| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225584 | A. Building<br>B. Wing | 12/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park Avenue Health Center | 146 Park Avenue<br>Arlington, MA 02174 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on observation, record review, and interview the facility failed to maintain accurate medical records for three residents (#35, #5 and #69), out of a total sample of 18 residents. Specifically,1. For Resident #35 the facility failed to ensure Certified Nursing Assistants (CNAs), accurately documented a. wandering and b. walking on his/her activities of daily living (ADLs) flow sheets. 2. For Resident #5, the facility failed to ensure CNAs, accurately documented wandering on his/her ADLs flow sheets. 3. For Resident #69 the facility failed to ensure CNAs, accurately documented his/her wandering behaviors, resulting in the development of an inaccurate Minimum Data Set (MDS) assessment. Findings include:<br><br>Review of the facility's policy titled, Charting Errors and/or Omissions, dated as revised December 2006, indicated that accurate medical records shall be maintained by this facility.<br><br>1. Resident #35 was admitted to the facility in April 2025 with diagnoses including major depression, anxiety, and failure to thrive.<br><br>Review of the most recent Minimum Data Set assessment, dated 10/16/25, indicated Resident #35 was cognitively intact as evidenced of a Brief Interview of Mental Status exam score of 15 out of 15. This MDS indicated that Resident #35 did not have any behaviors, did not reject care, and required assistance with activities of daily living.<br><br>a. On 12/1/25 at 7:54 A.M., the surveyor observed Resident #35 in bed. Resident #35 said he/she does not walk and has not walked for a while and uses a wheelchair if he/she needs to go places.<br><br>Review of Resident #35's Documentation Survey Report V2 (ADL sheets), indicated that CNAs documented Resident #35 wandered the following:<br><br>September 2025: 1 shift.<br><br>October 2025: 6 shifts.<br><br>November 2025: 1 shift.<br><br>During an interview on 12/2/25 at 3:13 P.M., CNA #3 said she is familiar with Resident #35 and said that he/she does not wander. CNA #3 said she must have coded the wandering on the ADL sheets incorrectly.<br><br>During an interview on 12/3/25 at 8:21 A.M. CNA #4 said she is familiar with Resident #35 and said that he/she does not wander. CNA #4 said she must have coded the wandering on the ADL sheets<br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | incorrectly.<br><br>During an interview on 12/3/25 at 8:25 A.M., Nurse #2 said that she is familiar with Resident #35 and he/she doesn't wander and never has wandered.<br><br>During an interview on 12/3/25 at 9:05 A.M., the Director of Nursing (DON) said CNAs should code ADL documentation correctly.<br><br>b. On 12/1/25 at 7:54 A.M., the surveyor observed Resident #35 in bed. Resident #35 said he/she does not walk and has not walked for a while.<br><br>Review of Resident #35's Documentation Survey Report V2, indicated CNAs documented Resident #35 walked the following:<br><br>- September 2025: 19 shifts walked 10 feet; 19 shifts walked 150 ft with 2 turns; 15 shifts walked 50 feet with 2 turns.<br><br>- October 2025: 22 shifts walked 10 feet; 25 shifts walked 150 ft 2 turns; 22 shifts walked 50 feet with 2 turns.<br><br>- November 2025: 23 shifts walked 10 feet; 26 shifts walked 150 feet with 2 turns; 25 shifts walked 50 feet with 2 turns.<br><br>During an interview on 12/2/25 at 3:14 P.M., CNA #3 said she is familiar with Resident #35 and said that he/she does not walk. CNA #3 said she must have coded the walking on the ADL sheets incorrectly.<br><br>During an interview on 12/3/25 at 8:22 A.M. CNA #4 said she is familiar with Resident #35 and said that he/she does not walk. CNA #4 said she must have coded the walking on the ADL sheets incorrectly.<br><br>During an interview on 12/3/25 at 8:26 A.M., Nurse #2 said that she is familiar with Resident #35 and he/she doesn't walk.<br><br>During an interview on 12/3/25 at 9:38 A.M., the Director of Rehabilitation said that she had worked with Resident #35 for therapy and he/she has never walked.<br><br>During an interview on 12/3/25 at 9:06 A.M., the Director of Nursing (DON) said CNAs should code ADL documentation correctly.<br><br>2. Resident #5 was admitted to the facility with diagnoses including Huntington's disease, anxiety, and apraxia.<br><br>Review of Resident #5's Minimum Date Set assessment, dated 10/16/25, indicated he/she was rarely/never understood, experienced wandering 1-3 days, and was dependent on staff for activities of daily living.<br><br>On 12/1/25 at 11:51 A.M. and at 4:25 P.M., the surveyor observed Resident #5 reclined in a tilted chair utilizing a seatbelt to restrict his/her movement.