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	03/05/2026

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 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** Based on observations, interviews, and record review, the facility failed to ensure that services provided met professional standards of practice for five Residents (#182, #7, #127, #20 and #90) out of 37 total sampled residents. Specifically,1. For Resident #182, the facility failed to complete liver function tests and a basic metabolic panel as ordered.2. For Resident #7 the facility failed to ensure weekly skin checks were completed.3. For Resident #127 the facility failed to ensure weekly skin checks were completed.4. For Resident #20 the facility failed to ensure weekly skin checks were completed as indicated in physician's orders.5. For Resident #90 the facility failed to implement a physician treatment order for a cheek wound.Findings include:1. Resident #182 was admitted to the facility in August 2023 with diagnoses including cerebral infarction. 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 or never understood. Review of Resident #182's March 2026 physician's orders indicated the following: Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 Milligrams (Divalproex Sodium), give 4 capsules by mouth three times a day for seizure disorder. Start date 8/11/25. -Valproic acid, BMP (Basic Metabolic Panel) and LFT (Liver Function Tests) every 6 months (February and August) every night shift every 6 month(s) starting on the 1st for 7 day(s) related to hyperlipidemia, 11-7 please complete lab (laboratory) slip and flag for A.M. (morning) draw. Start date 2/1/26. Review of the February and March 2026 Medication Administration Record (MAR) indicated that staff administered Depakote Sprinkles as ordered. Further review of Resident #182's medical record failed to indicate that a BMP and LFT was completed as ordered. During an interview and medical record review on 3/4/26 at 9:16 A.M., Unit Manager #2 reviewed the medical record and said that the LFT and BMP were not completed as ordered. Unit Manager #2 said physician's orders should be followed. During an interview and medical record review on 3/4/26 at 9:57 A.M., the Nurse Practitioner reviewed the medical record and said the February labs had not been completed. The Nurse Practitioner said physician's orders should be followed and Resident refusals should be documented. The Nurse Practitioner said if the Resident refuses labs, the Nurses should notify her and document that information. The Nurse Practitioner said staff have not notified her that the Resident has refused (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	labs. During an interview on 3/4/26 at 12:44 P.M., the Director of Nurses and the Regional Nurse Consultant said that physician's orders should be followed, and the Resident's labs should have been completed as ordered. 2. Resident #7 was admitted to the facility in February 2020 with diagnosis that included type two diabetes mellitus, vitamin deficiency, repeated falls and adult failure to thrive. Review of the Minimum Data Set (MDS) assessment, dated 1/2/26, indicated a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating severe cognitive impairment. Review of Resident #7's skin care plan indicated the following: I have skin breakdown and/or potential for skin breakdown r/t (related to) decreased mobility and DM (diabetes mellitus). Date Initiated: 4/11/25.Interventions included: Document skin checks weekly and PRN (as needed). Notify the physician and resident/RP (resident representative) of new areas if observed. Follow-up as indicated. I need reminding/assistance to turn/reposition at least every 2 hours, more often as needed or requested. Notify nurse immediately of any skin changes: redness, blisters, bruises, discoloration, etc. noted. Review of the Norton Assessment (an assessment to determine a resident's risk for skin breakdown and the development of pressure ulcers), completed 12/29/25, indicated a risk score of 12; indicating high risk for skin breakdown. Review of Resident #7's active physician orders indicated the following:-Weekly Skin Check Monday 3P.M. -11P.M. every evening shift every Mon (Monday). Complete in PCC (Point Click Care/Electronic Medical Record). Start Date 6/30/25. Review of the Electronic Medical Record (EMAR) indicated the last documented weekly skin check was completed on 2/16/26. Review of the Treatment Administration Record (TAR) for the months of February 2026 and March 2026 indicated the following:-Weekly Skin check dated 2/23/26 was checked off on the TAR as completed but failed to document the weekly skin assessment.-Weekly Skin check dated 3/2/26 was checked off on the TAR as completed but failed to document the weekly skin assessment. During an interview on 3/5/26 at 10:04 A.M., Nurse #7 said weekly skin checks must be documented under weekly skin assessments and not just checked off as completed on the TAR. Nurse #7 and the surveyor reviewed the medical record and Nurse #7 said the last documented skin check was on 2/16/26 and was not completed on 2/23/26 or 3/2/26. During an interview on 3/5/26 at 10:11 A.M., Unit Manager #3 said Resident #7 is missing documented skin assessments on 2/23/26 and 3/2/26 and said the skin checks should have been completed as ordered. Unit Manager #3 said some staff do not know they need to check off the order on the treatment record but must also complete the skin assessment to document the skin check. During an interview on 3/5/26 at 1:02 P.M., the Director of Nursing said weekly skin assessments must be documented and completed as ordered and not checked off as completed in the treatment record when they were not done. 3. Resident #127 was admitted to the facility in July 2025 with diagnoses that included malignant neoplasm of the brain, muscle weakness and history of falling. Review of the Minimum Data Set (MDS) assessment, dated 1/2/26, indicated a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderate cognitive impairment. Review of Resident #127's active care plan indicated the following: -I have skin breakdown and/or potential for skin breakdown r/t (related to) incontinence with (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interventions that included to document skin checks weekly and PRN. Notify the physician and resident of new areas if observed. Follow-up as indicated, dated as revised 10/27/25. Review of Resident #127's most recent Norton Assessment, dated 12/29/25, indicated a risk score of 7 which indicated that the Resident is at high risk for skin breakdown. Review of Resident #127's medical record since 12/1/25 indicated skin checks were completed on the following dates: 12/6/25, 12/13/25, 1/18/26. 1/25/26, 1/25/26, 2/1/26, 2/5/26 and 2/15/26. Resident #127's medical record indicated that weekly skin checks were completed 8 out of 13 weeks during the time period reviewed. During an interview on 3/5/26 at 8:49 A.M., Nurse #7 said that skin checks are completed weekly on all residents. She said competing the skin check includes completing the assessment in the electronic medical record. During an interview on 3/5/26 at 12:20 P.M., Unit Manager #3 said that the staff nurses complete skin checks weekly. She said they must enter the assessment into the assessment in the electronic medical record. During an interview on 3/5/26 at 1:10 P.M., the Director of Nurses said that skin checks are completed weekly on all residents. She said if a Resident refuses a skin check it should be documented in the medical record. She said that signing off completion of the skin check on the Treatment Administration Record does not indicate the skin check is completed, the nurses must also complete the assessment in the electronic medical record. 4. Resident #20 was admitted to the facility in August 2024 with diagnoses that included major depressive disorder and chronic pain syndrome. Review of the Minimum Data Set (MDS) assessment, dated 2/12/26, indicated a Brief Interview of Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. Further review of the MDS indicated that the Resident is dependent for bed mobility Review of the Residents active care plan indicated the following: -I have potential for skin breakdown r/t (related to) bowel and bladder incontinence, dated 5/30/25 with an intervention that included to document skin checks weekly and PRN. Notify the physician and resident of new areas if observed. Follow-up as indicated. Review of Resident #20's most recent Norton Assessment (a tool to determine a resident's risk for skin breakdown and pressure ulcer development), dated 2/9/26, indicated a score of 6, indicating that the Resident is at high risk for skin breakdown. Review of Resident #20's physician's orders indicated the following: -Weekly skin check Friday 3-11, every evening shift for Weekly Skin Monitoring complete weekly skin check in [electronic medical record], dated 7/4/25. (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 the medical record indicated that skin checks were not completed as indicated in physician's orders on 12/17/25, 12/24/25, 1/7/26, 2/25/26 or 3/4/26 During an interview on 3/5/26 at 8:49 A.M., Nurse #7 said that skin checks were completed weekly on all residents. She said competing the skin check includes completing the assessment in the electronic medical record. During an interview on 3/5/26 at 12:20 P.M., Unit Manager #3 said that the staff nurses complete skin checks weekly. She said they must enter the assessment into the assessment in the electronic medical record. During an interview on 3/5/26 at 1:10 P.M., the Director of Nurses said that skin checks were completed weekly on all residents. She said if a Resident refused a skin check it should be documented in the medical record. She said that signing off completion of the skin check on the Treatment Administration Record did not indicate the skin check is completed, the nurses must also complete the assessment in the electronic medical record. 