STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225598	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Lodge Llc, Rehabilitation & Healthcare	250 West Union Street Ashland, MA 01721

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to implement professional standards of practice for infection control and prevention for the facility's laundry processing system, ensure hand hygiene was performed before and after a medication administration by one Nurse (#3), and Unit Manager (UM) #3 and Certified Nurse Aide (CNA) #1 while they were distributing breakfast, and Housekeeping staff properly utilized equipment for cleaning of a Transmission Based Precaution (TBP- an infection control standard for residents who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission such as the use of gowns, gloves, eye protection, or masks) room. Specifically, the facility failed to ensure that:linens in the facility laundry room were cleaned and sanitized properly and in accordance with manufacturer's recommendations, placing facility residents at risk for infection. Nurse #3 performed hand hygiene before and after a medication administration to prevent the potential for cross contamination during medication administration. UM #3 and CNA #1 performed appropriate hand hygiene while distributing breakfast on Unit Four, placing residents at risk of foodborne illnesses.The Housekeeping Supervisor failed to change the mop head, mop water, or disinfect the mop bucket and mop after cleaning a TBP room and moving onto the next room placing the residents, staff and visitors of Unit Four at risk for contracting a drug-resistant organism. Review of the Centers for Disease Control and Prevention (CDC) Healthcare-Associated Infections guidance, titled Appendix D-Linen and Laundry Management, dated 3/19/24, indicated: -Always use and maintain laundry equipment to manufacturer instructions. -Use hot water and an approved laundry detergent. Review of Service Company #1's Service Request Note, dated 7/2/25, indicated the following related to laundry: -Using competitor's products. -Same issue going on for two years. -All linen brown and smells like poop. -Service Company #1's Representative (Rep) spoke with the Housekeeping Manager, Facility Repairman, and office staff about dangerous issue. -Service Company #1's Rep told the Housekeeping Manager again to contact another company so that Service Company #1's automated advanced laundry control system dispensers could be removed. (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/25/26 at 1:37 P.M., the surveyor observed the following in the facility's laundry area: -Two washing machines running, one containing bed linens and set to wash cycle 02 WHT SPECL (designed to use specific products, often with white or specialty formulas for sanitization and bleaching) and one containing personal items set to wash cycle 03 COLOR (designed for colored clothing). -Both washing machines were equipped with Service Company #1's automated advanced laundry control system. -One bucket of laundry detergent and one bucket of bleach were connected to the automated advanced laundry control system pumps located on the wall behind the washing machines. -The bucket of laundry detergent and the bucket of bleach were labeled with different names than that of Service Company #1's automated advanced laundry control system dispensers. -Written directions on the bucket of bleach indicated: >This product is to be used with a certified [Service Company #2] dispensing system. During an interview on 2/25/26 at 1:45 P.M., the Laundry Supervisor said the facility had not been using Service Company #1's laundry chemicals for over a year or more. The Laundry Supervisor said Service Company #1's automated advanced laundry control system is being used with different chemicals than what the automated advanced laundry control system was set up to use. The Laundry Supervisor said that the automated advanced laundry control system had not been serviced in more than a year and needed to be calibrated to ensure it was delivering the right amount of chemicals for the wash cycles selected. The Laundry Supervisor said Service Company #1 will not service and calibrate the system because the facility is using chemicals not approved for use in the system. During an interview on 2/25/26 at 2:31 P.M., the Maintenance Director said Service Company #1 used to service the facility's washing machines and that Service Company #1 stopped servicing the machines when the facility began using laundry chemicals not approved for use in the automated advanced laundry control system. The Maintenance Director said the facility has a company that services the washing machines, but that company cannot service and calibrate the automated advanced laundry control systems. The Maintenance Director said he thought the automated advanced laundry control system needed to be calibrated yearly, but he was not sure. The Maintenance Director said he did not think the facility had a copy of the user manual instructions for the automated advanced laundry control system to determine the frequency of recommended service and calibration for the system. During an interview on 2/25/26 at 2:57 P.M., Service Company #1's Representative (Rep) said he used to provide routine monthly service to the facility's automated advance laundry control systems and had not serviced the systems in about two years. Service Company #1's Rep said he continues to service the facility's dish machine and every