<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #5's Documentation Survey Report V2, CNAs documented he/she wandered the following:<br><br>- September 2025: 12 shifts.<br><br>- October 2025: 10 shifts.<br><br>- November 2025: 5 shifts.<br><br>During an interview on 12/2/25 at 3:25 P.M., CNA #3 said that she is familiar with Resident #5 and he/she does not wander, and he/she uses a seatbelt to prevent him/herself from sliding in the titled chair. CNA #3 said she must have coded the wandering in error on the ADL sheets.<br><br>During an interview on 12/3/25 at 8:20 A.M., CNA #4 said that Resident #5 does not wander and she must have documented wandering in error on the activities of daily living sheets.<br><br>During an interview on 12/2/25 at 12:45 P.M., the Assistant Director of Nursing said that she is familiar with Resident #5, and he/she does not wander and that the CNAs should document accurately.<br><br>During an interview on 12/3/25 at 9:14 A.M., the DON said that ADL sheets should be coded accurately.<br><br>3. Resident #69 was admitted to the facility in November 2019 and has diagnoses that include but are not limited to unspecified protein-calorie malnutrition, dysphagia (swallowing disorder), adult failure to thrive, other seizures, major depressive disorder, and dementia.<br><br>Review of the most recent Minimum Data Set assessment, dated 9/20/25 indicated Resident #69 scored a 6 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having severe cognitive impairment. Further, the MDS indicated Resident #69 wandered (wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction) in the last 4 to 6 days.<br><br>During an observation and interview on 12/2/25 at 7:58 A.M., Resident #69 was in bed. Resident #69 said he/she does not get out of bed too often.<br><br>Review of the document titled, Documentation Survey Report indicated the following:<br><br>-September 2025, documented Resident #69 wandered on 23 out of 30 days on the 3:00 P.M.-11:00 A.M., shift.<br><br>-October 2025, documented Resident #69 wandered on 20 out of 31 days on the 3:00 P.M.-11:00 P.M., shift.<br><br>-November 2025, documented Resident #69 wandered 20 out of 30 days on the 3:00 P.M.-11:00 P.M., shift.<br><br>During an interview on 12/2/25 at 10:36 A.M., Nurse #3 said she cares for Resident #69 and knows him/her well. Nurse #3 said Resident #69 spends his/her day in bed and refuses to get out of bed.<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Nurse #3 said the Resident is unable to move on his/her own and does not wander.<br><br>During an interview on 12/2/25 at 10:47 A.M., Certified Nursing Assistant (CNA) #6 said she cares for Resident #69 and that he/she does not get out of bed. CNA #6 said the Resident is offered to go to the dining room or go to activities and he/she declines. CNA #6 said she has not seen Resident #69 wander, and it has never been reported to her that he/she has the behavior of wandering.<br><br>During an interview on 12/2/25 at 2:35 P.M., CNA #5 said Resident #69 has behaviors of refusing care and he/she does not like to get out of bed, and he/she does not wander. Further, CNA #5 said she documents in the POC (Plan of Care), using a tablet. CNA #5 reviewed the documentation and said the Resident does not move on his/her own and does not wander and it should not have been documented.<br><br>During an interview on 12/3/25 at 9:07 A.M., Nurse Consultant #1 said the CNA documentation is reviewed daily for completion versus accuracy. Nurse Consultant #1 said the MDS relies on accurate documentation to have an accurate picture of a resident. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to implement the facility's abuse policy for one Resident #35 out of a total sample of 18 residents. Specifically, for Resident #35 the facility failed to ensure Certified Nurse Assistant (CNA #1), who was accused of neglect, left the facility after she was suspended (placed on leave). Findings include:Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated as revised September 2022, indicated that all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies, and thoroughly investigated by facility management. -Reporting Allegations to the Administrator and Authorities:6.Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions are needed for the protection of residents. -Investigating Allegations: 5. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. Resident #35 was admitted to the facility in April 2025 with diagnoses including major depression, anxiety, and failure to thrive. Review of the most recent Minimum Data Set assessment, dated 10/16/25, indicated Resident #35 was cognitively intact as evidenced of a Brief Interview of Mental Status exam score of 15 out of a possible 15. This MDS indicated that Resident #35 did not have any behaviors, did not reject care, and required assistance with activities of daily living. On 12/1/25 at 7:51 A.M., the surveyor observed Resident #35 in his/her bedroom yelling at CNA #1 saying I don't want you in my room, I called the cops on you this weekend, don't come in my room again. CNA #1 exited Resident #1's room, and she said that she was not sure why Resident #35 was screaming at her. The Resident requested the surveyor to get him/her some help to be boosted for breakfast. On 12/1/25 at 7:54 A.M., the surveyor stood outside Resident #35's door where he/she reported to two staff members I don't want her anywhere near me she neglected me, I want her reported, I don't want her anywhere near me. Review of Resident #35's progress note, dated 11/30/25 at 4:50 A.M., indicated:- At around 4:45 A.M., a call received from a caller (a man voice) identified as being from the police department reporting that resident called the police to report that he/she wants to be changed. This nurse went to resident's room to inquiry about what the matter was. Resident complained of not wanting the overnight staff CNA to touch him/her. Resident stated that they have being putting the same staff to work every night on purpose. Resident reported that he/she wants to leave the facility and wants someone to help him/her do that. Resident appears to be very agitated and frustrated. Resident stated: I can buy all of you and sell you a hundred times over. You should do as I say. Resident refused to calm down and expressed desire to report the facility for the way he/she has been treated since he/she got admitted . After 10 mins another caller (a woman voice) from the police department reporting the same complaint from resident. The caller stated that resident seems to have several ongoing issues at the same time. Resident was advised to talk to social service worker in the morning as this is not a matter for the police department to handle. (sic) On 12/1/25 at 8:32 A.M. the surveyor and the Administrator entered Resident #35's room. Resident #35 said She (CNA #1) neglects me, she doesn't meet my needs, and she thinks things are comical the surveyor offered to close Resident #35's door and Resident #35 said the staff should hear this, so they know there are repercussions to neglect. Resident #35 identified CNA #1 as the accused and the Administrator said that he would take care of things. Review of the Health Care Facility Reporting System, indicated on 12/1/25 at 9:18 A.M., the Director of Nursing created and submitted a case on 12/1/25 at 10:15 A.M., that stated:-Resident reported that neglect was experienced during care. CNA suspended until further investigative findings. CNA #1 was identified as the accused. On<br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 12/1/25 at 9:09 A.M., the surveyor observed CNA #1 on the unit providing care to a Resident. On 12/1/25 at 10:17 A.M., the surveyor observed CNA #1 exiting a resident room. On 12/1/25 at 11:55 A.M., two surveyors observed CNA #1 exiting the elevator on the ground floor (next to the Director of Nursing's office) with a Resident. On 12/1/25 at 12:57 P.M., two surveyors observed CNA #1 at the second-floor nursing station. CNA #1 identified herself and she said she was going to complete her activities of daily living documentation. During an interview on 12/1/25 at 4:20 P.M., Nurse #2 said that CNA #1 worked the entire day shift on 12/1/25. Nurse #2 said that when she receives an allegation of neglect, she is to report the allegation to her supervisor. During an interview on 12/1/25 at 4:54 P.M., the Director of Nursing (DON) said that she was made aware of the allegation of neglect by the Administrator. The DON said that she reported the event to the state agency and she and Nurse Consultant #2 suspended CNA #1 pending investigation on 12/1/25 at 9:30 A.M., and she had thought that CNA #1 had left the facility at that time. The surveyor shared the observations of the CNA in the building after 9:30 A.M., and the DON said that CNA #1 was supposed to leave the facility pending investigation. The surveyor and the DON reviewed CNA's #1 timecard that indicated that she left the faciity on [DATE] at 3:41 P.M., the DON then said she was not sure if Nurse Consultant #1 or Human Resources sent CNA #1 home. During an interview on 12/2/25 at 1:02 P.M., Human Resources said she wasn't made aware that CNA #1 was suspended until 12/1/25 around 5:30 P.M., she said she is typically made aware of suspensions, but she was not aware. During an interview on 12/3/25 at 9:00 A.M., Nurse Consultant #2 said that she sat with CNA #1 and the DON on 12/1/25 at 9:30 A.M., she said that she suspended CNA #1 and she expected her to leave the building pending investigation. During an interview on 12/1/25 at 5:24 P.M., the Administrator said that CNA #1 should have been suspended and left the building immediately pending the neglect investigation at 9:30 A.M. During an interview with the Nurse Consultant #1 and the Administrator on 12/2/25 at 10:00 A.M., they said that there was a breakdown in communication with staff during the suspension of CNA #1 pending the allegation of neglect and that CNA #1 should have left the building, but she did not. Nurse Consultant #1 said that CNA #1 thought she did nothing wrong and she returned back to the unit on 12/1/25 to finish her workday. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on record review and interview, the facility failed to revise the plan of care after two Minimum Data Set assessments for one Resident (#7) out of a total sample of 5 Residents selected for the unnecessary medication review. Specifically for Resident #7, the facility failed to revise three separate care plans related to diuretic use (medication used to decrease fluid) when his/her diuretic was discontinued on 5/19/25 and nursing documented his/her care plans were reviewed on 8/12/25 and 10/27/25. Findings include: Review of the facility policy titled, Care Planning - Interdisciplinary Team, dated as revised March 2022, indicated the interdisciplinary team is responsible for the development of resident care plans.1.Resident care plans are developed according to the timeframes and criteria established by S483.21. Resident #7 was admitted to the facility in November 2022 with diagnoses including Alzheimer's disease, atrial fibrillation, diabetes, and muscle weakness. Review of the Minimum Data Set assessments, dated 7/10/25 and 10/7/25, indicated the Resident #7 was not administered a diuretic medication. Review of Resident #7's provider progress note, dated 5/13/25, indicated:-We will discontinue to torsemide (diuretic medication). Review of Resident #7's discontinued physician's orders, dated 5/19/25, indicated:-Torsemide 10 milligrams, give one tablet by mouth in the morning every other day for congestive heart failure. (Discontinued) Review of Resident #7's Medication Administration Record, dated July 2025, August 2025, September 2025, and through October 2, 2025, failed to indicate that Resident #7 received a diuretic medication since the torsemide was discontinued on 5/19/25. Review of Resident #7's care plan reviews dated 8/12/25 and 10/27/25 indicated nursing reviewed and revised his/her care plan to ensure the most accurate information was included in his/her care plan was in place. Review of Resident #7's plan of care on 12/2/25, included the following care plan focus:- The resident is on diuretic therapy, dated as revised on 5/25/23.- The resident has potential for dehydration or fluid deficit related to cognitive function, mental state, diuretic use, dated as revised 10/15/24.- The resident is at risk for falls related to cognitive deficit, potential for alteration in functional ability, mental state (history of major depression, generalized anxiety disorder, insomnia), occasional bowel and urinary incontinence, and medications (diuretics, psychotropics), syncope, dated as revised on 8/13/25. During an interview on 12/2/25 at 12:55 P.M., the Assistant Director of Nursing (who completed the care plan reviews) said that the care plan for diuretic use should have been resolved (revised) during the care plan reviews but was not. During an interview on 12/3/25 at 9:16 A.M., the Director of Nursing said that care plans need to be revised after the MDS assessment to reflect the most current status of the Resident. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, interview, and record review the facility failed to ensure assistance with Activities of Daily Living (ADLs) was provided for one Resident (#47) out of a total sample of 18 residents. Specifically, for Resident #47 the facility failed to ensure one-to-one staff assistance was provided with meals.Findings include: Resident #47 was admitted to the facility in April 2023 and has diagnoses that include Alzheimer's disease, dysphagia, and dementia with psychotic disturbance. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/25/25, indicated Resident #47 had severe cognitive impairment as evidence by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. The MDS further indicated Resident #47 requires set-up or clean-up with assistance with eating. Review of the active physician orders indicated Resident #47 is a 1:1 (one-to-one) feed as of 8/29/25. Review of the Activities of Daily Living care plan, dated as revised 10/1/25, indicated Resident #47 had the following interventions:-Eating: The resident is assist- totally dependent on staff for eating. Will assist 1:1 and encourage adequate PO (by mouth) intake. Review of the Nutrition care plan, dated as revised 9/3/25, indicated Resident #47 had the following interventions:-Feeding assistance with all meals.