5. For Resident #90 the facility failed to implement a physician treatment order for a cheek wound. Review of the facility policy titled Wound Care, revised October 2010, indicated, but was not limited to, the following: Preparation: 1. Verify that there is a physician's order for this procedure. The following information should be recorded in the residents' medical record: The type of wound care given. The date and time the wound care was given. The position in which the resident was placed. The name and title of the individual performing the wound care. Any change in the resident's condition All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. How the resident tolerated the procedure. Any problems or complaints made by the resident related to the procedure. If the resident refused the treatment and the reason(s) why. The signature and title of the person recording the data. Resident #90 was admitted to the facility in June 2020 with a diagnosis of Alzheimer's disease. Review of the MDS, dated [DATE], indicated that Resident #90 was not able to complete a Brief (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview for Mental Status (BIMS) as the Resident was rarely/never understood. Review of Resident #90's active care plans indicated the Resident had potential for skin breakdown. Review of Resident #90's hospice services communication note, dated 2/11/26, indicated the Resident had a chronic scab on his/her right cheek which was getting larger and that the hospice nurse notified the hospice wound nurse. Review of Resident #90's hospice services communication note, dated 2/12/26, indicated the following: Wound rec per hospice wound nurse: cover chronic right cheek wound with 2x2 dry protective dressing to prevent picking; may apply A&D ointment. Review of Resident #90's active physician orders indicated the following order: Wash right check with wound cleanser, pat dry and cover with DPD (2x2) may apply A&D ointment daily and when needed to prevent picking (sic.), initiated 2/13/26. Further review of the orders scheduling details indicated a frequency of at least once per day shift between the hours of 7 A.M. and 3 P.M. On 3/3/26 at 9:38 A.M. the surveyor observed Resident #90 in his/her bed, the Resident had a wound on his/her right cheek; there was no dressing on the wound. Resident #90 was not able to participate in an interview. On 3/3/26 at 12:55 P.M. the surveyor observed Resident #90 in his/her bed, the Resident had a wound on his/her right cheek; there was no dressing on the wound. There was staff in the Residents room providing assistance to the Resident. On 3/3/26 at 4:15 P.M. the surveyor observed Resident #90 in his/her bed, the Resident had a wound on his/her right cheek; there was no dressing on the wound. On 3/4/26 at 7:51 A.M. the surveyor observed Resident #90 in his/her bed, the Resident had a wound on his/her right cheek and there was dried blood present on and around the perimeter of the wound; there was no dressing on the wound. There was staff in the Residents room providing assistance to the Resident. On 3/4/26 at 10:27 A.M. the surveyor observed Nurse #1 administer medication to Resident #90 who had a wound on his/her right cheek which had dried blood present on and around the perimeter of the wound; there was no dressing on the wound. The nurse did not attempt or offer to provide Resident #90's wound care treatment. On 3/4/26 at 11:46 A.M., 12:51 P.M., 1:31P.M., 2:11 P.M., 2:48 P.M., 3:23 P.M., and 3:57 P.M. the surveyor observed Resident #90 in his/her bed, the Resident had a wound on his/her right cheek and there was dried blood present on and around the perimeter of the wound; there was no dressing on the wound. Review of Resident #90's Medication/Treatment Administration Record (MAR/TAR) on 3/4/26 at 3:57 P.M. indicated that Nurse #1 had not yet completed the Residents right cheek wound treatment. On 3/4/26 from 3:57 P.M. to 4:05 P.M. during a continuous observation the surveyor observed that (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse #1 had not implemented or attempted to implement Resident #90's right cheek wound treatment. Resident #90 was in his/her bed, the Resident had a wound on his/her right cheek and there was dried blood present on and around the perimeter of the wound; there was no dressing on the wound. Review of Resident #90's Medication/Treatment Administration Record on 3/4/26 at 4:05 P.M. indicated Nurse #1 had documented that she had completed Resident #90s right cheek wound treatment. Review of Resident #90's electronic and physical medical record failed to indicate documentation regarding any issues, refusals, reapplication or attempts in implementing Resident #90s wound treatment on 3/3/26 or 3/4/26. During an interview on 3/4/26 at 4:18 P.M. Nurse #1 said she would expect a physician's order for a wound treatment to be implemented and that if the Resident refused this would be documented. Nurse #1 said Resident #90's right cheek wound should be cleaned with a wound cleanser, dried, ointment applied and then covered with 2x2 dry protective dressing as the Resident tended to pick at the right cheek wound. Nurse #1 said the order should read cheek not check as this was a typo. Nurse #1 said Resident #90 typically did not refuse treatment and had not refused his/her wound care treatment that day. Nurse #1 said Resident #90's right cheek wound treatment should have been completed during the 7-3 shift but that she had not completed it or attempted to complete it. Nurse #1 said she should not have marked the treatment order as completed on the MAR/TAR as she had not completed it. During an interview on 3/5/26 at 10:07 A.M. Nurse #10 said that Resident #90 had a wound/cancerous lesion on his/her cheek and that if the wound was dry and not draining that nurses would not cover it with dry protective dressing. Nurse #10 said she had applied the dry protective dressing on 3/4/26 but that the dressing came off and she had not reapplied it. During an interview on 3/5/26 at 9:51 A.M. Unit Manager #2 said she would expect a physician order for a wound treatment to be implemented. The Unit Manager said there should be a nursing note if the nurse was unable to implement the treatment order and that she would expect a nurse to reapply the dry protective dressing to Resident #90's cheek if it had come off. Unit Manager #2 said that Resident #90's dry protective dressing was in place to keep the Resident from scratching at the wound, which the Resident tended to do, as this would put the wound at risk for opening and becoming infected. During an interview on 3/5/26 at 11:19 A.M. the Director of Nursing (DON) said that she would expect a physician order for wound treatment to be implemented, and that if Resident #90's dry protective dressing had come off she would expect the nurse to reapply the dressing; the DON said the order should say cheek not check. The DON said that if the nurse was unable to reapply the dry protective dressing that this would be documented and reported to the Nurse Practitioner. The DON said that when an outside service makes a recommendation and it is reviewed by the physician, and even if the physician changes what was recommended, that staff should go by what the physician ordered.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interviews and record review, the facility failed to ensure that sufficient staffing levels were maintained to safely and adequately meet each resident's personal care needs. Finding Included:Review of the facility policy titled Minimum Staffing-Massachusetts, undated, indicated the following:-On or after April 1, 2021, sufficient staffing must include a minimum number of hours of care per resident per day of 3.580 hours, of which at least 0.508 hours must be care provided to each resident by a registered nurse.-The facility must provide adequate nursing care to meet the needs of each resident, which may necessitate staffing that exceeds the minimum required PPD. Review of the facility assessment indicated the following: Staffing Guidelines -Our facility has created a base staffing pattern to ensure a sufficient number of qualified staff to meet the needs of our residents on a consistent basis. Our staffing pattern is further developed based on the assessed nursing care needs of our residents, acuity, and census. The base staffing pattern represents typical staffing based upon the average daily census of the facility. The facility adjusts staffing based upon multiple factors including but not limited to, shifts in resident census, acuity, communicable disease outbreak, and admission or discharge volume. Revisions to staffing based upon currently identified resident needs may be reflected in an increase or decrease in staffing from what is noted in the base staffing pattern.-Staffing assignments are determined by looking at both census and acuity of the residents. We look at both admission and discharge volume to ensure that residents' needs are met. The staffing pattern fluctuates when it is determined that one unit or shift needs additional assistance. All efforts are made to promote consistent assignments. Our staffing process includes ensuring that resident needs are met in the face of challenges related to call outs or emergent situations.