was not completed because Resident #119 was documented as being rarely/never understood. During an interview on 3/31/25 at 8:15 A.M., Resident #119 was smiling but unable to engage in a conversation with the surveyor. During an interview on 4/1/25 at 7:44 A.M., Certified Nursing Aide (CNA) #3 said Resident #119 doesn't speak English but he/she could follow directions when staff speak with him/her. CNA #3 said that Resident #119 cannot express his/her needs in English and he did not know how to get an interpreter to communicate with Resident #119. CNA #3 said he did not know what Resident #119's primary language is. During an interview on 4/1/25 at 12:25 P.M., the Social Worker said that she completes section C on the MDS in the facility and she did not utilize an interpreter or attempt to interview Resident #119. The Social Worker said that she did not interview Resident #68 with an interpreter because Resident #119 is cognitively confused and would answer the questions wrong even in his/her own language. The Social Worker said she follows RAI guidelines for the interview process for Section C.

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Highland Park Rehabilitation and Healthcare Center	255 Central Avenue Chelsea, MA 02150

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observation, record review and interview, the facility failed to ensure six Residents (#12, #70, #88, #146, #77 and #94) received care in accordance with professional standards of practice, out of a total sample of 33 residents. Specifically, 1. For Resident #12, the facility failed to ensure nursing completed weekly skin assessment per the physician order. 2. For Resident #70, the facility failed to ensure nursing completed weekly skin assessment per the physician order. 3. For Resident #88, the facility failed to ensure nursing obtained a physician order for the use of his/her air mattress. 4. For Resident #146, the facility failed to ensure nursing applied ace wraps as per the physician's order. 5. For Resident #77, the facility failed to ensure staff applied a palm guard as per the physician's order. 6. For Resident #94, the facility failed to ensure physician's orders were transcribed correctly. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Resident #12 was admitted to the facility in December 2021 with diagnoses that included Parkinson's disease, dementia, major depressive disorder, and adult failure to thrive. Review of Resident #12's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she was assessed by staff to have moderate cognitive impairments. Further review of the MDS indicated he/she is at risk for developing pressure ulcers. Review of Resident #12's physician order, dated 9/1/23, indicated Weekly Skin Check every day shift every Fri (Friday). Review of Resident #12's evaluation tab in the electronic medical record (EMR) indicated the last skin check that was completed was 3/14/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #12's March 2025 Treatment Administration Record (TAR) indicated on 3/21/25 and 3/28/25 nursing staff marked on the TAR as the weekly skin check was completed. Review of Resident #12's skin care plan, dated 1/16/24, indicated Weekly skin evaluations. Review of Resident #12's Norton Scale for Predicting Risk of Pressure Ulcer, dated 3/3/25, indicated he/she scored an 11 indicating moderate risk. Review of Resident #12's March 2025 nursing progress notes failed to indicate the Resident refused or that nursing completed the weekly skin check on 3/21/25 and 3/28/25. During an interview on 4/2/25 at 7:27 A.M., Nurse #4 said nursing should be filling out a skin check weekly as ordered in the EMR and documenting that on a skin check assessment in the evaluations tab in the EMR. During an interview on 4/2/25 at 9:14 A.M., the Director of Nursing (DON) said nursing staff should follow the doctors order and complete the skin check under the evaluations tab in the electronic medical record. 2. Resident #70 was admitted to the facility in July 2014 with diagnoses that included dementia, delusional disorders, heart failure, and major depressive disorder. Review of Resident #70's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated he/she was assessed by nursing staff to have severe cognitive impairments. Further review of the MDS indicated he/she is at risk for developing pressure ulcers. Review of Resident #70's physician order, dated 9/4/23, indicated Weekly Skin Check every day shift every Mon (Monday). Review of Resident #70's evaluation tab in the electronic medical record (EMR) indicated the last skin check that was completed was 3/14/25. Review of Resident #70's March 2025 Treatment Administration Record (TAR) indicated on 3/24/25 and 3/31/25 nursing staff marked on the TAR as the weekly skin check was completed. Review of Resident #70's skin care plan, dated 1/15/24, indicated Weekly skin evaluations. Review of Resident #70's Norton Scale for Predicting Risk of Pressure Ulcer, dated 3/24/25, indicated he/she scored a 6 indicating high risk. During an interview on 4/2/25 at 7:27 A.M., Nurse #4 said nursing should be filling out a skin check weekly as ordered in the EMR and documenting that on a skin check assessment in the evaluations tab in the EMR. During an interview on 4/2/25 at 9:14 A.M., the Director of Nursing (DON) said nursing staff should follow the doctors order and complete the skin check under the evaluations tab in the electronic medical record. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the facility policy titled Pressure Relieving Devices, dated January 2023, indicated Appropriate Pressure Reduction devices will be available in each facility. Standard for proper inflation of specialty surfaces - a. Follow manufacturer's instruction for proper inflation of surfaces. b. Staff must be trained to monitor for proper setting on inflation devices. The proper setting may be attached to the actual monitor at each bed. Resident #88 was admitted to the facility in September 2023 with diagnoses that included dementia, adult failure to thrive, cognitive communication deficit, and pain disorder. Review of Resident #88's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated he/she was assessed by nursing staff to have moderate cognitive impairments. Further review of the MDS indicated he/she is at risk for developing pressure ulcers. On 3/31/25 at 7:58 A.M. and 4/1/25 at 7:28 A.M., the surveyor observed Resident #88 in bed on an air mattress. The air mattress was set to the highest setting. Review of Resident #88's active physician orders failed to indicate an order for the use of his/her air mattress. During an interview on 4/2/25 at 7:19 A.M., Nurse #4 said the Resident has been on an air mattress for so long and said the air mattress should have a doctors order in place. During an interview on 4/2/25 at 9:18 A.M., the Director of Nursing said a Resident who has an air mattress on their bed should have a doctors order in place with settings. 43807 4. Resident #146 was admitted to the facility in August 2024 with diagnoses including edema. A review of the most recent Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15 indicating intact cognition. During an interview on 3/31/25 at 8:18 A.M., Resident #146 said he/she has edema in his/her legs. He/she said both his/her legs should be wrapped daily in the morning and unwrapped in the evening. Resident #146 said his/her legs are not wrapped daily. A review of Resident #146's April 2025 physician's orders indicated the following: - Ace wrap to BLE (Bilateral Lower Extremity) apply daily in AM (morning), off at HS (at bedtime) one time a day. Apply Ace wrap daily and remove at bedtime. Order date, 9/18/24. Review of Resident #146's March 2025 Treatment Administration Record (TAR) failed to indicate nursing documented the physician's order to Ace wrap daily and remove at bedtime as completed on the following time and dates: - At 6:00 A.M., on 3/2/25, 3/4/25, 3/5/25, 3/7/25, 3/9/25, 3/10/25, 3/12/25, 3/19/25, 3/21/25, 3/23/25, 3/24/25, 3/26/25, and 3/28/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 4/2/25 at 7:12A.M., Unit Manager #1 said Nurses are expected to document in the TAR after wrapping Resident #146's legs. She said if the treatment was not documented as completed, that means the physician's order was not implemented. During an interview and record review on 4/2/25 at 8:29 A.M., the Director of Nurses (DON) said Nurses should always follow the physician's orders. The DON said if the treatment was not documented as completed, that means the physician's order was not implemented. 