-observe for signs and symptoms of aspiration, especially during meals. Review of Dietitian progress note, dated 10/24/25, indicated Resident #47 was at risk for weight loss as he/she was spitting out foods. Interventions included downgrading texture of his/her diet to a full liquid diet and 1:1 feeding assist. On 12/1/25 at 8:55 A.M., the surveyor observed Resident #47 seated in bed with the head of bed elevated. Staff set up his/her breakfast tray on table in front of him/her then left the room and continued to pass other trays. The surveyor continued to make the following observations:-Between 8:55 A.M., and 9:10 A.M. The Resident continued to drink or use a spoon to deliver fluids to his/her mouth, but there were no staff in sight of Resident #47 as he/she drank his/her fluid diet and no staff returned to the room to assist with the meal. On 12/1/25 at 12:39 P.M., the surveyor observed Resident #47 being set up for lunch in bed by a staff member, the staff then left room. He/she was able to drink independently. The surveyor continued to make the following observations:-Between 12:39 P.M., and 1:02 P.M. various staff members passed by the room or stood in doorway for a moment, but there were no staff that sat with Resident or assisted with his/her meal. On 12/2/25 at 8:58 A.M., the surveyor observed Resident #47 being set up for breakfast in bed by a staff member, the staff then left room. He/she did not attempt to drink any breakfast.Throughout the observation between 8:58 A.M., and 9:15 A.M., the Resident fell asleep and was leaning towards the right in bed. Staff did not offer to wake Resident and just removed the tray. On 12/2/25 at 12:42 P.M., the surveyor observed Resident #47 being set up for lunch in bed and then staff left the room. The surveyor observed Resident between 12:42 P.M. and 1:08 P.M. There were no staff in or in sight of his/her room during this time. On 12/3/25 at 8:28 A.M., the surveyor observed Resident #47 being set up for lunch in bed and then staff left the room. The surveyor observed Resident between 8:28 A.M. and 8:37 A.M. The were no staff in or in sight of his/her room during this time. During an interview with Resident #47's Certified Nursing Assistant (CNA) #7 on 12/3/25 at 8:45 A.M., she said that Resident only needs to be set up for meals. She does not require any supervision or assistance with meals. During an interview with Resident #47's Nurse #4 on 12/4/25 at 8:48 A.M., she said that the Resident only needs to be set up for meals and that he/she can eat alone. During an interview with the Assistant Director of Nursing (ADON) on 12/3/25 at 9:10 A.M., she said that Resident #47's level of assistance required for eating varies according to his/her level of alertness and his/her dementia therefore staff should observe Resident and offer the amount of assistance he/she needs. The ADON said she does not know if Resident has any aspiration issues. She said that staff learn the level of assistance each Resident needs by reading the Kardex (a form indicated the type of care a resident needs). During an interview with the Registered Dietitian on 12/3/25 at 9:59 A.M., she said that Resident #47 requires 1:1 feeding assistance related to his/her impaired cognition and history of spitting out foods. She said that Resident is discussed in risk meetings and any interventions that the<br>(continued on next page) |

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|---|---|---|---|
| | 225584 | A. Building<br>B. Wing | 12/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park Avenue Health Center | 146 Park Avenue<br>Arlington, MA 02174 |

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

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | interdisciplinary team determine are communicated to direct care staff by the Director of Nursing or any Nursing staff that is present at the meeting. During an interview with Nurse Practitioner #1 on 12/3/25 at 10:43 A.M., she said that if Resident #47 has an order for 1:1 assistance for eating then the order should be followed. She said the Resident is at risk for aspiration if the assistance is not provided for eating. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the administration of enteral nutrition is consistent with and follows the practitioner's orders for one Resident (#47) out of a total sample of 18 residents. Specifically, for Resident #47 the facility failed to ensure the tube feeding was delivered at the frequency it was ordered.Findings include:Review of the facility's policy titled, Enteral Nutrition, dated as revised November 2018, indicated that adequate nutritional support through enteral nutrition is provided to residents as ordered. Resident #4 was admitted to the facility in August 2025 and has diagnoses including stroke, dysphagia, gastrostomy status (nutrition provided through a tube inserted into the stomach), and congestive heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/6/25, indicated Resident #4 was rarely/never understood and a staff assessment for Brief Interview for Mental Status indicated severe cognitive impairment. The MDS further indicated Resident #4 receives his/her nutrition through a feeding tube. Review of Resident #4's physician order, dated 9/9/25, indicated Enteral Feed Order: [NAME] Farms Peptide 1.5 Cal liquid via feeding tube pump set at 55 milliliters (ml)/ hour for 18 hours, total volume 990 ml/day. Pump on at 2 P.M., and off at 8 A.M. Review of Resident #4's plan of care, dated as revised 8/6/25, indicated The resident requires tube feeding related to dysphagia, swallowing problem.Interventions include:-provide tube feed per physician orders.-Dietitian to evaluate and monitor caloric intake and make diet change recommendations as needed.-Monitor/document any signs and symptoms of aspiration.-Obtain and monitor labs as ordered. Review of Resident #4's Quarterly Nutrition Assessment, dated 11/7/25, indicated he/she remains on enteral feedings at rate of 55ml/hour for 18 hours. Review of physician's progress note, dated 11/25/25, indicated Resident #4 continued [NAME] Farms Peptide 1.5 Cal liquid at 55 ml/hour x 18 hours, up at 2 P.M. and off at 8 A.M. Review of Resident #4's Medication Administration Record (MAR), dated 12/1/25 through 12/3/25, indicated a box for the nurse to initial when she hung the feeding at 2 P.M., but not a box to initial when the feeding was turned off at 8 A.M. On 12/1/25 at 12:07 P.M., the surveyor observed Resident #4's tube feeding infusing at 55 ml/hour. The tube feeding bag was dated 12/1. On 12/1/25 at 12:57 P.M., the surveyor observed Resident #4's tube feeding being turned off by Assistant Director of Nursing. On 12/2/25 at 8:57 A.M., 10:24 A.M., 11:26 A.M., and 12:36 P.M., the surveyor observed Resident #4's tube feeding was infusing at 55 ml/hour. On 12/3/25 at 8:38 A.M., the surveyor observed Resident #4's tube feeding infusing at 55 ml/hour. The tube feeding bag was dated 12/3. During an interview on 12/3/25 at 9:20 A.M., the Assistant Director of Nursing said that she knows that tube feeding comes down during the day and that when a new bag is hung the pump should be cleared so nurse can monitor how much feeding has infused. She said that she had turned the feeding off on 12/1/25 after she realized Resident #4's nurse had not turned it off. She said that anytime orders are not followed that the practitioner should be notified. She said Resident could be at risk related to receiving extra fluids. During an interview on 12/3/25 at 9:39 A.M., Nurse #4 said that she had not received any report about what time the tube feeding bag was hung and she said the orders were for the Resident to receive the tube feeding for 24 hours/day. On 12/3/25 at 10:29 A.M. the surveyor, Nurse Consultant #1, and the Director of Nursing observed Resident #4's tube feeding running at 55 ml/hour and Resident #4's order for the tube feeding be turned off at 8 A.M. They both said the Resident was at risk for fluid overload by not following the physician orders and that the physician should be notified. During an interview on 12/3/25 at 10:35 A.M., Nurse Practitioner #1 said she was not aware that Resident #4 had been receiving tube feeding at any time other than according to orders. She said she would expect that the physician orders be followed and that she be notified if they are not. She said that Resident is on a fluid restriction and is at high risk for fluid overload related to his/her diagnoses of Congestive Heart Failure. |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a therapeutic diet was provided for one Resident (#4) out of a total sample of 18 residents. Specifically, for Resident #4 the facility failed to ensure a 1200 mL (milliliter) fluid restriction was followed.Findings include:Review of the facility policy titled Encouraging and Restricting Fluids, dated as revised October 2010, indicated the purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids. Restricting fluids:-Record the amount of fluid consumed on the intake side of the intake and output record. Record fluid intake in milliliters (mLs). Resident #4 was admitted to the facility in August 2025 and has diagnoses that include stroke, dysphagia, gastrostomy status (nutrition provided through a tube inserted into the stomach), and congestive heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/6/25, indicated Resident #4 was rarely/never understood and a staff assessment for Brief Interview for Mental Status indicated severe cognitive impairment. The MDS further indicated Resident #4 receives his/her nutrition through a feeding tube. Review of Resident #4's active physician orders indicated:-Nothing By Mouth (NPO) diet.