time he is in the facility, he observes the laundry area and sees that the facility continues to use laundry chemicals that the automated advance laundry control system was not set up to use. Service Company #1's Rep said the automated advance laundry control systems were set up and calibrated specifically for Service Company #1's laundry chemicals to ensure linens were cleaned properly. Service Company #1's Rep said he would not be able to service and calibrate the automated advance laundry control systems at the facility because the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility was using chemicals that are not approved for use in the automated advance laundry control systems. Service Company #1's Rep said he has been in the facility's laundry area since the facility began using laundry chemicals not approved for use in the automated advance laundry control systems and that the white linens look like they have not been bleached properly as demonstrated by a brownish discoloration. Service Company #1's Rep said the automated advance laundry systems are supposed to be inspected monthly and if it was determined re-calibration was needed, they would be re-calibrated. Service Company #1's Rep said he had alerted the facility that the automated advance laundry systems were meant to be used only with laundry chemicals approved for use in the systems and that not using the proper laundry chemicals increased risk for infection transmission. Service Company #1's Rep said he spoke with the facility's Laundry Supervisor and observed the washing machine squeeze tubes (small, flexible tube used in washing machines to deliver detergent, bleach, or fabric softener from the dispenser to the wash water at the right time during a cycle which ensures chemicals are dispensed in the correct sequence for optimal cleaning) were damaged and required replacement. Service Company #1's Rep said squeeze tubes were supposed to be routinely changed approximately every four to six months, or at a minimum yearly. Service Company #1's Rep said if the squeeze tubes are not replaced and are not in proper condition, the right amount of chemicals will not get pulled into the washing machine to effectively clean linens. On 2/25/26 at 4:23 P.M., the surveyor observed the following on the Unit Four Clean Linen Storage Cart: -One bath towel with multiple yellow stains. -One top sheet with a yellow stained area. -One blue bedspread with a large discolored white spot on it. During an interview at the time, Nurse #3 said that a lot of the linen is stained and that it has been a bad issue lately. During an interview on 2/25/26 at 4:28 P.M., the Administrator said the facility does not have a policy and procedure relative to routine maintenance and service for the washing machines and automated advanced laundry system, and that the facility does not have a user manual for the automated advanced laundry system. The Administrator said the facility does not have any evidence that the laundry chemicals currently in use were evaluated and determined to be of the same effectiveness as the products for which the automated advanced laundry control system pumps had been set up and calibrated for. During an interview on 2/25/26 at 4:42 P.M., the Infection Preventionist (IP) said the facility included her in the discussion about changing laundry chemical products from those provided through Service Company #1 and that she was responsible to ensure whatever chemicals were selected by the facility were EPA approved. The IP said she was not included in how the chemicals were to be distributed through the automated advanced laundry control system. The IP said it was important to ensure the right amount of chemical is used to launder clothing and linens to reduce the risks for infection and infection transmission. The facility failed to provide any evidence prior to survey end that the laundry equipment had been maintained according to the instructions of Service Company #1 and that the laundry chemicals being used were approved for use with the automated advanced laundry control system. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2.Review of the facility policy titled Infection Control and Prevention Policy, revised 2/25/24, included but was not limited to:*Standard precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered. These practices are designed to both protect and prevent healthcare professionals (HCP) from spreading infections among patients. -Hand hygiene.*Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications:-After touching a patient or the patient's immediate environment. On 2/19/26 at 8:02 A.M., the surveyor observed the following during medication administration by Nurse #3:-Nurse #3 approached the medication cart, opened the cart, removed medications from inside the medication cart and poured the medications into a clear plastic medication cup without performing hand hygiene prior to removing medications from the cart or pouring medications into the medication cup. -Nurse #3 then administered the medication to the resident using a spoon. During an interview on 2/19/26 at 9:19 A.M., Nurse #3 said that she should have performed hand hygiene prior to starting the medication administration and after she had completed the medication administration. Nurse #3 said that it was important to perform hand hygiene to prevent the spread of infections. During an interview on 2/19/26 at 10:10 A.M., the Director of Nursing (DON) said that hand hygiene prior to administering medications was important to prevent the spread of infections and Nurse #3 should have washed her hands prior to beginning the medication administration. 