- In the event of staffing challenges, our facility may utilize contracted staff to ensure that the needs of the residents are met. Contracted staff would be provided with appropriate education to ensure knowledge of the facility systems and processes. The Administrator provided the surveyor with the hours per patient per day (HPPD) report that indicated the staffing levels for the building. The report indicated the following: -The budgeted hours per patient per day (HPPD) for the facility census is 3.5 and indicated for the months of November, December, January and February the facility failed to meet the appropriate staffing levels for 120 of 120 days. During an interview on 3/5/26 at 12:00 P.M., the Corporate Administrator said she would expect the minimum staffing levels to be maintained but it has been challenging, and we have been utilizing agency to help with our staffing levels.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a sanitary and comfortable environment on three of four resident floors. Specifically, the facility failed to:Maintain and replace stained and bowed ceiling tiles in resident hallways on the third, fourth and fifth floors.Patch holes in walls in resident bedrooms.Findings include:On 3/5/26 at 10:00 A.M., the surveyor observed resident floors three, four and five. Each of the identified ceiling tiles listed below had circular brown stains measuring at least 10 inches in diameter.Third floor:Hallway in front of room [ROOM NUMBER] four stained and bowed tiles.Hallway in front of room [ROOM NUMBER] two stained tiles.Hallway in front of room [ROOM NUMBER] five stained and bowed tiles. Fourth floor:Hallway in front of room [ROOM NUMBER] two stained tiles.Hallway in front of room [ROOM NUMBER] two stained tiles.room [ROOM NUMBER] 1/2 x 10 gap between back of toilet and wall. room [ROOM NUMBER] 1 diameter hole in bedroom wall. Several 1 holes in bathroom walls Hallway in front of room [ROOM NUMBER] two stained ceiling tiles.Hallway in front of room [ROOM NUMBER] two stained and bowed tiles.Hallway in front of exit door located between rooms [ROOM NUMBERS] two stained tiles.Hallway in front of room [ROOM NUMBER] two stained ceiling tiles. Fifth floor:room [ROOM NUMBER] 1 diameter hole at the bottom of the wall next to entry door. Hallway in front of the activity room three stained ceiling tiles.Ceiling tiles next to air vent located in front of the nursing station are stained black.room [ROOM NUMBER] and 517 common bathroom peeled baseboard with two holes in the wallsHallway in front of room [ROOM NUMBER] two stained ceiling tiles On 3/5/26 at 11:30 A.M. the surveyor and the Maintenance Director toured the third, fourth and fifth resident floors. The Maintenance Director observed the stained hallway ceiling tiles and the holes in the walls in rooms [ROOM NUMBERS] and in the common bathroom for rooms [ROOM NUMBERS]. The Maintenance Director said he was aware of the stained ceiling tiles and had been able to replace two or three in the past month, but that the building did not have any more tiles in the building. The Maintenance Director said he had been working in the building for less than a month and had not been made aware of the holes in the walls in residents' bedrooms. During an interview with the Administrator on 3/5/26 at 11:56 A.M., the surveyor described the conditions of the ceiling tiles on the third, fourth and fifth floors and the holes in the walls in rooms 408, 504, 515 and 517. The Administrator said she was aware of the physical condition of the residents' floors and staff were doing their best to maintain the building. The Administrator said there are plans to renovate the building and that walls and ceiling tiles would be repaired.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and observation, the facility failed to implement the contracted Pest Control Company's recommendations to make repairs for the control of mice and cockroaches on three of four resident floors. Findings include:Review of the Pest Control Company report dated 2/26/26 indicated it maintained bait traps and inspected the facility's physical environment for mice and cockroaches. The report indicated:room [ROOM NUMBER]. Condition, hole in wall located near floor. Baseboard split from wall. room [ROOM NUMBER]'s condition was identified by the Pest Control Company on 9/12/25.On 3/5/26 at 10:00 A.M., the surveyor observed that room [ROOM NUMBER] had holes in the bedroom walls and the baseboard had peeled away from the wall and exposed holes in the wall. The floor had areas of mice droppings.room [ROOM NUMBER]. Cluttered conditions - closet is cluttered. Mice are nesting. room [ROOM NUMBER]'s condition was identified by the Pest Control Company on 10/22/25.On 3/5/26 at 10:07 A.M., the surveyor observed that the bathroom shared by rooms [ROOM NUMBERS] had several holes measuring 1 to 4 in diameter. The floor had areas of mice droppings.room [ROOM NUMBER]. Hole in the wall located near floor need to be patched. Several holes in bathroom. Active mice activity in room. room [ROOM NUMBER]'s condition was identified by the Pest Control Company on 2/12/26.On 3/5/26 at 10:15 A.M., the surveyor observed a hole in room [ROOM NUMBER]'s wall, which measured approximately 1 in diameter. The bathroom walls had several holes which measured 1 to 2 in diameter. The floor had areas of mice droppings.On 3/5/26 at 11:30 A.M. the Maintenance Director, accompanied the surveyor, observed holes in the walls in rooms 408, 515 and 618. The Maintenance Director said he was unaware the Pest Control Company recommended that these holes be patched to prevent the entry of mice and roaches.During the resident group meeting held on 3/4/26 at 11:11 A.M., several residents said that for approximately the past six months mice and cockroaches have infested their bedrooms.During an interview with the Administrator on 3/5/26 at 11:56 A.M., the surveyor described the condition of rooms 408, 515 and 618. The Administrator said she was aware of the Pest Control Company's repair recommendations and that the facility had a mice and cockroach problem. The Administrator said the facility was doing its best to eradicate the pests.

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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** Based on observation, record review and interview, the facility failed to provide a dignified existence for one Resident (#78) out of a total sample of 37 residents. Specifically, for Resident #78, the facility failed to remove unwanted facial hair.Findings include:Review of the facility policy titled Activities of Daily Living (ADL), Supporting, dated 4/25, indicated the following:-Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).-Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.-Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with:a. hygiene (bathing, dressing, grooming, and oral care)By the end of the survey the facility was unable to provide a policy on dignity.Resident #78 was admitted to the facility in August 2025 with diagnoses including gender identity disorder, dementia and depression. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #78 is severely cognitively impaired, scoring a 5 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #78 requires supervision to touching assistance with activities of daily living. Review of the CNA (Certified Nurse's Aide) personal hygiene daily documentation record dated 2/3/26 through 3/4/26 failed to indicate Resident #78 refused care. On 3/3/26 at 8:41 A.M., 12:17 P.M., and 1:28 P.M., the surveyor observed Resident #78 to have significant facial hair. During an interview on 3/3/26 at 8:41 A.M., Resident #78 said that he/she did not like the facial hair and found it embarrassing. Resident #78 then asked if there was any way to take it off and replied that would be great if it could be removed. On 3/4/26 at approximately 8:00 A.M., 9:00 A.M., and 10:45 A.M., the surveyor observed Resident #78 with significant facial hair. During an interview on 3/4/26 at approximately 10:45 A.M., Certified Nurse's Aide #4 said that she hasn't had time yet to care for Resident #78. During an interview on 3/4/26 at 12:00 P.M., Resident #78 said that the hair on his/her face is horrible. Resident #78 then said that no one had been in today, except for the surveyor, to offer to remove the facial hair. During an interview on 3/4/26 at 12:03 P.M., Nurse #3 said that she just interviewed Resident #78 and he/she wanted the facial hair removed. Nurse #3 then said that Resident #78's facial hair should have been removed with daily care.