-Enteral Feed Order: [NAME] Farms Peptide 1.5 Cal liquid via feeding tube pump set at 55 mLs/ hour for 18 hours, total volume 990 mL/day. Pump on at 2 P.M. and off at 8 A.M.-Enteral Feed Order: every four hours 100 mL of water for hydration/ total 600 mL.-Fluid Restriction: 1200 mL total in 24 hours; Nursing: 300 mL/24 hours (100 mL on 7-3, 100 mL on 3-11, 100 mL on 11-7); Dietary 900 mL/24 hours (420 mL at breakfast, 240 mL at lunch, 240 mL at dinner).-Flush PEG (feeding) tube with 30mL of warm water before each medication pass. Flush with at least 15mL of warm water between each medication. Final flush with 30 mL of warm water after administering last medication every shift for enteral medication administration.-Protein liquid 30 mL in the morning via gastrostomy tube for wound healing. Review of Resident #4's plan of care, dated as revised 8/6/25, indicated The resident requires tube feeding related to dysphagia, swallowing problem.Interventions include:-provide tube feed per physician orders.-Dietitian to evaluate and monitor caloric intake and make diet change recommendations as needed.-Monitor/document any signs and symptoms of aspiration.-Obtain and monitor labs as ordered. Review of Resident #4's plan of care failed to indicate Resident #4 was on a fluid restriction. Review of Resident #4's Quarterly Nutrition Assessment, dated 11/7/25, indicated the following assessment/plan:-he/she remains on enteral feedings at rate of 55 mL/hour for 18 hours which provides 752 mL free water daily.- he/she continues a 1200 mL fluid restriction to help manage electrolytes.-flush and free water meet restriction parameters. Review of the [NAME] Farms 1.5 Peptide formula nutrition label indicates that the formula provides 70% free water (amount of water in the formula). The ordered tube feeding regime at 55 ml/hour for 18 hours would provide a total of 693 mL of free water. Water flushes and medication flushes add over 600 ml of extra free water, exceeding the 1200 mL fluid restriction ordered by the physician. On 12/1/25 at 12:07 P.M., the surveyor observed Resident #4's tube feeding infusing at 55 mL/hour, four hours after the tube feeding was supposed to be taken down at 8:00 A.M. On 12/2/25 at 8:57 A.M., 10:24 A.M., 11:26 A.M., 12:36 P.M., and 2:21 P.M., the surveyor observed Resident #4's tube feeding was infusing at 55 mL/hour, over six hours after the tube feeding was supposed to be taken down. On 12/3/25 at 8:38 A.M., the surveyor observed Resident #4's tube feeding infusing at 55 mL/hour 38 minutes after the tube feeding was to be taken down. During an interview on 12/3/25 at 9:20 A.M., the Assistant Director of Nursing said that she knows that tube feeding comes down during the day and that when a new bag is hung the pump should be cleared so nursing can monitor how much feeding has infused. She said that she had turned the feeding off on 12/1/25 as she realized Resident #4's nurse had not turned it off. She said that anytime orders are not followed then the practitioner should be notified.<br>(continued on next page) |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | She said Resident could be at risk related to receiving extra fluids. During an interview on 12/3/25 at 9:39 A.M., Nurse #4 said that she had not received any report about what time the tube feeding bag was hung and she said the orders were for the Resident to receive the tube feeding for 24 hours each day. During an interview on 12/3/25 at 9:59 A.M., the Dietitian said that she works with the practitioner to determine the appropriate orders to maintain Resident #4's nutrition and fluid restriction of 1200 ml. She said that she calculated the amount of fluid Resident #4 received by adding the 752 ml (she multiplied 55 ml/hour x 18 hours x 70% = 752 ml) of free water that the Resident received from [NAME] Farms 1.5 Peptide formula to the 400 ml (she multiplied 100 ml flush x 4) of flushes Resident received daily for a total of 1152 ml. She said that she would expect nursing to follow the fluid restriction and if it is not followed that Resident could be at risk for fluid overload. On 12/3/25 at 10:29 A.M. the surveyor, Nurse Consultant #1, and the Director of Nursing observed Resident #4's tube feeding running at 55 ml/hour and Resident #4's order for the tube feeding to be turned off at 8:00 A.M. They both said the Resident was at risk for fluid overload by receiving more than the 1200 mL fluid restriction and that the physician should be notified. During an interview on 12/3/25 at 10:35 A.M., Nurse Practitioner #1 said she was not aware that Resident #4 had been receiving tube feeding outside of the ordered times. She said she would expect that the physician orders be followed and that she be notified if they were not. She said that Resident is on a fluid restriction and is at high risk for fluid overload related to his/her diagnoses of Congestive Heart Failure. |