3. On 2/19/26 at 8:34 A.M., on Unit Four dining room, the surveyor observed the following during the breakfast meal:-UM #3 and CNA #1 were serving meals. -A drink station including coffee, juices pitchers, water, sealed juices, coffee mugs, and glasses. The beverage cart was observed positioned next to the steam table door in the dining room. -The cook was plating meals from the steam table located at the back of the dining room wearing gloves and a hair restraint. -CNA #1 took an egg from a resident without performing hand hygiene and peeled the egg for the resident with ungloved hands. -CNA #1 cleared soiled utensils, plates, and cups from two tables and placed the soiled dish ware into a meal cart. CNA #1 then returned to the steam table without performing hand hygiene after touching the soiled dish wear with ungloved hands. -CNA #1 picked up a clean meal tray with a resident meal and exited the dining room without performing hand hygiene. During an interview on 2/19/26 at 8:48 A.M., CNA #1 said that she should have washed her hands prior to peeling the resident's egg and did not. CNA #1 also said that when she picked up the dirty plates and cups, she should have washed her hands prior to picking up a clean tray and serving the meal to another resident. CNA #1 said that washing her hands between picking dirty plates and serving resident's meals prevents the transmission of infection and she forgot to wash her hands. During an interview on 2/19/26 at 10:10 A.M., the DON said hand hygiene during dining was important to prevent the spread of infection. The DON said that staff should wash their hands and wear gloves prior to touching the resident's meal. The DON also said that staff should wash their hands when dirty plates were removed from the tables prior to touching a meal tray to prevent the spread of infections. 4. Review of the facility policy titled Daily Cleaning of Transmission-Based Precaution (TBP) rooms, last reviewed 12/18/24 included the following: -Purpose of the policy is to establish standard procedures for safe and effective daily cleaning and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	disinfection of rooms occupied by residents on Contact Precautions (a specific type of TBP infection control measure that prevents the spread of infectious agents transmitted through direct or indirect contact). -Use dedicated equipment when required. On 2/19/26 between 2:05 P.M. through 2:15 P.M., the surveyor observed the Housekeeping Supervisor mopping the floor in a resident room which had signage on the doorway indicating: STOP-CONTACT PRECAUTIONS, EVERYONE MUST: -Clean their hands .before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: -Put on gloves before room entry. Discard gloves before room exit. -Put on a gown before room entry. Discard gown before leaving the room. -Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another patient. The surveyor observed the Housekeeping Supervisor exit the room, place the mop into the mop bucket, doffed his gown and gloves then cleansed his hands with alcohol-based hand sanitizer. The surveyor then observed the Housekeeping Supervisor roll his mop and bucket to the doorway of the adjacent resident room. The Housekeeping Supervisor was observed to remove the mop from the bucket and began to mop the floor of the adjacent room. During an interview at the time, the Housekeeping Supervisor said he used the same mop and bucket in both the TBP and Non-TBP rooms but should not have because the germs were being brought from the TBP room into the adjacent room. During an interview on 2/19/26 at 3:00 P.M., the Infection Preventionist (IP) said the residents in the TBP room had bacteria that required TBP. The IP said the Housekeeping Supervisor should have cleaned the TBP room last. The IP said that if the Housekeeping Supervisor was unable to clean the TBP room last, he should have changed the mop and mop bucket after the disinfection of the TBP room before moving onto the next room because germs can be transmitted from the TBP room to other rooms affecting other residents, staff, and visitors.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, interviews and document review, the facility failed to ensure residents had access to grievance forms to formulate grievances anonymously on three (Unit Two, Unit Three and Unit Four) out of three units.Specifically, the facility failed to ensure that residents were able to formulate grievances anonymously and had grievance forms easily accessible for the facility residents to complete a grievance without having to rely on the staff to provide them with the form. Findings include: Review of the facility's policy titled Resident Grievance Procedure, undated, indicated:-the facility wants the residents to make known any complaints about the services they receive, or grievances they may have .to the Administrator.-when a complaint is offered by a resident, family member, friend or visitor, the person receiving the complaint will listen carefully, acknowledge the complainant's situation and attempt to resolve the problem. -if the complaint cannot be resolved immediately, a Grievance/Complaint form will be completed and processed.