5. Resident #77 was admitted to the facility in July 2020 with diagnoses including hemiplegia and hemiparesis. A review of the most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 4 out of a possible 15 indicating severe cognitive impairment. Further review of the MDS indicated impairment on both sides of the upper extremities. On 3/31/25 at 8:45 A.M., and 1:27 P.M., the Surveyor observed Resident #77 lying in bed. The left-hand fingers were in a balled fist. Resident #77 did not have a palm guard in his/her left hand. On 4/1/25 at 7:54 A.M., the Surveyor observed Resident #77 lying in bed. The left-hand fingers were in a balled fist. Resident #77 did not have a palm guard in his/her left hand. On 4/1/25 at 5:28 P.M., the Surveyor observed Resident #77 lying in bed. The left-hand fingers were in a balled fist. Resident #77 did not have a palm guard in his/her left hand. A review of Resident #77's April 2025 physician's orders indicated the following: - Left palm guard: DON during AM care, DOFF for hygiene and skin assessment as tolerated every shift. Order date, 8/31/23. During an interview and observation on 4/2/25 at 7:18 A.M., Certified Nurse's Assistant (CNA) #7 said Resident #77 should have a left palm guard on. CNA #7 looked around in the Resident's room and could not find the palm guard. She said the palm guard was in the laundry room. During an interview on 4/2/25 at 7:19 A.M., Resident #77 said he/she has not worn the palm guard in a few weeks. He/she said he/she needs help from staff to put on the palm guard. During an interview and observation on 4/2/25 at 7:24 A.M., Unit Manager #1 said staff should always follow the physician's orders. Unit Manager #1 said Resident #77 should have a palm guard on his/her left hand. She said the palm guard was taken to the laundry room and got lost. During an interview on 4/2/25 at 8:39 A.M., the Director of Nurses said Resident #77 should wear a left hand palm guard as ordered by the physician. 6. Resident #94 was admitted to the facility in February 2025 with diagnoses including dysphagia. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the most recent Minimum Data Set (MDS), dated [DATE], did not indicate a Brief Interview for Mental Status (BIMS) score because the Resident is rarely/never understood. Further review of the MDS indicated that the Resident has a feeding tube. A review of Resident #94's April physician's orders indicated the following: - Resident is NPO (nothing by mouth) every shift. Order date, 2/12/25. - Hydralazine HCl oral tablet 10 milligrams, give 1 tablet by mouth two times a day related to hypertension. - Metoprolol Tartarate Tablet 25 milligrams, give 0.5 tablet by mouth one time a day for hypertension. During an interview and record review on 4/2/25 at 7:40 A.M., Unit Manager #1 said Resident #94's medications in the physician's orders should not be transcribed by mouth because the Resident is NPO. During an interview and record review on 4/2/25 at 8:36 A.M., the Director of Nursing said Resident #94's physician's orders should not read by mouth because the Resident is NPO.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36876 Based on observations, interviews, and record review, the facility failed to provide necessary assistance with activities of daily living (ADLs) for two Residents (#21 and #160) out of a total sample of 33 residents. Specifically, 1. For Resident #21, the facility failed to provide necessary nail care. 2. For Resident #160, the facility failed to ensure the Resident maintained good oral hygiene when staff did not ensure supervision with oral hygiene was provided, as indicated in the care plan, and the Resident was not provided with a toothbrush. Findings include: 1. Resident #21 was admitted to the facility in June 2017 with diagnoses including unspecified dementia and hypercholesterolemia. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident was severely cognitively impaired and required assistance with bathing and transfers. The MDS also indicated Resident #21 had no behaviors of rejecting care. On 3/31/25 at 8:22 A.M., the surveyor observed Resident #21 resting in bed. His/her fingernails were visibly long (approximately 1/2 inch) and crusted with a brownish-blackish substance. Resident #21 was unable to engage in the interview process due to his/her cognition. Review of Resident #21's care plans indicated: Focus: Self care deficit r/t (related to) decreased functionality, generalized muscle weakness, dx of Dementia and COPD, 11/29/23. Interventions: Dependent with ADL's (hygiene, bathing, grooming, dressing, toileting) Indep/Assist PRN (as needed) with meals. Focus: Resident has a history of the following behaviors: screaming, scratching, and refusing care, revised 2/18/25. Interventions: Do not argue with resident - reporach (sic) as necessary. Monitor/Assess resident's episodes of inappropriate behaviors, document on the behavior flow sheet including interventions used and its effectiveness, (9/22/23). On 4/1/25 at 7:52 A.M., the surveyor observed Resident #21 resting in bed. His/her fingernails were long, visibly dirty and crusted with a brownish-black unknown substance. Review of Resident #21's progress notes and activites of daily living documentation failed to indicate Resident #21 had refused care on 3/30/25 and 3/31/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/25 at 1:14 P.M., the surveyor observed Resident #21 sitting in the activity room eating his/her lunch. Resident #21's nails were long and visibly dirty. During an interview on 4/1/25 at 1:16 P.M., Certified Nursing Aide (CNA) #5 said she provided morning care for Resident #21 earlier in the morning and he/she did not refuse any care. Resident #21 does not like to get his/her nails cut. CNA #5 said she did not attempt to cut Resident #5's nails. On 4/1/25 at approximately 1:20 P.M., the surveyor observed CNA #5 and another CNA remove Resident #21 from the activity room and say to another staff person that they were going to cut his/her nails, (after the surveyor inquired about Resident #21's nail care). During an interview on 4/2/25 at 7:20 A.M., Nurse #4 said CNA's provide resident with nail care. Nurse #4 said that Resident #21 does not usually refuse care. During an interview on 4/2/25 at 9:06 A.M., the Director of Nursing (DON) said that CNA's should provide residents nail care. 48990 2. Review of the facility policy titled 'ADL - Personal Hygiene', revised October 2022, indicated: - Policy: Mouth care and teeth brushing will be given with AM/PM care and prn to ensure mouth is free of debris and the oral cavity is moist. - Procedure: Review the resident's care plan and Kardex for any special care or needs of the individual resident. Resident #160 was admitted to the facility in February 2025 with diagnoses including sepsis and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/14/25, indicated Resident #160 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. This MDS also indicated Resident #16 required supervision/touching assistance with oral hygiene. On 3/31/25 at 8:34 A.M., the surveyor observed Resident #160 in his/her room. Resident #160 said he/she was upset because they were never given a toothbrush and had been unable to brush his/her teeth in a month and a half. They surveyor observed Resident's teeth which were covered in a thick layer of a yellowish-white substance. There was no toothbrush in his/her room. Review of Resident #160's care plan related to self-care activities of daily living, revised 2/26/25, indicated: - Oral hygiene: Supervision/Touching. Review of Resident #160's Kardex (a summary of patient care needs used by certified nurse assistants), dated 3/31/25, indicated: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Oral hygiene: Supervision/Touching. Review of Resident #160's report titled 'Documentation Survey Report' (a report including certified nurse assistant (CNA) documentation), dated 3/1/25 to 3/31/25, failed to indicate Resident refused oral hygiene. This 'Documentation Survey Report' indicated oral hygiene was documented as completed with set-up assistance or independently 58 out of 62 times, instead of with supervision or touching assistance, as indicated was required in his/her care plan and Kardex. During an interview on 4/1/25 at 9:13 A.M., Certified Nurse Assistant (CNA) #1 said oral hygiene should be performed as directed on the Kardex and care plan. CNA #1 could not locate a toothbrush in Resident #160's room and said he/she should have one stored in his/her room. During this observation, Resident #160 said he/she does not have a toothbrush and would like to brush his/her teeth this morning. Review of Resident #160's report titled 'Documentation Survey Report' indicated: - On 3/28/25: CNA #1 documented set-up assistance provided for oral hygiene. - On 3/31/25: CNA #1 documented the Resident performed oral hygiene independently. During a follow-up interview on 4/1/25 at 9:22 A.M., CNA #1 said he was assigned to Resident #160 on 3/28/25 and 3/31/25. CNA #1 said he never set-up or checked that Resident #160 had performed oral hygiene or had a toothbrush those days but should have. CNA #1 said since there wasn't a toothbrush in the room, he/she hasn't had one. CNA #1 said Resident #160 doesn't refuse personal care and he should have provided him/her with a toothbrush and supervision with oral hygiene but did not. During an interview on 4/1/25 at 9:32 A.M., Nurse #2 said CNAs should always follow the Kardex and care plan interventions for the assistance needed for oral hygiene and to ensure it is completed. Nurse #2 said the CNAs should have ensured Resident #160 had a toothbrush. Nurse #2 said CNAs should report to the nurse if a Resident refuses oral hygiene. Nurse #2 said sometimes Resident #160 refuses medical care, like insulin or blood sugar checks, but never refuses personal care because hygiene is very important to him/her. During an interview on 4/1/25 at 11:28 A.M., the Director of Nursing (DON) said each resident's toothbrush should be stored in their room. The DON said CNAs should always follow the Kardex and care plan interventions for the assistance needed for oral hygiene and to ensure it is completed. The DON said CNAs should report to the nurse if a Resident refuses oral hygiene and document any refusals that occur.