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review and interview, the facility failed to accommodate the needs of one Resident (#20) out of a total of 37 sampled residents. Specifically, the facility failed to provide a wheelchair or other seating able to fit Resident #20, resulting in Resident #20 being unable to get out of bed.Findings include:Resident #20 was admitted to the facility in August 2024 with diagnoses that included major depressive disorder and chronic pain syndrome. Review of the Minimum Data Set (MDS) assessment, dated 2/12/26, indicated a Brief Interview of Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. The MDS further indicated a diagnosis of depression is present. Further review of the MDS indicated that the Resident was Dependent for bed mobility and transfers. On 3/3/26 at 8:36 A.M., the surveyor observed Resident #20 awake and in bed. The Resident was weepy and said that he/she does not get out of bed because there was not a wheelchair large enough to accommodate him/her. There was a wheelchair in the corner of the Resident's room that was small and piled with many briefs, blankets and other supplies. The Resident said that they hadn't been able to sit in that chair for some time now. On 3/3/26 at 1:13 P.M., the surveyor observed Resident #20 in bed. He/she said they had not gotten out of bed today and were not offered by staff to get out of bed. On 3/4/26 at 9:00 A.M., the surveyor observed Resident #20 in bed. The Resident said that he/she had not gotten up out of bed in a few months because of not having a wheelchair to accommodate him/her. The Resident said that he/she had recently gained a lot of weight and could no longer utilize the wheelchair in his/her room. He/she said that they cannot attend activities or socialize because they are unable to get out of bed due to lack of seating. Resident #20 said, I feel like I am just stuck here and can't get up. On 3/5/26 at 8:38 A.M. and 11:43 A.M., the Resident was observed awake in bed. Review of the Psychiatric Evaluation and Consultation note, dated 2/9/26 indicated the following:-Resident is alert and oriented and was observed lying in bed. Mood appeared irritable, tearful, and sad. He/she reports significant frustration with his/her functional limitations, stating, I am 63 y/o (years old) and I am not able to get out of bed and walk. Concentration is poor, though he/she expressed some interest in socialization. -Resident presents with emotional distress related to functional decline and loss of independence. Review of the medical record failed to indicate that Resident #20 was assessed and provided an appropriate seating accommodation to enable him/her to get out of bed. Further review of the medical record failed to indicate that the Resident was offered and refused opportunities to get out of bed. Review of Resident care plan indicated the following:I experience social isolation related to being bed bound and choosing to not get OOB (out of bed), updated 8/25/25.-Interventions included: Facilitate one on one interactions with others with similar interests and desires for social interaction. -Invite [Resident] to group activities and assist with attending as needed. Review of the activities of daily living (ADL) care plan, dated 5/30/25 indicated the following:I have an ADL Self Care Performance Deficit r/t (related to) Rheumatoid arthritis, lymphedema with venous insufficiency, generalized chronic pain with muscle weakness and immobility.Interventions included: AMBULATION: I am non-ambulatory. I use a manual wheelchair. Mobility Device: I use a manual wheelchair. During an interview on 3/4/26 at 11:14 A.M., Certified Nurse Aide (CNA) #2 said that she has been taking care of Resident #20 for about three months. She said that the Resident does not have a wheelchair or stationary chair available to him/her that they fit in and are able to get up to. She said that at this time if the Resident wanted to get out of bed, he/she would not be able to. During an interview on 3/4/26 at 11:21 A.M. the Regional Director of Rehab said that if a resident required a specialty wheelchair of any kind, then therapy would be the one to provide it. She said she did not recall a referral to see Resident #20 for appropriate seating. She said ideally every resident should have a chair as a means to get up and out of bed if they desire. She said she would expect nursing to make a referral for seating if they had no way of getting out of bed. During a follow up interview on 3/4/26 at 2:26 P.M., the Regional Director of Rehab said that she evaluated Resident #20 for seating, and the Resident was not able to utilize (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the chair in the Resident's room because it was too small. She said the Resident was in agreement with the facility ordering a chair to trial so that he/she can get up and out of bed. During an interview on 3/5/26 at 1:27 P.M., the Director of Nurses and Regional Nurse Consultant said that therapy should be doing routine screens and should notice and be aware of the fact that Resident #20 doesn't have an appropriate chair for when he/she wants to get out of bed. They further said that the Resident should have the opportunity to get up and have a wheelchair to accommodate him/her. She said that the Resident can't refuse if they don't have the appropriate accommodations. Review of documentation provided by the facility after survey exit on 3/6/26, indicated the facility had ordered a wheelchair on 2/23/26 for an unspecified resident. However, during the survey, staff were unable to locate the chair and Resident #20 remained in bed.

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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** Based on observation, record review and interview, the facility failed to promote resident rights to make choices about aspects of his/her life in the facility that are significant for one Resident (#134) out of a total of 37 sampled Residents. Specifically, the facility failed to allow Resident #134, an alert and oriented resident who is responsible for their own decision making, to leave the premises independently. Findings include:Review of the facility policy titled Resident Rights, undated, indicated:1. Federal and state laws guarantee certain basic rights to all residents of this facility.-These rights include the resident's right to:-a. a dignified existence-e. self-determination. Resident #134 was admitted to the facility in January 2025 in with diagnoses including paraplegia, post-traumatic stress disorder and major depressive disorder. Review of the Minimum Data Set assessment (MDS), dated [DATE], indicated he/she is cognitively intact as evidenced by a score of 13 out of possible 15 on the Brief Interview for Mental Status Exam. Additional review of the MDS indicated Resident #134 is dependent on staff for bathing and dressing. During an interview on 3/3/26 at 9:30 A.M., Resident #134 reported he/she has been upset that he/she was not allowed to go outside or off facility grounds independently. Resident #134 said the facility is like a prison and he/she can get around easily in his/her motorized scooter. Resident #134 said that staff have told him/her that he/she could not leave the premises without an escort. Review of Resident #134's clinical record indicated he/she did not have an activated health care proxy. Review of Resident #134's physicians orders indicated: Resident #134 may have supervised LOA (leave of absence) privileges at this time, initiated 11/24/25. Review of Resident #134's care plans indicated: Focus: I have a substance abuse disorder r/t (related to) opioid use. History of pocketing/hoarding pills when administered.Interventions: Facility to provide supervision/escort if resident has appointments or need to leave facility due to history of drug use while out on facility leave. During an interview on 3/4/26 at 7:32 A.M., Certified Nursing Assistant (CNA) #2 and CNA #3 said that no residents on the unit can leave the facility or go outside without being supervised. During an interview on 3/4/26 at 7:34 A.M., CNA #1 said that no residents can leave the facility or sit outside by themselves without being supervised. During an interview on 3/4/26 at 7:40 A.M., Nurse #2 said that Residents on the unit cannot leave the facility or go outside unsupervised. Nurse #2 said that some residents are allowed to go downstairs to activities independently. During an interview on 3/4/26 at 7:49 A.M., Resident #134 said that he/she feels like a child because he/she has not been able to leave the building or even sit outside by himself/herself. Resident #134 said that he/she has been asking for months about being able to leave independently. During an interview on 3/4/26 at approximately 8:00 A.M., Unit Manager #1 said that residents who were alert and oriented and were their own decision makers could leave the building unsupervised if there was a physician's order saying so. When asked if Resident #134 could leave the building independently he said he would have to check to see if he/she had an order. During an interview on 3/4/26 at 8:34 A.M., Social Worker #1 said that residents who were alert and oriented times three and were their own decision makers could leave the facility independently if there was a physician's order. Social Worker #1 said that some residents cannot leave the facility unsupervised despite being their own decision makers. Social Worker #1 says this was done for safety reasons and to maintain the wellbeing of residents while they were in the community and to make sure they did not bring contraband back. Social Worker #1 said Resident #134 had asked her in the past what he/she would have to do to be able to leave independently. During an interview on 3/4/26 at 8:55 A.M., the Regional Clinical Nurse and the Administrator said that residents who are alert and oriented times three and were their own decision makers were allowed to leave the building and sit outside independently with a physician's order. The Regional Clinical Nurse and the Administrator said they have had concerns about Resident #134's safety due to past behaviors and (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being found with contraband in his/her possession. The Administrator and the Regional Clinical Nurse said there have been conversations with him/her about being able to leave the building or sit outside, but with supervision.