-the Grievance/Complaint form will be delivered to the Social Service Director who will investigate the complaint and attempt a resolution. Review of the facility's Notice of Nursing Facility Resident's Rights, last revised January 2001, indicated:-residents have the right to voice grievances about their treatment or care without discrimination or reprisal for voicing grievances.-residents have the right to prompt efforts by the facility to resolve any grievances they may have, including those concerning other residents. Review of the facility's Grievance Book for 2025 indicated that four grievance forms were completed. On 2/18/26 at 2:39 P.M., during a tour of Unit Four, the surveyor did not observe or locate any grievance forms or grievance information readily available for the residents/resident's responsible parties on the unit. On 2/18/26 at 2:45 P.M., during a tour of Unit Three, the surveyor did not observe or locate any grievance forms or grievance information readily available for the residents/resident's responsible parties on the unit. On 2/18/26 at 2:50 P.M., during a tour of Unit Two, the surveyor did not observe or locate any grievance forms or grievance information readily available for the residents/resident's responsible parties on the unit. During a group meeting on 2/19/25 at 11:06 A.M., eight out of eleven residents in attendance said they do not know what a grievance form was or where the grievance forms were located in order for them to file a grievance independently. The eight residents further said they were never offered a grievance form when voicing concerns to a staff member. During an interview on 2/19/26 at 1:28 P.M., the Administrator said the facility does not have a way for residents to file grievances anonymously. The Administrator said that the facility system is to tell the Social Worker (SW) the concern that a resident is having and then the SW will complete the grievance form on the resident's behalf. The Administrator also said that the grievance forms were not available on the resident's units. During an interview on 2/19/26 1:51 P.M., SW #1 said only the Social Workers complete the grievance forms in the facility. SW #1 said that the grievance forms are not available for residents or others on the resident units.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure that the Minimum Data Set (MDS) Assessment was completed to accurately reflect the status of four Residents (#69, #5, #12, and #57) out of a total sample of 21 residents, increasing each Resident's risk for inaccurate assessments, and ineffective care planning and delivery of care.Specifically, 1.For Resident #69, the facility failed to conduct four consecutive Brief Interview for Mental Status (BIMS) Assessments on three non-comprehensive MDS Assessments and one comprehensive MDS Assessment using the Resident's preferred language (which was not English), when: -none of the facility staff spoke the Resident's preferred language. -an interpreter was not offered for the Resident to complete the Assessments.2.For Resident's #5, #12, and #57, the facility failed to conduct BIMS Assessments on singular, non-consecutive MDS Assessments using the Residents' preferred languages. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated October 2025, indicated the following: -Comprehensive MDS assessments include both the completion of the MDS as well as completion of the CAA process and care planning. -Non-Comprehensive MDS assessments include a select number of items from the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. -Inability to make needs known and to engage in social interaction because of a language barrier can be very frustrating and can lead to social isolation, depression, resident safety issues, and unmet needs. -Language barriers can interfere with accurate assessment. -Planning for Care: -When a resident needs or wants interpreter services, the nursing home must ensure that an interpreter is available. -An alternate method of communication also should be made available to help ensure that basic needs can be expressed at all times (e.g., communication board with pictures on it for the resident to point to, if able). -Identifies residents who need interpreter services in order to answer interview items or participate in consent process. -Steps for Assessment: 1. Ask for the resident's preferred language. 2. Ask the resident if they need or want an interpreter to communicate with a doctor or health care staff. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	language]. -monitor effectiveness of communication strategies and assistive devices (daily). -prefers communicating:(face to face, while family is present to translate, .). Review of Resident #69's comprehensive MDS Assessment, dated 1/17/26, indicated: -preferred language was [specific non-English language]. -did not need or want an interpreter to communicate with a doctor or healthcare staff. -has unclear speech, rarely/never understood others, and rarely/never made him/herself understood. -BIMS Assessment should not be conducted with the Resident due to the Resident being rarely/never understood. -Staff assessment of the Resident's cognitive skills for daily decision-making was completed in place of the BIMS Assessment being completed with the Resident. -Communication triggered for the Resident, and the facility's decision was to care plan Communication for the Resident. During a telephone interview on 2/19/26 at 1:24 P.M., Resident #69's Legal Guardian said that the rationale for having been appointed as Legal Guardian for Resident #69 was due to the ability to speak the Resident's preferred language