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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** 36876 Based on observation, record review and interview, the facility failed to provide the necessary care and treatment for one Resident (#141) out of a total of 33 sampled residents. Specifically, the facility failed to notify the physician and implement recommendations made by the orthopaedic (a branch of medicine specializing in diagnosing and treating conditions related to the musculoskeletal system, which includes bones, joints, ligaments, tendons, and muscles) specialist for pain management, the use of splints and occupational therapy services. Findings include: Resident #141 was admitted to the facility in April 2023 with diagnoses including chronic pain, cerebrovascular disease and osteoarthritis. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #141 was cognitively intact evidenced by a score of 13 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). The MDS also indicated Resident #141 required assistance with bathing and transfers. During an interview on 3/31/25 at 11:02 A.M., Resident #141 reported he/she has pain in his/her hand regularly. Resident #141 said that he/she receives medication for the pain but it does not help. Review of the clinical record indicated Resident #141 had an orthopedic physician on 9/19/24. The visit summary indicated: On exam he/she has tenderness and decreased range of motion of the thumbs as well as the index and middle fingers bilaterally. We reviewed imaging which suggests possible underlying inflammatory arthropathy. Likely components of osteoarthritis as well. We will have him/her see OT (occupational therapy) for new splints to be made for bilateral hands. Also recommend Volatren gel (a topical pain medication) to be used as needed up to four times daily. Recommend follow-up with rheumatology for further evaluation and consideration of medical management. He/she will follow up with us if symptoms do not improve or worsen. Review of Resident #141's progress notes, physicians orders and care plans failed to indicate the recommendations made regarding OT, bilateral splints, Voltaren Gel or a referral to rheumatology were implemented. Review of the Nurse Practitioner and Physician notes, dated 11/26/24, 1/31/25, and 2/8/25, failed to indicate the attending physician reviewed or were made aware of the recommendations made by the orthopedic physician. During an interview on 4/1/25 at 10:18 A.M., Nurse #4 said that when residents return from appointments, their paperwork is reviewed and recommendations for treatments are communicated with the physician. During an interview on 4/1/25 at 10:47 A.M., Resident #141 said that he/she had been told six months ago he/she would be given splints for his/her hands but he/she hasn't heard anything about it since. Resident #141 could not recall if he/she had been told at an outside appointment or in the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/25 at 1:00 P.M., the [NAME] President of Case Management said that Resident #141 had not been on OT services in the past six months. During an interview on 4/2/25 at 7:23 A.M., the Medical Records Staff member said she is responsible for managing resident appointments. She said on 2/3/25 (approximately 127 days after Resident #141's ortho appointment) she was in the hospital's electronic health care system (which differs from the facility's electronic records) arranging for Resident #141 to have a follow up appointment with ortho. She said that she then saw Resident #141 had a referral in that system for rheumatology. She said she then alerted Nurse Practitioner (NP) #1 and set up an appointment for Resident #141 to be seen, but there was no availability until April 2025. During an interview on 4/2/25 8:50 A.M., NP #1 said that recommendations from specialists are communicated via phone call, or a communication book to either her or the physician and then implemented in the Resident record. NP #1 said that if the recommendations are not indicated in the electronic health records, they were most likely not communicated to the team. NP #1 said she reviewed Resident #141's notes and it did not appear as though the recommendations were relayed to the team. During an interview on 4/2/25 at 9:11 A.M., the Director of Nursing said that recommendations made by specialists during appointments are supposed to be communicated by nursing staff to the NP or on-call provider to ensure the interventions are implemented.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to ensure treatments related to pressure ulcers were implemented per the physicians orders for one Resident (#21) out of a total of 33 sampled residents. Specifically, the facility failed to a.) ensure Resident #21's air mattress was at the correct setting and b.) ensure the Wound Physician's treatment orders were implemented. Findings include: Review of the Monitoring and Staging policy dated January 2023 indicated: Residents will receive appropriate treatment for pressure ulcers until healed. The Wound Care Coordinator or licensed nurse that is responsible for the wound care will examine wounds weekly to assess and document findings. Resident #21 was admitted to the facility in June 2017 with diagnoses including unspecified dementia and hypercholesterolemia. Review of the Minimum Data Set Assessment (MDS), dated [DATE] indicated Resident was severely cognitively impaired and required assistance with bathing and transfers. The MDS also indicated Resident #21 had two Stage III pressure injuries. a. On 3/31/25 at 8:22 A.M. the surveyor observed Resident #21 resting in bed on an air mattress set at 350 lbs. Resident #21 was unable to participate in the interview process due to his/her cognition. Review of Resident #21's physicians orders indicated: Low air loss mattress: check setting closest to resident's current weight and mattress functionality every shift for monitoring setting 150, initiated 8/31/23. On 4/1/25 at 7:17 A.M., the surveyor observed Resident #21 resting in bed on an air mattress set at 210 lbs. Review of Resident #21's most recent weight documented on 3/28/25 indicated he/she weighed 144 lbs. Review of Resident #21's care plans indicated: Focus: Resident is at risk for skin breakdown due to decreased mobility, incontinence and diabetes. Air Mattress in use, initiated 11/29/23. Interventions: Low air mattress as ordered. Check settings and function every shift. Skin checks with am/pm care - CNA's to report any red or open areas promptly to nurse. Focus: Resident has stage 3 pressure ulcers on the sacrum, initiated 1/31/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: Administer treatments as ordered and monitor for effectiveness. Low air loss mattress: check setting closest to resident's current weight and mattress functionality, (2/18/25) During an interview on 4/2/25 at 9:04 A.M., The Director of Nursing (DON) said that air mattress settings should be followed as ordered by the physician. b. Review of the Wound Physician Note dated 2/5/25 indicated the following treatment recommendations: Alginate calcium apply every two days for 16 days; Skin sub application (complete) apply once weekly for: DO NOT REMOVE or disturb the wound bed. Change the secondary dressing(s) with care as per the recommendations. The skin substitute graft will be re-evaluated by the wound physician during the indicated next visit.; Oil emulsion apply once weekly for. Gauze sponge non-sterile apply every two days; Gauze island w/ bdr apply every two days. Review of Resident #21's Treatment Administration Record (TAR), dated 2/5/25 to 2/10/25, indicated the following treatment was documented as implemented: - Wash Sacrum wound with NS (normal saline) Pat dry, apply Alginate Calcium and cover with border gauze dressing. every day shift for wound care, (initiated 1/25/25 and discontinued 2/10/25). Review of Resident #21's medical record failed to indicate that the Wound Physician's treatment recommendation made on 2/5/25 was ever addressed or implemented. Review of the Wound Physician notes dated 2/12/25, 2/19/25, and 2/26/25 indicated the following treatment recommendations: Alginate calcium apply every two days; Oil emulsion apply once weekly; Skin sub application apply once weekly: DO NOT REMOVE or disturb the wound bed. Change the secondary dressing(s) with care as per the recommendations. The skin substitute graft will be re-evaluated by the wound physician during the indicated next visit. Gauze sponge non-sterile apply every two days; Gauze island w/ bdr apply every two days. Review of Resident #21's TAR's, dated 2/12/25 to 3/4/25, indicated the following treatment was documented as implemented: - Wash Sacrum wound with NS Pat dry, apply Alginate Calcium and skin sub application and oil emulsion, gauze sponge, and cover with border gauze dressing. every day shift for wound care, (initiated 2/10/25 and discontinued 3/18/25). Review of Resident #21's medical record failed to indicate that the Wound Physician's treatment recommendations made on 2/12/25, 2/19/25, and 2/26/25 were ever addressed or implemented. Review of the Wound Physician's notes dated 3/5/25 and 3/12/25 indicated the following treatment recommendations: Hydrogel gel apply once daily. Gauze sponge non-sterile apply once daily; Gauze island w/ bdr apply once daily. Review of Resident #21's TAR dated 3/5/25 to 3/18/25, indicated the following treatment was documented as implemented: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Wash Sacrum wound with NS Pat dry, apply Alginate Calcium and skin sub application and oil emulsion, gauze sponge, and cover with border gauze dressing. every day shift for wound care, (initiated 2/10/25 and discontinued 3/18/25). Review of Resident #21's medical record indicated that the Wound Physician's treatment recommendations made on 3/5/25 and 3/12/25 were not implemented until 3/18/25. During an interview on 4/1/25 at 1:17 P.M., Nurse #4 said that the Wound Physician rounds with nursing staff and will alert the nurse about treatment recommendations. Nurse #4 said the nurse then alerts the attending physician, and then will update the treatment orders in the record. Nurse #4 did not say that attending physicians declined. During an interviews on 4/2/25 at 9:04 A.M., and 4/3/25 at 10:17 A.M. The DON said that attending physicians defer to the Wound Physician have not disagreed with the treatment orders indicated in the Wound Physician notes. The DON said that the Wound Physician completes her rounds and then will alert nursing about treatment changes. The DON said that nurses are then responsible to update the clinical record of the orders.