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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** Based on record review and interviews, the facility failed to formulate an advance directive for one Resident (#85) out of a sample of 37 Residents. Specifically, the facility failed to include an antipsychotic medication in a [NAME] treatment plan (a court-approved, legally mandated document authorizing a guardian to make decisions about extraordinary medical treatment, primarily antipsychotic medication for an incapacitated person who cannot consent to their own care).Findings include:Review of the facility policy titled Advance Directives, undated, indicated the following:-Advance directives will be respected in accordance with state law and facility policy.-If the Resident is incapacitated and unable to receive his or her information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative.-Changes or revocations of a directive must be submitted in writing to the administrator. The administrator may require new documents if changes are extensive. The care plan team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment and care plan. Resident #85 was admitted to the facility in October 2023 with diagnoses including schizoaffective disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/20/26, indicated a Brief Interview for Mental Status (BIMS) score of 2 out of possible 15 indicating severe cognitive impairment. Review of Resident #85's medical record indicated a Guardianship decree dated 11/30/22. Review of Resident #85's Amended [NAME] Treatment Plan with an expiration date of 7/15/26 indicated the following:-Paliperidone (Invega, an antipsychotic) Sustenna,117 milligrams-234 milligrams IM (intramuscular) every 1-4 weeks. A review of Resident #85's March 2026 physician's orders indicated the following:-Paliperidone ER Oral Tablet Extended Release 24 Hour 1.5 Milligram (Paliperidone), give 1 tablet by mouth two times a day related to Schizoaffective disorder. Start date:1/9/26. A review of Resident #85's March 2026 Medication Administration Record (MAR) indicated that staff administered the medication as ordered. During an interview and record review on 3/5/26 at 8:18 A.M., Social Worker #1 said Resident #85 should not be administered an antipsychotic medication that is not on the [NAME] treatment plan. Social Worker #1 said the Resident was currently being administered Invega by mouth, but the [NAME] treatment plan has only given permission for the Resident to be administered Invega intramuscularly. Social Worker #1 said that she has to start the paperwork to go back to court to add the correct medication on the [NAME] treatment plan. During an interview on 3/5/26 at 8:27 A.M., the Director of Nurses said the Resident should not be administered medication that was not listed on the [NAME] treatment plan. During an interview and record review on 3/5/26 at 12:19 P.M., the Corporate Social Worker/Administrator consultant said the by mouth Invega that the Resident was already being administered should have been added to the [NAME] Treatment plan prior to administering the medication.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician of a significant change in the resident's mental health. Specifically, for Resident #8, the facility failed to notify the physician of vocalized suicidal ideations. Findings include: Review of the facility policy titled Change in a Resident's Condition or Status dated revised February 2021 indicated that the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition. Resident #8 was admitted to the facility in April 2023 with diagnoses including alcohol induced mood disorder, Wernicke's encephalopathy and bipolar disorder. Review of the minimum Data Set assessment dated [DATE] indicated that Resident #8 is moderately cognitively impaired scoring a 10 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #8 scored a 14 on the Resident Mood Interview (PHQ-2 to 9), indicating moderate depression. Review of the nursing progress note dated 2/17/26 at 10:22 A.M., indicated that Resident #8 told staff that he/she wanted to kill him/herself and that GOD had already approved this. Review of the social service progress note dated 2/17/26 at 15:29 P.M., indicated that Resident #8 had made the statement I should die to nursing. Review of the health status note dated 2/19/26 at 14:25 P.M., indicated the following: Specialty Program Director met for therapeutic support. Resident #8's thoughts are grandiose, delusional and inconsistent. He/she remains obsessed with the idea of turning this facility into a nursery for children and plants. The resident was slightly escalated this morning, more settled as the day progressed. Further review failed to indicate that the topic of recent suicidal ideations was addressed. Review of the medical record failed to indicate that Resident #8 was seen by psychiatry after making suicidal statements. Review of the care plan failed to indicate a focus for suicidal ideations or interventions to address the suicidal ideations. During an interview on 3/3/26 at 2:34 P.M., Unit Manager #2 said that when a resident vocalizes suicidal ideations I notify the administrator, the Director of Nursing, the nurse practitioner and the Specialty program Director. Unit Manager #2 then said that the Resident would be put on one-to-one supervision. During an interview on 3/3/26 at 2:51 P.M., Unit Manager #2 said that I notified the Administrator, the acting Director of Nursing and the Behavioral Director. Review of the medical record failed to indicate that the physician or a nurse practitioner was notified of the Resident's suicidal ideations. During an interview on 3/04/26 at 9:19 A.M., Nurse Practitioner (NP) #1 said that she was not notified of Resident #8's suicidal ideations until 3/3/26. NP #1 said that she should have been notified and psych services should have been notified. NP #1 said that the Resident should have been placed on one-to-one supervision. NP #1 said that a qualified, licensed practitioner would need to evaluate Resident #8 face to face before determining the Resident was safe to come off of one-to-one supervision. During an interview on 3/4/26 at 12:05 P.M., the Specialty Program Director said that he was not informed that Resident #8 had vocalized suicidal ideations. He then said that he should have been made aware.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observations, interviews and record review, the facility failed to identify and assess the use of pillows underneath a fitted sheet as a potential restraint for one Resident (#127) out of a total sample of 37 Residents.Findings Include:Review of facility policy titled Use of Restraints, dated as revised April 2017, indicated the following:-Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.-Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessments shall be used to determine possible underlying causes of the problematic medical symptoms and to determine if there are less restrictive interventions that may improve the symptoms. Resident #127 was admitted to the facility in July 2025 with diagnoses that included malignant neoplasm of the brain, muscle weakness and history of falling. Review of the Minimum Data Set (MDS) assessment, dated 1/2/26, indicated a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderate cognitive impairment. The MDS failed to indicate restraints were utilized. During an interview and observation on 3/3/26 at 9:06 A.M., the surveyor observed Resident #127 awake in bed. The left side of the bed was close to the wall and heater with no room to exit the left side of the bed. On the right side, there were multiple pillows under the fitted sheet along the right side of the Resident. The Resident said, the staff think I am going to escape out of the bed. On 3/4/26 at 7:07 A.M., 8:17 A.M. and 11:11 A.M., the surveyor observed Resident #127 awake in bed. The left side of the bed was close to the wall and heater with no room to exit the left side of the bed. On the right side, there was multiple pillows under the fitted sheet along the right side of the Resident. On 3/5/36 at 6:31 A.M., the surveyor observed Resident #127 awake in bed. The left side of the bed was close to the wall and heater with no room to exit the left side of the bed. On the right side, there were multiple pillows under the fitted sheet along the right side of the Resident. Review of the medical record failed to indicate that an assessment was completed to assess whether the use of pillows under the fitted mattress could be a restraint. Review of the active care plan failed to indicate the use of pillows under a fitted sheet for positioning purposes or as a potential restraint. Review of physician's orders failed to indicate orders for pillows under the fitted sheet or any other type of potential restraint. During an interview on 3/5/26 at 6:35 A.M., Certified Nurse Aide (CNA) #8 said that sometimes the Resident swings his/her legs over the side of the bed so she puts pillows under the sheet so that he/she cannot do that. She said the pillows help to keep him/her in bed. She said she puts them under the sheet so that he/she can't remove them. During an interview on 3/5/26 at 6:37 A.M., Nurse #9 said that he works overnight on the unit. He said that Resident #127 had poor muscle coordination, so the pillows help keep his/her legs and arms in the bed. He further said that the use of the pillows in that manner should be assessed to show that it was not functioning as a restraint for the Resident. During an interview on 3/5/26 at 8:50 A.M., Nurse #7 said that she was not sure if anyone assessed Resident #127 to determine if the use of pillows could be a restraint, but she could see why it could be considered a restraint. During an interview on 3/5/26 at 12:31 P.M., Unit Manager #3 said that pillows under the fitted sheet could be considered a restraint. She said the use of them were the preference of Resident #127, but an assessment should have been completed prior to implementing the practice to ensure it would not restraint the Resident. During an interview on 3/5/26 at 1:11 P.M., the Director of Nurses said that she is not sure why the pillows were being utilized under the fitted sheet. She said a restraint assessment should be