and communicate with the Resident. Resident #69's Legal Guardian said he/she has only communicated with the Resident using the Resident's preferred language and that, although some of their conversations are circular (repetitive), it is easy for him/her to communicate with the Resident. Resident #69's Legal Guardian said the Resident understands and speaks to him/her using the Resident's preferred language. During an interview on 2/20/26 at 7:58 A.M., MDS Nurse #1 said Resident #69 was not offered an interpreter to complete MDS Assessment interviews because Resident #69 was the only Resident at the facility who speaks [specific non-English language] and that no one at the facility seemed to be able to communicate with the Resident. During an interview on 2/20/26 at 11:21 A.M., Social Worker (SW) #1 said Resident #69 speaks [specific non-English language] and she was unsure whether the Resident's Dementia would affect the Resident's ability to participate in a BIMS Assessment. SW #1 said she did not think the Resident could cognitively understand the questions included in a BIMS assessment. When the surveyor asked how this was determined, SW #1 said she did not speak the Resident's language. SW #1 said the BIMS Assessments for each MDS Assessment the surveyor inquired about (4/19/25, 7/19/25, 10/18/25, and 1/17/26) had not been attempted with the Resident in the Resident's preferred language. SW #1 said she thought there should be more effort in addressing that. 2a. Resident #5 was admitted to the facility in September 2024 with diagnoses including Alzheimer's Disease and Anxiety. Review of Resident #5's Minimum Data Set (MDS) assessment dated [DATE] indicated: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-preferred language was [a non-English language]. -did not need or want an interpreter to communicate with a doctor or healthcare staff. -had unclear speech, rarely/never understood others, and rarely/never made him/herself understood to others. -The Brief Interview for Mental Status (BIMS) Assessment could not be conducted with the Resident due to the Resident being rarely/never understood. -Staff assessment of the Resident's mental status and cognitive skills for daily decision-making was completed in place of the BIMS Assessment being completed with the Resident. Review of Resident #5's active Person-Centered Care Plan failed to include focus or interventions for language deficits or a preferred language. 2b. Resident #12 was admitted to the facility in April 2021 with diagnoses including Schizophrenia. Review of Resident #12's MDS Assessment, dated 12/1/25 indicated: -preferred language was [a non-English language]. -did not need or want an interpreter to communicate with a doctor or healthcare staff. -had unclear speech, sometimes understood others, and sometimes made him/herself understood. -The BIMS Assessment could not be conducted with the Resident due to the Resident being rarely/never understood. -Staff assessment of the Resident's mental status and cognitive skills for daily decision-making was completed in place of the BIMS Assessment being completed with the Resident. Review of Resident #12's active Person-Centered Care Plan failed to indicate a focus or interventions for language deficit or a preferred language. 2c. Resident #57 was admitted to the facility in October 2022 with diagnoses including Dementia and Anxiety. Review of Resident #57's MDS Assessment, dated 2/4/26 indicated: -preferred language was [a non-English language]. -did not need or want an interpreter to communicate with a doctor or healthcare staff. -had unclear speech, rarely/never understood others, and rarely/never made him/herself understood. -The BIMS Assessment could not be conducted with the Resident due to the Resident being rarely/never understood. (continued on next page)

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	225598	A. Building B. Wing	02/25/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff assessment of the Resident's mental status and cognitive skills for daily decision-making was completed in place of the BIMS Assessment being completed with the Resident. Review of the Resident #57's active Person-Centered Care Plan failed to indicate a focus or interventions for language deficit or a preferred language. During an interview on 2/20/26 at 1:47 P.M., MDS Nurse #1 said she completed the preferred language section on the MDS Assessments for Resident's #5, #12, and #57. MDS Nurse #1 said she never selected a yes response for a need of an interpreter because the Resident's families are available to interpret for the Residents. MDS Nurse #1 further said if the families were required to translate for the Residents, then that would be considered an interpreter service and should have been coded as such. MDS Nurse #1 said that the coding for Resident's #5, #12, and #57 need for interpreter services was inaccurate and should probably be corrected. During an interview on 2/20/26 at 2:16 P.M., Social Worker (SW) #1 said she had completed the entries relative to the most recent BIMS assessments for Resident's #5, #12, and #57. SW #1 said she did not attempt any MDS Assessments in any of the Resident's preferred languages. SW #1 said that the Residents could benefit from assessments completed with interpreter services and maybe even improve their outcomes if the MDS Assessments were conducted in the Resident's preferred languages. SW #1 said the facility did not have contracted translation services available for use.