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interviews, the facility failed to implement OT (Occupational Therapy) recommendations for one Resident (#77) out of a sample of 33 Residents. Specifically, the facility failed to implement a functional maintenance program after the Resident was discharged from OT. Findings include: Resident #77 was admitted to the facility in July 2020 with diagnoses including hemiplegia and hemiparesis. A review of the most recent Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 4 out of a possible 15 indicating severe cognitive impairment. Further review of the MDS indicated impairment on both sides of the upper extremities. On 3/31/25 at 8:45 A.M., and 1:27 P.M., the Surveyor observed Resident #77 lying in bed. The right-hand fingers were in a balled fist. Resident #77 did not have any orthotic device in the right hand. On 4/1/25 at 7:54 A.M., the Surveyor observed Resident #77 lying in bed. The right-hand fingers were in a balled fist. Resident #77 did not have any orthotic device in the right hand. On 4/1/25 at 5:28 P.M., the Surveyor observed Resident #77 lying in bed. The right-hand fingers were in a balled fist. Resident #77 did not have any orthotic device in the right hand. Review of the OT discharge summary with dates of service 6/18/24-9/6/24 indicated the following: - Diagnosis-contracture of muscle, right hand. - Discharge recommendations and status: - Restorative program established/trained = restorative splint and brace program. Splint and brace program established/trained: wear right hand roll as tolerated, remove for hygiene and care. - Functional maintenance program established/trained = Splint and Brace Program. Splint and brace program=Established/trained: wear right hand roll as tolerated, remove for hygiene and care. - Prognosis-to maintain current level of function = good with staff follow through. During an interview and record review on 4/2/25 at 10:53 A.M., Unit Manager #1 said when Residents are discharged from OT with recommendations, the staff from OT meet with the Nurse to communicate the recommendations. Unit Manager #1 reviewed the physician's orders. The physician's orders failed to indicate that the recommendations from OT were transcribed after the resident was discharged from therapy. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/25 at 10:53 A.M., the Director of Nurses said after discharge from OT, the OT staff are supposed to communicate any recommendations made for residents from therapy so that the Nurses and Certified Nurse's Assistants can continue the functional maintenance program. During a telephone interview on 4/2/25 at 11:13 A.M., the Director of Rehabilitation (DOR) services said that Resident # 77's functional maintenance program should have continued after the Resident discharged from OT. The DOR said that OT staff should communicate recommendations to Nursing staff after residents are discharged from OT. The DOR said the facility does not keep a record of residents on a functional maintenance program on the units. The DOR said after a resident is discharged from OT, the discharging therapist documents training a Nurse in the discharge recommendations. The DOR said the Nurse is then expected to add a physician's order in the medical record so that the recommendations can be implemented on the Unit.

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F 0689 Level of Harm - Minimal harm or potential for 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** 45984 Based on observation, record review, and interview, the facility failed to ensure it provided an environment free of potential safety hazards for two Residents (#3 and #155) out of a total sample of 33 residents. Specifically, 1. For Resident #3, the facility failed to investigate and assess the Resident after sustaining a fall resulting in a left ankle fracture. 2. For Resident #155, the facility failed to attempt to reapply his/her wandergaurd bracelet after multiple days of it not being on the Resident. Findings include: Review of the facility policy titled Accident and Incidents dated and revised October 2022, indicated the following: Process- The following data, as applicable, shall be included on the Incident/Accident report form: a. The date and time the incident/accident took place; b. The nature of the injury/accident (bruise, fall, skin tear, new pressure ulcer); c. The circumstances surrounding the incident/accident; d. Where the accident/ incident took place; e. The name (s) of witnesses if incident/accident observed; f. The resident or victim's account if applicable; g. Exactly what was observed or heard regarding the accident/incident; h. The time the resident's Attending Physician was notified, as well as the time the physician responded and his or her instructions; i. The date/time the resident's family was notified and by whom; j. The condition of the resident and his/her vital signs; k. Type of injury; diagram location of injury; l. If first aid was administered; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	m. The disposition of the resident (transferred to hospital, put in bed). If employee (sent home, sent to physician, returned to work, etc.); n. Any corrective actions taken or interventions immediately put in place to prevent further incident; o. Other pertinent data, to include health status information. p. Follow-up information; q. The signature and title of the person completing the report Incident/Accident Statement Form, by RN Supervisor, Charge Nurse, Manager; a. How did you learn of incident/accident; Actions taken; c. List of nursing staff caring for the resident at the time of the incident and one shift prior d. Resident statement of incident/accident if applicable e. Was the physician and family notified f. Any witnesses (list the names) and was statement completed on the Incident/Accident Form Involved Party Statement Reporting: 1. If the resident has sustained any suspected or actual significant injury, is sent to the hospital or abuse is suspected, the supervisor/manager must notify immediately the Administrator/Director of Nurses 2. The nurse Supervisor shall ensure that incident and accident packet is complete and submit the original to the Director of Nursing 5. DON and Admin are responsible to review incident/investigation and conclusion to determine if incident requires reporting to outside agencies 1. Resident #3 was admitted to the facility in April 2023 with diagnoses including schizoaffective disorder and cerebral palsy. Review of Resident #3's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident has a Brief Interview for Mental Status score of 12 out of 15 indicating moderate cognitive impairment. Further review of the MDS indicated that the Resident requires assistance from staff with activities of daily living and transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing progress notes indicated the following: - Dated 7/5/24 at 10:23 A.M.: Patient found on the floor with suspected left ankle fracture, he/she is on blood thinners. Called and sent patient to ED (emergency department), NP (nurse practitioner) made aware, family member contacted. - Dated 7/6/25 at 6:04 A.M.: Pt. (patient) transferred back to facility at 2:00 am with left ankle Trimalleolar fracture. During a telephone interview on 4/1/25 at 9:08 A.M., Resident #3's Health Care Proxy (HCP) said the Resident had a fall in July and broke his/her ankle. The HCP said staff just found him/her on the floor and called her. Review of Resident #3's hospital discharge paperwork, dated 7/5/24, indicated the following: - Reason for visit: fall - Diagnoses: Trimalleolar fracture of ankle, closed, left, initial encounter. - XR (X-ray) ankle (left): Ankle: Trimalleolar fracture with lateral displacement of the distal fracture fragment. Review of Resident #3's care plans indicated the following: - Focus: Resident is at risk for injuries related to hx (history) of falls, impaired mobility - dated 1/14/24 - Interventions: Patient sent out to emergency department for evaluation - dated 7/5/24, Re-educated patient to ask for assistance before any ambulation or transfers - dated 7/12/24. Review of Resident #3's medical record failed to indicate that a post-fall evaluation was completed. The surveyor asked for the full investigation/incident report for the fall and the facility was unable to provide one. During an interview on 4/1/25 at 11:08 A.M., Nurse #6 said she remembers that Resident #3 had a fall and fractured his/her ankle in