completed to indicate that it was not a restraint, and it should be included in the Resident's plan of care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to develop and implement a plan of care for two Residents (#8 and #175) out of 37 residents. Specifically:For Resident #8 the facility failed to develop a plan of care for the vocalization of suicidal ideations.For Resident #175 to facility failed to implement a plan of care for assist with eating. Findings include: Review of the facility policy titled Care Plans, Comprehensive Person-Centered dated revised March 2022 indicated that the care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 1. Resident #8 was admitted to the facility in April 2023 with diagnoses including alcohol induced mood disorder, Wernicke's encephalopathy and bipolar disorder. Review of the minimum Data Set assessment dated [DATE] indicated that Resident #8 is moderately cognitively impaired scoring a 10 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #8 scored a 14 on the Resident Mood Interview (PHQ-2 to 9), indicating moderate depression. Review of the nursing progress note dated 2/17/26 at 10:22 A.M., indicated that Resident #8 told staff that he/she wanted to kill him/herself and that GOD had already approved this. Review of the social service progress note dated 2/17/26 at 15:29 P.M., indicated that Resident #8 had made the statement I should die to nursing. Review of the health status note dated 2/19/26 at 14:25 P.M., indicated the following: Specialty Program Director met for therapeutic support. Resident #8's thoughts are grandiose, delusional and inconsistent. He/she remains obsessed with the idea of turning this facility into a nursery for children and plants. The resident was slightly escalated this morning, more settled as the day progressed. Further review failed to indicate that the topic of recent suicidal ideations was addressed. Review of the care plan failed to indicate a focus for suicidal ideations or interventions to address the suicidal ideations. During an interview on 3/3/26 at 2:51 P.M., Unit Manager #2 said that I notified the Administrator, the acting Director of Nursing and the Behavioral Director. Unit Manager then said that a care plan should have been developed to address the vocalizations of suicidal ideations. During an interview on 3/4/26 at 12:05 P.M., the Specialty Program Director said that he was not informed that Resident #8 had vocalized suicidal ideations. He then said that he should have been made aware. The Specialty Program Director then said that a plan of care should have been developed to address the vocalized suicidal ideations. 2. Resident #175 was admitted to the facility in October 2018 with diagnoses including dysphagia (difficulty swallowing), Review of the Minimum Data Set assessment dated [DATE] indicated Resident #175 is severely cognitively impaired, scoring a 0 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that resident #175 is totally dependent on staff for all ADL's (activities of daily living). Review of the current care plan indicated a focus of ADL self-care performance deficit with an intervention of I require hands on assistance for eating and drinking. Review of the Kardex (a document indicating the level of care a resident requires) dated as of 3/4/26 indicated that Resident #175 requires hands on assistance for eating and drinking. On 3/3/26 at 8:50 A.M., the surveyor observed Resident #175 alone in his/her room with the door closed and with a food tray in front of him/her on the over the bed table. The surveyor also observed that Resident #175 was sleeping. On 3/03/26 at 12:51 P.M., the surveyor observed Resident #175 sitting in the dining room, asleep, with the food tray in front of him/her. After 5 minutes a Certified Nurse's Aide approached and attempted to feed Resident #175. After two attempts the CNA left the dining room. The Resident then attempted to feed him/herself unsuccessfully. The CNA returned after 2 min to assist the Resident. On 3/04/26 at 8:03 A.M., the surveyor observed Resident #175 lying in bed with a breakfast tray on an over the bed table in front of him/her. On 3/04/26 at 8:15 A.M., through 9:05 A.M., the surveyor observed Resident #175 alone in his/her room sleeping with meal in front of him/her. Resident #175 was observed holding the spoon in his/her hand and dropping the spoon in his/her lap. During an interview (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 3/04/26 at 8:55 A.M., Certified Nurse's Aide (CNA) #5 said that she was not sure where to find the level of assistance a resident need when eating. CNA #5 then looked for a book of Kardex's behind the nurse's station but could not locate one. During an interview on 3/4/26 at 9:05 A.M., Unit Manager #2 said that residents that require an assist with eating should have a staff member in the room assisting the resident. Unit Manager #2 then said that Resident #175 should have a staff member assisting him/her with his/her meal. Unit Manager #2 then said that the CNAs can locate a resident's required level of assist in the Kardex, in the computer. On 3/4/26 9:26 AM the surveyor observed Unit Manger #2 enter Resident #175's room and assist Resident #175 with his/her breakfast, more than an hour and a half after Resident #175 received his/her meal.

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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** Based on observations, record review and interviews the facility failed to ensure two Residents (#148 and #105), who are unable to carry out activities of daily living, received the necessary services to maintain good grooming and hygiene out of a total sample of 37 residents. Specifically,1. For Resident #105 the facility failed to provide incontinence care as indicated in the plan of care. 2. For Resident #105 the facility failed to remove unwanted facial hair.3.For Resident #148 the facility failed to provide nail care.Findings include:Review of the facility policy titled Activities of Daily Living (ADL), Supporting, dated 4/25, indicated the following: -Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). -Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. -Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care) c. elimination (toileting) -The refusal and details of the interventions refused are documented in the resident's clinical record. 1.Resident #105 was admitted to the facility in February 2022 with diagnoses including Parkinson's Disease, heart failure and urinary incontinence. Review of Resident #105's most recent Minimum Data Set assessment (MDS), dated [DATE], indicated Resident #105 had severe cognitive impairment as evidence by a Brief Interview for Mental Status (BIMS) score of 7 out of a possible score of 15. The MDS further indicated the following: -Resident #105 was dependent on staff for all daily care and the Resident had not exhibited behaviors related to rejection of care. -Resident #105 was documented as always being incontinent of urine and bowel. -Resident #105 was a risk for pressure ulcers/injuries During an interview on 3/3/26 at 9:22 A.M., Resident #105 said there were times that he/she will not get changed by the Certified Nursing Assistants (CNAs) that work the overnight shift. Resident #105 said he/she was told that the facility was short staffed and he/she was left unchanged for twelve to thirteen hours. Resident #105 also said that the CNAs were changing him/her before lunch and after dinner. Resident #105 said when he/she pushes his/her call light for incontinence care the CNAs come in and say they will be back but never return. He/she further said that because the CNAs never return, he/she doesn't bother calling anymore. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #105's plan of care, dated 5/15/25, indicated the following: -Focus: I have urinary incontinence related to Parkinson's Disease. -Intervention: Check resident approximately every 2 hours and provide incontinence care as needed. -Focus: I have potential for skin breakdown and or/actual breakdown related to impaired mobility, and incontinence. -Interventions: I need reminding/assistance to turn/reposition at least every 2 hours, more often as needed or requested. During an interview on 3/4/26 at 6:19 A.M., Resident #105 said he/she was changed around 5:30 A.M., by the CNAs. Resident #105 said he/she needs two incontinent briefs because he/she urinated a lot and the morning and the evening shift were putting two incontinent briefs due to his/her incontinence. Resident #105 said he/she was told by the CNAs that they use two incontinent briefs because he/she urinates a lot. The surveyor made the following continuous observations on 3/4/26: - At 6:10 A.M., Resident #105 was lying in bed sleeping. -At 6:15 A.M. the overnight nurse assigned to Resident #105 administered 6:00 A.M. medications to the Resident but did not check or provide incontinence care. - At 7:34 A.M., CNA #6 entered Resident #105's room and closed the door behind him. CNA #6 adjusted Resident up in bed and set up the bedside table for breakfast. CNA #6 said to Resident #105 he will be back by 11:00 A.M., to give him/her a shower. CNA #6 did not check for or provide incontinence care to Resident #105. -At 7:44 A.M., A CNA delivered the Residents breakfast tray and did not check for or provide incontinence care to the Resident. -At 8:19 A.M., A CNA took the breakfast tray from Resident #105's bedside table. The CNA did not check for or provide incontinence care to the Resident. -From 6:10 A.M., to 10:08 A.M. Resident #105 was lying in bed, no staff member checked for or provided incontinent care. -At 10:08 A.M., CNA #6 entered Resident #105's room and closed the door behind him. During an observation at 10:11 A.M., the surveyor observed CNA #6 provide morning care to Resident #105. CNA #6 performed a complete bed bath, including washing Resident #105's entire face and combing his/her hair. Resident #105's incontinent brief was saturated with urine. CNA #6 applied two incontinent briefs; one brief was tan and the other was blue. During an interview on 3/4/26 at 10:30 A.M., CNA #6 said Resident #105 required total assistance for ADL's and he/she never refused or declined daily care. CNA #6 said Resident #105 was usually incontinent all the time