July but she does not remember what happened. During an interview on 4/1/25 at 11:12 A.M., Unit Manager #2 said he was not working in the facility when Resident #3 fell but he heard that the Resident fractured his/her ankle. During an interview on 4/1/25 at 12:05 P.M., the Director of Nursing (DON) said when a resident has any incident it must be reported to the Medical Doctor or Nurse Practitioner and the Resident's HCP. The DON said a fall evaluation should be done after a resident has a fall and a full investigation including staff witness statements should be done. The DON said she was not aware an investigation or post-fall evaluation was completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	43846 2. Review of the facility policy titled Elopement Prevention, dated 10/22, indicated The facility maintains a process to assess all residents for risk for elopement, implement prevention strategies for those identified as an elopement risk, institute measures for resident identification at the time of admission, and conduct a missing resident procedure. Elopement is the ability of a resident who is not capable of protecting himself and herself from harm to successfully leave the facility unsupervised and unnoticed an who may enter into harm's way. Wandering refers to a cognitively-impaired resident's ability to move about inside the facility aimlessly and without an appreciation of personal safety needs and who may enter into a dangerous situation. a. Wander Bracelet - i. Initiate wander bracelet for resident that is deemed at risk for elopement iv. Resident who refuses to wear a bracelet will be assessed by the interdisciplinary team and determine alternate placement site options. v. Wander bracelet should be checked frequently for proper placement and document on MAR/EMAR. vii. Facility should check wander bracelet on resident's wrist or ankle, obtain another wander bracelet and reapply as applicable. Resident #155 was admitted to the facility in June 2024 with diagnoses that include cerebral infarction, aphasia, dysphagia and depression. Review of Resident #155's most recent Minimum Date Set (MDS), dated [DATE], indicated he/she was assessed by nursing staff to have moderate cognitive impairments. On 4/1/25 from 8:01 A.M. to 8:08 A.M., the surveyor observed Resident #155 wandering the unit up and down halls and by the elevator multiple times. Staff were observed to be passing meal trays. The units wanderguard system was not triggered when the Resident walked by the elevator. On 4/2/25 at 7:27 A.M., the surveyor observed Resident #155 wandering the unit and walking by the unit elevator. The units wanderguard system was not triggered when the Resident walked by the elevator. Nursing staff were giving other residents care and the unit nurses were preparing medications. Review of Resident #155's elopement care plan, dated 8/7/24, indicated Wanderguard was placed on residents lower left ankle. Resident continues to remove his/her wanderguard. Review of Resident #155's nursing progress notes, dated 3/18/25, 3/19/25, 3/22/25, 3/23/25, 3/25/25, 3/26/25, 3/28/25, 3/31/25, indicated Note Text: Wandergaurd off. Review of Resident #155's Nurse Practitioner progress note, dated 3/24/25, indicated he/she lacks safety awareness and remains an elopement risk. Review of Resident #155's Elopement Evaluation, dated 2/6/25, indicated he/she scored a 5 indicating the Resident is an elopement risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #155's physician order dated 7/19/24, indicated check placement and function for wanderguard to LLE (left lower extremity) every shift for elopement risk. Review of Resident #155's nursing progress notes from 3/5/25 through 4/1/25 failed to indicate any attempts were made to replace the wanderguard on the Resident. During an interview on 4/2/25 at 7:21 A.M., Nurse #4 said nursing staff should attempt to replace the wanderguard every shift and document the outcome in a nursing progress note. Nurse #4 said she is not sure when the last time staff attempted to replace the wanderguard on Resident #155. Nurse #4 said the wanderguard has not been on the Resident for a long time and the Resident does wander about the unit. During an interview on 4/2/25 at 9:16 A.M., the Director of Nursing (DON) said the Resident is known to remove his/her wandergaurd all the time and does not have another intervention in place if he/she does remove it. The DON said staff should be attempting to re-apply the wanderguard and document the results in a progress note. The DON said the facility staff should reassess the resident for new interventions but has not.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review, and interviews, the facility failed to provide care and services consistent with professional standards of practice for two Residents (#17 and #122) who required renal dialysis (a life sustaining treatment that helps the body remove extra fluids and waste products from the blood when the kidneys are not able to) out of a total sample of 33 residents. Specifically, 1. For Resident #17, the facility failed to ensure nursing staff documented they obtained blood pressures from his/her arm with the AV (arteriovenous fistula, is when an artery and vein connect directly, allowing blood to flow) fistula. 2. For Resident #122, the facility failed to a. ensure nursing staff documented they obtained blood pressures from his/her arm with the AV (arteriovenous fistula, is when an artery and vein connect directly, allowing blood to flow) fistula and b. maintain an updated dialysis communication book between the facility and the dialysis clinic. Findings include: Review of the facility policy titled Dialysis Management dated and revised October 2022, indicated the following: - Residents receiving Hemodialysis treatments will be assessed and monitored to ensure quality of life and well-being. - Facility will establish open communication with the Resident's Dialysis Center utilizing a Dialysis Communication Book completing the Dialysis Communication Form. - On return from the Dialysis Center, the nurse will review the communication returning from the Dialysis Center. The Nurse should review specifically, pre and post vital signs, treatment tolerance, any meds given and any new orders for resident care. 1. Resident #17 was admitted to the facility in November 2023 with diagnoses that included end stage renal disease, dependence on renal dialysis, mood disorder, and insomnia. Review of Resident #17's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairments. Further review of the MDS indicated he/she is dependent on dialysis. Review of Resident #17's physician order, dated 2/20/25, indicated No blood pressures or blood draws in left arm every shift for Left Arm AV Fistula. Review of Resident #17's most recent documented blood pressures (BPs) indicated : - 11/7/24 132 / 72 mmHg (millimeters of mercury) Sitting l/arm (left/arm) - 10/20/24 137 / 68 mmHg Sitting l/arm (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 10/18/24 130 / 70 mmHg Standing l/arm - 10/18/24 136 / 73 mmHg Sitting l/arm - 10/17/24 130 / 76 mmHg Standing l/arm - 10/17/24 130 / 76 mmHg Standing l/arm - 10/15/24 134 / 76 mmHg Standing l/arm - 10/15/24 132 / 82 mmHg Lying l/arm - 10/14/24 134 / 76 mmHg Sitting l/arm - 10/12/24 123 / 75 mmHg Standing l/arm - 10/12/24 123 / 76 mmHg Sitting l/arm - 10/12/24 133 / 78 mmHg Sitting l/arm - 10/9/24 138 / 74 mmHg Sitting l/arm - 10/9/24 130 / 70 mmHg Lying l/arm Review of the Nurse Practitioner's progress note, dated 8/31/24, indicated: Patient with past medical history significant for end-stage renal disease on dialysis with LUE AV fistula. Review of Resident #17's skin check, dated 9/2/24, indicated Skin note: dialysis port on left arm. Both sites are clean and dry. Review of Resident #17's dialysis care plan, dated 4/8/24, indicated Protect access site from injury. Site: Left AV fistula Avoid constriction on affected arm, such as carrying purse and constrictive clothing No BP on limb with shunt/ CV dialysis catheter. During an interview on 4/2/25 at 7:27 A.M., Nurse #4 said nurses should not be documenting the left arm, staff only take the BP on the right arm for Resident #17. During an interview on 4/2/25 at 9:14 A.M., the Director of Nurses (DON) said the expectation is that nursing staff document the BP in the right arm for Resident #17 45984 2. Review of Resident #122's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 15 out of 15 indicating intact cognition. Further review of the MDS indicated that the Resident receives dialysis. a. Review of Resident #122's physician's orders indicated the following: (continued on next page)

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Highland Park Rehabilitation and Healthcare Center	255 Central Avenue Chelsea, MA 02150

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dated 8/31/23: Monitor shunt functions. Site: left arm - Dated 1/28/25: ***AV Fistula located in L (left) arm. NO BP (blood pressure) in left arm*** every shift related to chronic kidney disease. Review of Resident #122's hemodialysis care plan, dated and revised 1/31/25, indicated the following interventions: - Dated 10/23/23: Do not draw blood or tale BP in left arm - Dated 3/7/25: AV fistula L arm, No Blood pressures/blood draws to L arm. Review of Resident #122's Kardex (a document describing the type of a care a resident requires) indicated the following: Resident Care - AV fistula L arm, No blood pressures/blood draws to L (left) arm Review of Resident #122's Blood Pressure vitals indicated that the Resident had his/her blood pressure taken on his/her left arm (where the dialysis fistula is located) 45 times since the 1/28/25 physician's order was implemented. During an interview on 4/2/25 at 12:03 P.M., Unit Manager #2 said staff should not be taking Resident #122's blood pressure on his/her left arm where his/her dialysis fistula is located. During an interview on 4/2/25 at approximately 12:30 P.M., the Director of Nursing (DON) said staff should not be taking Resident #122's blood pressure in his/her left arm. b. Review of Resident #122's physician's order dated 9/23/24 indicated the following: Resident to attend dialysis 3 times a week on M-W-F (Monday, Wednesday, Friday). Pick up time at 11:45am in lobby. During an interview on 3/31/25 at 10:03 A.M., Resident #122 said he/she stopped taking his/her communication book because staff do not give it to him/her when he/she leaves. Review of Resident #122's Dialysis Communication book indicated 11 documentations of the Resident going to dialysis treatment since 8/2/24. Review of Resident #122's hemodialysis care plan, dated and revised 1/31/25, failed to indicate that the Resident refuses to take his/her dialysis communication book with him/her. Review of Resident #122's nursing progress note, dated 3/31/25 at 2:42 P.M., indicated the following: Resident refused dialysis book prior to leaving for dialysis today. Nurse Practitioner aware-No new orders at this time. Review of Resident #122's medical record failed to indicate any other documentation that the Resident refuses to take his/her communication book with him/her to dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/25 at 12:03 P.M., Unit Manager #2 said the facility uses a dialysis book to communicate between the facility and the dialysis center. Unit Manager #2 said Resident #122 refuses to take his/her book with him. Unit Manager #2 said he should be documenting that Resident #122 refuses to take the book with him/her and it should be in his/her care plan. During an interview on 4/2/25 at approximately 12:30 P.M., the Director of Nursing (DON) said staff should be documenting that Resident #122 refuses to take his/her dialysis communication book to dialysis and the facility should be communicating in some way with the dialysis facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on record review and interview the facility failed to ensure monthly Medication Regimen Review (MRR) recommendations made by the consulting pharmacist were addressed timely for three Residents (#21, #68, and #3) out of five residents reviewed, out of a total sample of 33 residents. Findings include: 1. Resident #21 was admitted to the facility in June 2017 and has diagnoses that include, but are not limited to, unspecified dementia with other behavioral disturbance, and Type 2 Diabetes Mellitus with diabetic neuropathy. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/5/25, indicated Resident #21 had a staff assessment for mental status completed indicating he/she as having a moderately impaired cognition and is dependent for daily care activities. Further review of the MDS indicated Resident #21 is administered medications in the high-risk drug classes. Review of Resident #21's medical record indicated the consulting pharmacist monthly MRR, dated 8/27/24, 9/23/24, and 10/28/24, recommended an A1C f/u. (An A1C is a blood test that measures the average blood glucose levels. It is used to monitor how well diabetes plans are working). Record review indicated a laboratory report, dated 10/28/25, with an A1C of 7.5 (high) was obtained 63 days after the pharmacist made the recommendation to follow up with an A1C. During an interview on 4/1/25 at 2:19 P.M., Nurse #4 said the pharmacy recommendations are sent to the Director of Nursing, reviewed with the doctor, and then followed through or a reason is given by the doctor if they do not agree with the recommendation. Nurse #4 said the recommendation to get an A1C for Resident #21 is because he/she is diabetic. Nurse #4 reviewed the record and said the only lab result was dated 10/28/25 and she did not know why the recommendation was not followed up on. 2. Resident #68 was admitted to the facility in October 2018 and has diagnoses that include, but are not limited to, unspecified dementia, type 2 diabetes mellitus, acute kidney failure, unspecified protein calorie malnutrition and hyperlipidemia. Review of Resident #68's MDS, dated [DATE], indicated Resident #68 as having severe cognitive impairment and as dependent on staff for most daily care activities. Review of Resident #68's medical record indicated the consulting pharmacist monthly MRR, dated 10/28/24, 11/25/24, 12/23/24 1/27/25 and 2/24/25, indicated 'nursing rec for BMP CBC f/u'. (A BMP CBC is a blood test that measures amounts and sizes of red blood cells, hemoglobin, white blood cells, and platelets. Providers use it to diagnose and monitor medial conditions). Further review of Resident #68's medical record indicated results of a BMP CBC, dated 2/28/25, which was completed four months after the pharmacist made the first recommendation for a BMP CBC. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/1/25 at 2:19 P.M., Nurse #4 said the pharmacy recommendations are sent to the Director of Nursing, reviewed with the doctor, and then followed through or a reason is given by the doctor if they do not agree with the recommendation. Nurse #4 said Resident #68 had been on hospice care and that she did not know if that was why the recommendation for labs were not followed. During an interview on 4/2/25 at 8:31 A.M., and 11:10 A.M., Regional Nurse #1 said her review of the medical record and pharmacy binder in the DON's office did not indicate why the recommendations for obtaining laboratory values for Resident #21 and Resident #68 were not completed. Regional Nurse #1 said the pharmacy recommendations should be followed up timely and/or include why they may not have been implemented. 45984 3. Resident #3 was admitted to the facility in April 2023 with diagnoses including schizoaffective disorder and cerebral palsy. Review of Resident #3's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident has a Brief Interview for Mental Status score of 12 out of 15 indicating moderate cognitive impairment. Review of Resident #3's medical record indicated the consulting pharmacist monthly MRR, dated 11/26/24, 12/23/24, 1/27/25 and 2/24/25, indicated the following: Rec (Recommend) Nursing: lipids, A1C (An A1C is a blood test that measures the average blood glucose levels. It is used to monitor how well diabetes plans are working). Review of Resident #3's lab results history indicated that the Resident had his/her lipid panel and A1C values obtained on 3/5/25, over three months after the pharmacist made the initial recommendation. During an interview on 4/1/25 at 2:19 P.M., Nurse #4 said the pharmacy recommendations are sent to the Director of Nursing, reviewed with the doctor, and then followed through or a reason is given by the doctor if they do not agree with the recommendation. During an interview on 4/1/25 at 12:05 A.M., the Director of Nursing (DON) said when the pharmacist makes recommendations they should be acknowledged immediately and then sent to the physician for approval/disapproval and then get implemented right away. The DON said Resident #3's pharmacy recommendations should have been done sooner.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48990 Based on observations and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal laws. Specifically, the facility failed to ensure treatment carts were locked when unattended. Findings include: Review of the facility policy titled 'Medication Storeage [sic]', revised October 2022, indicated: - With the exception of Emergency Drug Kits, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined in the facility policy. On 3/31/25 at 8:48 A.M., the surveyor observed the sixth floor treatment cart was unlocked without any staff within view of the treatment cart. The surveyor opened the treatment cart and observed multiple prescription ointments and biologicals within this treatment cart. During an interview on 3/31/25 at 8:50 A.M., Nurse #1 said the treatment cart should be have been locked when unattended but was not. On 4/1/25 at 7:04 A.M., the surveyor observed the sixth floor treatment cart was unlocked without any staff within view of the treatment cart. The surveyor opened the treatment cart and observed multiple prescription ointments and biologicals within this treatment cart. During an interview on 4/1/25 at 7:06 A.M., Nurse #2 said the treatment cart should be have been locked when unattended but was not. During an interview on 4/1/25 at 11:28 A.M., the Director of Nursing (DON) said treatment carts should be locked when unattended by the nurse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43807 Based on observations, record review and interview, the facility failed to ensure staff maintained an accurate medical record for three Residents (#77, #146, and #122) out of a sample of 33 residents. Specifically: 1. For Resident #77, the facility inaccurately documented that a left palm guard was applied. 