and the Resident has always been incontinent since he/she has been in the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility. CNA #6 said he uses two incontinent briefs because Resident #105 urinates a lot and double briefing is better for the staff because the incontinent pads aren't enough when a resident urinates a lot. CNA #6 said this was the first time today that he washed and changed the Resident. During an interview on 3/4/26 at 2:19 P.M., Unit Manager #1 said Resident #105 was one assistance with bathing and toileting. Unit Manager #1 said the CNAs should be following the residents Kardex (a form indicating the level of care a resident needs) and getting reports from the nurses to ensure they are implementing the plan of care. Unit Manager #1 said that if resident refuses care, the CNAs should document the refusal in the electronic medical record, report the refusal to the nurse and the nurse is expected to write a progress note of the resident's refusal. Unit Manager #1 also said he would expect the CNAs to follow the care plan and perform incontinent care every 2 hours. During an interview on 3/5/26 at 10:52 A.M., the Director of Nursing (DON) and Regional Nurse Consultant said the CNAs should be assessing for incontinence every two hours and doing incontinence care if the resident was known to have frequent incontinence. The Regional Nurse Consultant said the CNAs should be making sure they offer incontinent care even if the resident refuses and double briefing is not good practice for a resident's skin. 2. Resident #105 was admitted to the facility in February 2022 with diagnoses including Parkinson's Disease and heart failure. Review of Resident #105's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #105 had severe cognitive impairment as evidence by a Brief Interview for Mental Status (BIMS) score of 7 out of a possible score of 15. The MDS further indicated that the Resident was dependent on staff for all daily care and the Resident had not exhibited behaviors related to rejection of care. During an interview on 3/3/26 at 9:22 A.M., Resident #105 said the Certified Nursing Assistants (CNAs) have removed his/her facial hair when the hair gets too long but they haven't got around to it lately. Resident #105 said he/she would like it removed but needs assistance. On 3/3/26 at 9:22 A.M., and 1:45 P.M., 3/4/26 at 6:10 A.M., and 10:11 A.M., Resident #105 was observed with chin hair. Review of Resident #105's nursing progress notes failed to indicate he/she refused assistance with facial hair removal. On 3/4/26 at 10:11 A.M., the surveyor observed CNA #6 provide morning care to Resident #105. CNA #6 performed a complete bed bath, including washing Resident #105's entire face and combing his/her hair. CNA #6 failed to offer or provide assistance with facial hair removal. During an interview on 3/4/26 at 10:30 A.M., CNA #6 said Resident #105 is total assistance for ADL's and he/she never refuses or declines daily care. CNA #6 said shaving residents with facial hair is part of the Resident's morning care. During an interview on 3/4/26 at 2:19 P.M., Unit Manager #1 said Resident #105 is a one assist for bathing and that it is the responsibility of the CNAs to remove unwanted facial hair while providing care to the residents. Unit Manager #1 also said that if resident's refuse care, the CNA's would document the refusal in the electronic medical record, report the refusal to the nurse and the nurse is (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected to write a progress note of the resident's refusal. During an interview on 3/5/26 at 10:52 A.M., the Director of Nursing said she would expect unwanted facial hair to be removed during routine care. 3. Resident #148 was admitted to the facility in November 2025 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, carpal tunnel syndrome and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/4/26, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. Further review of the MDS indicated functional limitations in range of motion to the upper and lower extremity, impairment to one side. Further, the MDS indicated that the Resident was dependent for Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands. The MDS failed to indicate refusal of care was exhibited by the Resident. On 3/3/26 at 8:22 A.M., the surveyor observed the Resident awake in bed. The surveyor observed that on the Resident's right hand there was a brown substance under his/her fingernails. The surveyor was unable to observe the fingernails on the left hand due to a tight fist. On 3/4/26 at 8:44 A.M., the surveyor observed the Resident sleeping in bed. The Resident's right hand had a brown substance under his/her fingernails. The surveyor was unable to observe left hand due to a tight fist. On 3/4/26 at 11:09 A.M., the surveyor observed the Resident awake in bed. The Resident said that he/she had been washed up already by the aid. The surveyor observed the Resident's right hand had a brown substance under his/her fingernails. The surveyor was unable to observe left hand due to a tight fist. On 3/5/26 at 6:49 A.M., the surveyor observed the Resident sleeping in bed. The Resident's right hand had a brown substance under his/her fingernails. The surveyor was unable to observe left hand due to a tight fist. Review of Resident #148's active activities of daily living (ADL) care plan, dated 11/12/25, indicated that the Resident required the assistance of two staff members for bathing. Review of Resident 148's personal hygiene Certified Nurse Aide (CNA) documentation over the last 14 days failed to indicate that the Resident refused care. During an interview on 3/5/26 at 7:06 A.M., CNA#2 and CNA #9 said that ADL care includes not only washing the residents but also checking and cleaning under their nails and brushing their hair and teeth. They said if any portion of the ADL was refused by the resident it would be documented in the medical record. During an interview on 3/5/26 at 12:34 P.M., Unit Manager #3 said that nail care if a part of ADL care every day. She said if anything is refused by the Resident then it needs to be documented in the medical record. She said she is not aware of Resident #148 refusing any care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/5/26 at 1:06 P.M., the Director of Nurses said that CNAs should be checking fingernails during ADL care and keeping them clean. Ref. F725

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to implement treatment orders as recommended by the Wound Physician for one Resident (#173) out of a total of 37 sampled residents. Specifically, the facility failed to implement hydrogel orders for Resident #173's skin tear timely. Findings include: Review of the facility policy titled Wound Care dated as revised October 2010 indicated: Verify there is a physician's order for this procedure. Resident #173 was admitted to the facility in November 2019 with diagnoses including unspecified dementia, chronic obstructive pulmonary disease and major depressive disorder. Review of the Minimum Set assessment (MDS), dated [DATE], indicated Resident #173 had severe cognitive impairment as evidenced by a score of two out of a possible 15 on the Brief Interview for Mental Status Exam. Additional review of the MDS indicated Resident #173 was dependent on staff for all activities of daily living. On 3/3/26 at approximately 8:15 A.M., the surveyor observed Resident #173 resting in bed. Resident #173 was unable to engage in the interview process. Review of Resident #173's incident reports indicated on 1/22/26, Resident #173 sustained a skin tear to his/her hip from his/her brief. Review of the clinical record indicated Resident #173's wound was being monitored by the Wound Physician. Review of the Wound Physician note dated 1/29/26 indicated a skin tear that measured 2.2 CM (centimeters) X 3 CM X .05 CM. Primary Dressings: Hydrogel gel apply once daily and as needed; if saturated, soiled or dislodged. Gauze island with bdr apply once daily and as needed. Review of Resident #173's physicians orders indicated: Skin tear on left hip (trochanter): Cleanse site with normal saline, pat dry, apply calcium alginate and cover with gauze island, every day shift for wound care; active 1/24/26 through 2/6/26.Skin tear on left hip(trochanter): Cleanse site with normal saline, pat dry, apply hydrogel, then non-sterile gauze sponge and cover with gauze island once daily. Initiated 2/7/26. The Wound Physician's treatment was not implemented as ordered until 2/7/26, 9 days after it was recommended. During an interview on 3/4/26 at 10:50 A.M., Nurse #4 said that a nurse will round with the Wound Physician and then inputs the treatments as orders into the electronic record. During an interview on 3/4/26 at 1:43 P.M., Nurse #5 said that the Wound Physician comes into the building on Thursdays and uploads her notes into the record. Nurse #5 said the nurse who rounds with the Wound Physician is responsible to input the treatment recommendations as orders into the electronic health record. During an interview on 3/4/26 at approximately 2:00 P.M., Unit Manager #1 said that the Wound Physician rounds with the nursing staff and the nurse will input the treatments as orders into the record. Unit Manager #1 said that the orders were reviewed and approved by the attending physician or nurse practitioner, and he has never seen them disagree with the treatment recommendations. Unit Manager was not aware of the delay in implementing Resident #173's hydrogel order. During an interview on 3/5/26 at 11:39 A.M., the Director of Nursing (DON) said the wound doctor comes in weekly and tells the nursing staff of her new recommendations for each wound. The DON said then nursing will then update the physician order. During an interview on 3/5/226 at 12:33 P.M., the Wound Physician said that she rounds the facility weekly with nursing staff who then put in the treatment recommendations as orders. The Wound Physician said that she is in contact with the facility nurse practitioner and the nurse practitioner defers to her for treatments. The Wound Physician said she expects wound treatments be implemented timely. The Wound Physician was not aware the implementation for the use of hydrogel for Resident #173's skin tear was delayed.