2. For Resident #146, the facility documented that staff unwrapped ace wraps on the Resident's legs on days they did not wrap the Resident's legs. 3. For Resident #122, the facility failed to provide an appropriate and accurate diagnosis for the use of a psychotropic medication. Findings include: 1. Resident #77 was admitted to the facility in July 2020 with diagnoses including hemiplegia and hemiparesis. A review of the most recent Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 4 out of a possible 15 indicating severe cognitive impairment. Further review of the MDS indicated impairment on both sides of the upper extremities. On 3/31/25 at 8:45 A.M., and 1:27 P.M., the Surveyor observed Resident #77 lying in bed. The left-hand fingers were in a balled fist. Resident #77 did not have a palm guard in his/her left hand. On 4/1/25 at 7:54 A.M., the Surveyor observed Resident #77 lying in bed. The left-hand fingers were in a balled fist. Resident #77 did not have a palm guard in his/her left hand. On 4/1/25 at 5:28 P.M., the Surveyor observed Resident #77 lying in bed. The left-hand fingers were in a balled fist. Resident #77 did not have a palm guard in his/her left hand. A review of Resident #77's April 2024 physician's orders indicated the following: - Left palm guard: DON during AM care, DOFF for hygiene and skin assessment as tolerated every shift. Order date, 8/31/23. A review of Resident #77's March 2025 Treatment Administration Record (TAR) indicated that staff signed off that they applied the left palm guard on the following shift: - Day shift on 3/31/25. A review of Resident #77's April 2025 TAR indicated that staff signed off that they applied the left palm guard on the following shift: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Day and evening shift on 4/1/25. During an interview on 4/2/25 at 7:19 A.M., Resident #77 said he/she has not worn the palm guard in a few weeks. He/she said he/she needs help from staff to put on the palm guard. During an interview and observation on 4/2/25 at 7:24 A.M., Unit Manager #1 said Resident #77's palm guard got lost when it was sent to the laundry room. She said staff should document accurately in the medical record. During an interview on 4/2/25 at 8:39 A.M., the Director of Nurses said staff should not be documenting that the Resident is wearing a palm guard when he/she is not. She said staff should document in the medical record accurately. 2. Resident #146 was admitted to the facility in August 2024 with diagnoses including edema. A review of the most recent Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15 indicating intact cognition. During an interview of 3/31/25 at 8:18 A.M., Resident #146 said he/she has edema in his/her legs. He/she said both his/her legs should be wrapped daily in the morning and unwrapped in the evening. Resident #146 said his/legs are not wrapped daily. A review of Resident #146's April 2025 physician's orders indicated the following: -Ace wrap to BLE (Bilateral Lower Extremity) apply daily in AM (morning), off at HS (at bedtime) one time a day. Apply Ace wrap daily and remove at bedtime. Order date, 9/18/24. Review of Resident #146's March 2025 Treatment Administration Record (TAR) failed to indicate nursing documented the physician's order to Ace wrap daily and remove at bedtime as completed on the following time and dates: - At 6:00 AM: on 3/2/25, 3/4/25, 3/5/25, 3/7/25, 3/9/25, 3/10/25, 3/12/25, 3/19/25, 3/21/25, 3/23/25, 3/24/25, 3/26/25, and 3/28/25. Review of Resident #146's March 2025 TAR indicated that the ace wraps were unwrapped on the following time and dates: - At 8:00PM: on 3/2/25, 3/4/25, 3/5/25, 3/9/25, 3/10/25, 3/12/25, 3/19/25, 3/21/25, 3/23/25, 3/24/25, 3/26/25, and 3/28/25. During an interview and record review on 4/2/25 at 7:12A.M., Unit Manager #1 said since the Nurse did not wrap the Resident's legs in the morning, there would be no ace wraps to unwrap in the evening. She said Nurses should document accurately in the medical record. During an interview and record review on 4/2/25 at 8:29 A.M., the Director of Nursing said nurses should document accurately in the medical record. She said nurses should not document unwrapping ace wraps at night when they did not wrap them in the morning. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45984 3. Resident #3 was admitted to the facility in April 2023 with diagnoses including schizoaffective disorder and cerebral palsy. Review of Resident #3's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident has a Brief Interview for Mental Status score of 12 out of 15 indicating moderate cognitive impairment. Review of Resident #3's physician's orders indicated the following: - Dated 8/16/24: Olanzapine (a psychotropic medication used for schizophrenia) Oral Tablet 5 MG (milligrams) Give 5 mg by mouth two times a day for psych. - Dated 2/13/25: Olanzapine Oral Tablet 5 MG (milligrams) Give 1 tablet by mouth at bedtime for psych. Review of Resident #3's care plan, dated and revised 2/11/25, indicated the following: - Focus: Psychotropic: Psychotropic drug use related to diagnosis of: schizoaffective disorder. During an interview on 4/1/25 at 11:19 A.M., Unit Manager #2 said he was the one who put the order in with a diagnosis of psych. He continued to say Resident #3 has psych symptoms and diagnoses, so he just put it in like that. During an interview on 4/1/25 at 12:05 P.M., the Director of Nursing (DON) said all physician's orders should have an accurate diagnosis. The DON said Resident #3's order for Olanzapine should not say it is used for psych.

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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. 45984 Based on observations, record review, and interviews the facility failed to implement the infection prevention and control program. Specifically: 1. The facility failed to implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting of infections, communicable diseases and outbreaks among residents and staff. 2. The facility failed to ensure staff appropriately donned (put on) a precaution gown while performing wound care for a Resident on enhanced barrier precautions (EBP). 3. The facility failed to ensure staff performed appropriate hand hygiene after removing gloves during wound care. Findings include: 1. Review of the facility policy titled Infection Control - surveillance, revised and dated February 2023, indicated the following: - The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections. - Infections that will be included in routine surveillance include those with: a. Evidence of transmissibility in a healthcare environment b. Available processes and procedures that prevent or reduce the spread of infection c. clinically significant morbidity or mortality associated with infection d. Pathogens associated with serious outbreaks Data Collection and Recording: - For Residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: a. Identifying information b. diagnoses c. admitted , date of onset of infection (may list onset symptoms) d. Infection site (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Pathogens f. Invasive procedures or risk factors g. Pertinent remarks h. Treatment measures and precautions Review of the facility's Facility Assessment, dated 3/20/25, indicated the following: - The IP will gather data for infection tracking & reporting and provide consultation and education as needed. - The IP or designee will monitor the residents with infections and/or potential infections by completing the Monthly Infection Report by Unit. - The IP will review the infection report monthly for trends and new bacteria in the facility. Review of the facility's binder titled Infection Control Line Listings provided by the Director of Nursing who is also the Infection Preventionist (IP) indicated documents titled Monthly Infection Control Log (Line List) for the months of December 2023, January 2024, February 2024 and March 2024. Each Monthly Line Listing indicated Residents with infections, Resident location, type of infection, body site, date of infection onset, the type of organism, antibiotic information with start/stop dates, classification and resolved date - of which, some sections were completed and others were left blank. The Infection Control Line Listing Binder did not contain any Infection Control Surveillance information after March 2024. During an interview on 4/2/25 at 10:57 A.M., the Director of Nursing (DON), who is also the IP, said there is another IP in the facility who should be competing monthly surveillance, but they are not in the building today. The DON said she was unable to find any updated surveillance information relating to infection control, but it should have been completed to track the infections in the building. When the surveyor asked about the infection control surveillance binder the DON said she doesn't know much about it and she found it in the facility's former Administrator's office and does not know who completed it back in March 2024. 48990 2. Review of the facility policy titled Enhanced Barrier Precautions, dated 4/1/2024, indicated, but was not limited to the following: - Enhanced Barrier Precautions is applicable for residents with any of the following: Wounds. - EBP requires wearing disposable gloves and an isolation gown prior to high contact activity. - High contact resident care activities include: wound care: any skin opening requiring a dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of sign titled 'Enhanced Barrier Precautions', which is posted at the room entrance door for residents on enhanced barrier precautions, indicated, but was not limited to: - Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities: wound care: any skin opening requiring a dressing. On 4/1/25 at 9:43 A.M., the surveyor observed Nurse #3 and Unit Manager #1 perform wound dressing change for a Resident with one unstageable pressure ulcer and one stage two pressure ulcer. Certified Nurse Assistant (CNA) #2 assisted with repositioning during this wound care. There was a sign at the Resident's doorway indicating the Resident titled 'Enhanced Barrier Precautions' indicating staff must wear gloves and precaution gowns during wound care. Nurse #3, Unit Manager #1, and CNA #2 all wore gloves, but did not wear precaution gowns during the entire duration of both wound dressing changes. During an interview on 4/1/25 at 9:56 A.M., Nurse #3 and Unit Manager #1 said the Resident required enhanced barrier precautions because of his/her pressure ulcers. Nurse #3 and Unit Manager #1 said they should have worn precaution gowns in addition to the gloves but did not. During an interview on 4/1/25 at 11:28 A.M., the Director of Nursing (DON) said precaution gowns, in addition to gloves, are required during wound care for any resident on enhanced barrier precautions. 3. Review of the facility policy titled 'Hand Washing', revised December 2019, indicated, but was not limited to the following: 6. Use an alcohol-based hand rub, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: after removing gloves. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. a. Perform hand hygiene before and after glove use. Review of the facility policy titled 'Non-sterile Dressing Change', revised January 2023, indicated, but was not limited to the following: - Procedure: Remove soiled dressing: place it in the trash bag. Remove gloves, wash hands, apply new gloves. - Procedure: Clean wound with normal saline or prescribed cleanser. Pat the tissue surrounding the wound dry with 4x4. Remove gloves, wash hands, apply new gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225557	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Rehabilitation and Healthcare Center	255 Central Avenue Chelsea, MA 02150

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/1/25 at 9:43 A.M., the surveyor observed Nurse #3 and Unit Manager #1 perform wound dressing change for a Resident with one unstageable pressure ulcer on right ischium (the lower, back part of your hip bone) and one stage two pressure ulcer on mid back. Nurse #3 wore gloves to cleanse the right ischium pressure ulcer with normal saline. Nurse #3 removed her gloves and did not perform hand hygiene prior to applying a new pair of gloves. Nurse #3 applied hydrogel (a gel used to treat wounds) to right ischium wound bed. Nurse #3 removed her gloves and did not perform hand hygiene prior to applying a new pair of gloves. Nurse #3 applied new dressing to right ischium. Nurse #3 removed her gloves, sanitized her hands, and applied a new pair of gloves and cleansed the mid back pressure ulcer with normal saline. Nurse #3 removed her gloves and did not perform hand hygiene prior to applying a new pair of gloves. Nurse #3 applied hydrogel to mid back wound bed. Nurse #3 removed her gloves and did not perform hand hygiene prior to applying a new pair of gloves. Nurse #3 then applied dressing to mid back. Nurse #3 did not wash or sanitize her hands after removing her gloves four out of five times during this Resident's wound care. During an interview on 4/1/25 at 9:56 A.M., Nurse #3 and Unit Manager #1 said Nurse #3 should have sanitized or washed her hands each time she removed her gloves before applying new gloves but did not. During an interview on 4/1/25 at 11:28 A.M., the Director of Nursing (DON) said the nurse's hands should have been washed or sanitized every time gloves were removed during wound care.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on record review and interview, the facility failed to provide the pneumococcal and influenza vaccinations to two Residents (#121 and #4) out of five sampled residents. Findings include: Review of the policy titled Pneumococcal Vaccination, revised and dated February 2023, indicated the following: - All residents will be offered pneumococcal vccines to aid in preventing pneumonia/pneumococcal infections. - This facility will offer pneumococcal to all admitted residdnts [AGE] years of age and older unless such resident has already received the vaccination, is not in need of a booster, or is a person for whom is it medically contraindicated. - The ACIP standard of care for pneumococcal vaccination of adults is that both pneumococcal conjugate vaccine (PCV13) and pneumococcal polysaccharide vaccine (PPSV23) be routinely administered to all adults aged [AGE] years and older, according to the schedule described below. - Adults aged [AGE] years or older should first be vaccinated with PACV14 and then be vaccinated with PPSV23 at least 1 year later. - Adults [AGE] years of age of older who had previously received PPSV23, should receive a dose of PCV13 at least 1 year after the first dose. - If a patient has previously received PPSV23 is one year. Review of the facility policy titled Influenza Vaccination, revised and dated August 2020, indicuated the following: - Influenza vaccination is the primary method for preventing influenza and its severe complications. Therefore, vaccination against influenza will be offered to residents of this facility. - All persons, upon admission to long term care programs, shall be assessed for recent and past flu vaccinations. - The influenza vaccine shall be administered to residents annually, October 1st through March 31st. - The resident or resident's representative may refuse immunization. - The influenza vaccine may be given at the same time as the pneumococcal vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The healthcare professional administering the vaccine shall obtain a consent form for the influenza vaccination (if required by state law and regulation) from the resident or guardian at the time of admission or anytime afterward before the next influenza season. - All residents shall be routinely vaccinated, except those with medical contraindication(s) to receipt of influenza vaccine (under Standards of Practice or with concurrence of the residents' respective attending physicians), at one time, annually, before the influenza season. Those residents who are admitted during the winter months after completion of the program's vaccination program, will be offered the vaccine at the time of their admission. 1. Resident #121 was admitted to the facility in September 2023 with a diagnosis of dementia. Review of Resident #121's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident did not receive the Influenza vaccine and was not offered it. Review of Resident #121's immunization history in the electronic medical record indicated that the Resident last received his/her Influenza vaccination on 12/14/23 and his/her Pneumococcal PPSV23 vaccination on 8/28/15. Review of Resident #121's Consent form for Pneumococcal and Influenza vaccinations dated 8/27/24 indicated that the Resident consented to receiving both vaccinations. During an interview on 4/2/25 at 9:21 A.M., the Director of Nursing, who is also the Infection Preventionist (IP), said residents should be offered the influenza vaccination each year and the pneumococcal vaccination if they are aged 65 and older and eligible. The IP said she was not sure why Resident #121 did not receive the Influenza and Pneumococcal vaccinations. 2. Resident #4 was admitted to the facility in August 2024 with a diagnosis of dementia and psychosis. Review of Resident #4's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident did not receive his/her Influenza vaccination with no reason indicated. The MDS further indicated that Resident #4's Pneumococcal vaccination is not up to date and he/she was not offered it. Review of Resident #4's immunization history in the electronic medical record indicated that the Resident last received his/her Influenza vaccination on 10/30/23 and did not indicate that he/she received a Pneumococcal vaccination. During an interview on 4/2/25 at 9:21 A.M., the Director of Nursing, who is also the Infection Preventionist (IP), said residents should be offered the influenza vaccination each year and the pneumococcal vaccination if they are aged 65 and older and eligible. The IP said she was not sure why Resident #4 did not receive the Influenza and Pneumococcal vaccinations.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on record review and interview, the facility failed to provide the COVID-19 vaccination to one Resident (#121) out of five sampled residents. Findings include: Review of the facility policy titled Vaccine Administration, revised and dated September 2022, indicatd the following: - It is the goal of the facility to provide the COVID-19 vaccine to all residents and employees in a timely manner. - The facility must offer residents, visitors, and staff vaccination against COVID-19 when vaccine supplies are available to the facility. Resident #121 was admitted to the facility in September 2023 with a diagnosis of dementia. Review of Resident #121's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident is not up to date with his/her COVID-19 vaccination. Review of Resident #121's immunization history in the electronic medical record indicated that the Resident last received his/her COVID -19 booster vaccination on 12/14/22. Review of Resident #121's COVID-19 Vaccination consent form indicated that the Resident consented to receiving the 2023/2024 COVID-19 vaccination on 4/30/24. During an interview on 4/2/25 at 9:21 A.M., the Director of Nursing, who is also the Infection Preventionist (IP), said residents should be offered the COVID-19 vaccination yearly if the Resident consents to receiving it. The IP said she was not sure why Resident #121 did not receive the COVID-19 vaccination for the 2023/[AGE] year.