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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. Based on observation, record review and interview, the facility failed to ensure one Resident (#3) with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing, out of a total sample of 37 residents. Specifically, for Resident #3 the facility failed to implement recommendations from the Wound Doctor.Findings include:Resident #3 was admitted to the facility in October 2025 with diagnoses that included pressure ulcer of the sacral region, type 2 diabetes, hemiplegia and hemiparesis, and malignant neoplasm of lung. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/8/26, indicated he/she was assessed by nursing staff to have severe cognitive impairments. The MDS also indicated the Resident had one stage four and one stage three unhealed pressure ulcers. Review of Resident #3's impaired skin care plan, dated 10/9/25, indicated administer treatments as ordered and monitor effectiveness. Review of Resident #3's physician order, dated 1/12/26, indicated Pressure wound on Sacrum: Cleanse site with normal saline, apply Santyl (prescription ointment that breaks down collagen in damaged or dead skin), cover with superabsorbent gelling fiber with silicone faced border once daily. Review of Resident #3's Wound Physician recommendations, dated 2/19/26 and 2/26/26, indicated: apply to sacrum wound - calcium alginate apply once daily and as needed: if saturated, soiled, or dislodged. Superabsorbent gelling fiber w/ silicone border apply once daily and as needed: if saturated, soiled, or dislodged. Review of Resident #3's March 2026 Treatment Administration Record indicated that nursing staff were administering the following order to Resident #3's Sacrum: Cleanse site with Normal Saline, apply Santyl, cover with Superabsorbent Gelling Fiber with silicone faced border once daily. During an interview on 3/5/26 at 10:38 A.M., Nurse #6 said Resident #3 has chronic wounds and said the Wound Physician comes in weekly to assess the wounds. Nurse #6 said when the Wound Physician makes new recommendations that the new order should go in as soon as possible. During an interview on 3/5/26 at 11:39 A.M., the Director of Nursing (DON) said the wound doctor comes in weekly and tells the nursing staff of her new recommendations for each wound. The DON said then nursing will then update the physician order. During an interview on 3/5/26 at 12:33 P.M., the Wound Physician said that she rounds the facility weekly with nursing staff who then put in the treatment recommendations as orders. The Wound Physician said that she is in contact with the facility Nurse Practitioner and the Nurse Practitioner defers to her for treatments. The Wound Physician said she expects wound treatments be implemented timely. The Wound Physician was not aware the implementation of her recommendations were not in place for Resident #3.

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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** Based on observation, record review and interview, the facility failed to ensure nursing implemented a splinting device as ordered for contracture prevention for one Resident (#148) out of a total sample of 37 residents. Specifically, the facility failed to ensure Resident #148 was wearing a hand roll as ordered and recommended by the therapy department. Findings include:Resident #148 was admitted to the facility in November 2025 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, carpal tunnel syndrome and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/4/26, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. Further review of the MDS indicated functional limitations to range of motion to the upper and lower extremity, impairment to one side. The MDS failed to indicate refusal of care was exhibited by the Resident. Review of the Occupational Therapy Discharge summary, dated [DATE], indicated the following:-STG (short term goal) #4 met on 2/12/26: Pt (patient) will tolerate WHO (wrist hand orthosis) up to 4 hours/day without redness, skin breakdown, edema for decreased contracture risk. Review of the Occupational Therapy (OT) Treatment Encounter note, dated 2/16/26, indicated the following:-Pt (patient) was edu (educated) on dc (discharge) from therapy services due to max potential achieved. Patient was edu on splinting scheduled to continue with upon OT dc. Patient is to wear splint overnight from 8pm-8am. Nursing team notified and orders were placed in [electronic medical record]. [sic] Review of physician's orders, dated 2/17/26, indicated the following:-Assist patient with doffing LUE (left upper extremity) resting hand splint for contracture management at 8am. [sic]-Assist patient with donning LUE resting hand splint for contracture management at 8pm for overnight wear. [sic] Review of February and March 2026 TAR indicated use of the orthotic. Review of the Resident's active care plan failed to indicate use of any orthotic device. On 3/4/26 at 7:05 A.M., the surveyor observed the Resident sleeping in bed with his/her arms under a blanket. The surveyor asked Resident #148 if he/she was utilizing a brace or orthotic device at this time and they responded, yes. The surveyor observed the left hand, and no device was in use, or visible in the Resident's room. The Resident's left hand was in a tight fist, and no hand splint or orthotic device was in place. On 3/5/26 at 6:30 A.M., the surveyor observed the Resident awake in bed. The Resident's left hand was in a tight fist, and no hand splint or orthotic device was in place. On 3/5/26 at 8:42 A.M., during an observation of Resident #148's room, no orthotic device or brace was seen. During an interview on 3/5/26 at 6:43 A.M., Certified Nurse Aide (CNA) #7 said that she worked overnight and took care of Resident #148. She said that the Resident does not wear anything on his/her left hand. She said she has never seen anything applied to the Resident's left hand. During an interview on 3/5/26 at 7:04 A.M., Nurse #9 said that he worked overnight and Resident #148 had not had any type of brace or orthotic on his/her left hand. During a phone interview on 3/5/26 at 10:46 A.M., the Regional Director of Rehab said that Resident #148 was on services, and upon discharge recommendations were made for a hand roll, with an eventual goal of using a splint to prevent contracture formation of the left hand. She said nursing should have been implementing the hand roll, but that she was unable to find any hand roll or splint in the Resident's room. She said if they did not have a roll or splint, nursing should have made them aware. During an interview on 3/5/26 at 12:36 P.M., Unit Manager #3 said that nursing should be implementing splinting as indicated in the physician's orders and as recommended by the therapy department. She said that if they did not have a splint then it should be reported. She said that she was not provided any type of education on the splinting plan for Resident #148 from the rehab department. During an interview on 3/5/26 at 12:49 P.M., Rehab Staff #2 said that today a brace was provided to Resident #148 because she did not have one available for use in her room. She said rehab will continue trialing it and provide education to the (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	03/05/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff. During an interview on 3/5/26 at 1:07 P.M., the Director of Nurses said that nursing should be implementing the hand splint as indicated in the recommendations from therapy and physician's orders to prevent a contracture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. Based on observations and interviews the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically,The facility failed to ensure treatment carts were locked while a nurse was not present on two out of four unitsThe facility failed to ensure nursing staff stayed with the surveyors while doing the medication storage task on two out of four units.Findings include:Review of facility policy titled Medication Labeling and Storage, dated as revised February 2023, indicated the following:-The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. 1. On 3/3/26 at 8:18 A.M., there was an unlocked and unattended treatment cart on the 6th floor unit. The surveyor was able to gain access to the cart which contained medicated creams and treatments. The cart was accessible to staff and residents in the area. On 3/4/26 at11:47 A.M., there was an unlocked and unattended treatment cart on the 4th floor unit. The surveyor was able to gain access to the cart which contained medicated creams and treatments. The cart was accessible to staff and residents in the area. During an interview on 3/4/26 at 1:58 P.M., the Director of Nurses said that all treatment carts should be locked when unattended. 2. On 3/4/26 at 1:04 P.M., the surveyor was left alone with an unlocked medication cart on the 4th floor unit while completing the medication storage task. The Nurse returned at 1:09 P.M. and then left the surveyor at the unlocked medication cart again to assist with passing meal trays. During an interview on 3/4/26 at 1:11 P.M., Nurse #8 said that he should not have left the surveyor alone with the medication cart.On 3/4/26 at 1:17 P.M., a staff nurse opened the medication room for the surveyor and left the surveyor unattended and unsupervised in the medication room during the medication storage task. When the surveyor exited the medication room at 1:20 P.M., the nurse who let the surveyor in the medication room was no longer outside of the room, and was unable to be located by the surveyor.During an interview on 3/4/26 at 1:58 P.M., with the Director of Nurses and Regional Nurse Consultant said that the surveyors should not have left the surveyor unsupervised but probably thought that they could because it was a surveyor.