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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, interview, and record review, the facility failed to provide a dignified experience during a medication request for one Resident (#46) out of a total sample of 21 residents.Specifically, the facility failed to ensure that Resident #46 was treated with respect and dignity when Nurse #1 was observed pointing a finger in his/her face and yelling at him/her, resulting in the Resident becoming upset. Findings include:Review of the facility policy titled Resident Dignity and Respect, dated 8/26/25 included the following:-All residents have the right to be treated with dignity and respect regardless of age ., or disability.-Speak in a calm, courteous, and professional tone.-Conduct conversations about care in private settings.-Residents have the right to be free from mistreatment.-Treat every resident as a valued individual, not a task.-Demonstrate professionalism and empathy in all interactions. Resident #46 was admitted to the facility in December 2021 with diagnoses including anxiety and Paranoid Schizophrenia. Review of Resident #46's Minimum Data Set (MDS) Assessment, dated 1/16/26, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15. On 2/18/26 at 4:13 P.M., the surveyor was standing in the hallway outside room [ROOM NUMBER] and observed yelling at the nurse's station. The surveyor observed Nurse #1 moving towards Resident #46 with her right index finger pointed at the Resident's face with her voice raised and brow furrowed said stop harassing me, it is not time for your medication, I will tell you when it is time for your medications. The surveyor approached the nurse's station where the Resident and Nurse #1 were standing face to face and observed Unit Manager (UM) #3 was sitting at the nurse's station with his back turned towards Resident #46 and Nurse #1. The surveyor observed Resident #46 become tearful and then cry out loudly to Nurse #1 you do not have to speak to me like that, I don't deserve that. Resident #46 then walked down the hallway and into his/her room. During an interview at the time, UM #3 said he had not exactly heard the interaction between Resident #46 and Nurse #1, but he was going to talk to Nurse #1 to find out what the interaction was all about. The surveyor reported the observed interaction to the facility Administrator. During an interview on 2/19/26 at 11:37 A.M., Social Worker (SW) #1 said she interviewed Resident #46 following the interaction between Resident #46 and Nurse #1 on 2/18/26. SW #1 said Resident #46 said that he/she was yelled at by Nurse #1 and was feeling hurt. SW #1 said it was a violation of Resident #46's right to dignity to be yelled at by Nurse #1. During an interview on 2/19/26 at 12:20 P.M., the Director of Nursing (DON) said she interviewed Resident #46 following the interaction between Resident #46 and Nurse #1 on 2/18/26. The DON said Resident #46 reported that Nurse #1 yelled at him/her because Resident #46 had asked for medication and it was not time for the medications. The DON said Resident #46 had psychiatric issues and when Nurse #1 yelled at him/her, the yelling was derogatory and impacted the Resident's right for dignity. The DON said Nurse #1 should have attempted to redirect the Resident or use other nonmedical interventions like distractions and activities, instead of yelling at the Resident. The DON said when Nurse #1 yelled at Resident #46, it violated the facility policy of dignity and respect for not speaking in a calm, courteous and professional tone. The DON said that Nurse #1 had been placed on leave and was not available for interview.

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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 interview, the facility failed to accurately execute Advance Directives for two Residents (#1 and #42) out of a total sample of 21 residents. Specifically, the facility failed to:1. For Resident #1, ensure that the MOLST (Massachusetts Medical Order for Life-Sustaining Treatment) form was valid and reflected the signature of Resident #1's legal guardian (someone granted legal authority to care for another person who cannot make decisions independently due to age, illness, disability, or incapacity).2. For Resident #42, ensure that the MOLST form and Physician's orders accurately reflected the Resident/Resident Representative's wishes putting the Resident at risk for being resuscitated (perform full measures including cardiopulmonary resuscitation and intubation) when the advanced directive wishes were for no resuscitation (Do Not resuscitate [DNR] and Do Not Intubate [DNI]). Findings include: Review of the facility policy for Advance Directives and Resident's Rights to Refuse Medical Treatment, undated, indicated: -Each Resident has the right to refuse medical treatment or procedures with the provisions of applicable law. -The facility will endeavor to implement each Resident's documented wishes (or those of a legal representative acting on the behalf of an incompetent resident), concerning the refusal or withdrawal of medical treatment or procedures in accordance with state and federal law. -The facility will, under federal law, advise the resident/legal representative of the at the time of admission, of the policy on Advanced Directives and Resident Right to Refuse Medical Treatment. -Furthermore, the facility will make available information concerning any applicable state law regarding the use of advanced directive and/or authorizing the withholding or withdrawal of life sustaining treatment or procedures. -In addition, the facility will document in the Resident's record the existence of a signed Advanced Directive. -Do Not Resuscitate (DNR) Order: A written physician's order, supported by appropriate consent and medical documentation to suspend the otherwise automatic initiation of cardio-pulmonary resuscitation, in the event of cardiac arrest. In some states or jurisdictions, the use of the term no code or no CPR is synonymous with DNR. 1. Resident #1 was admitted to the facility in [DATE], with diagnoses including Dementia and Type II Diabetes Mellitus and Liver Cell Carcinoma. Review of Resident #1's clinical record indicated: -was appointed a permanent legal guardian on [DATE]. -a MOLST form signed on [DATE] by an unknown Provider with the words verbal guardian on Section D of the form, which requires the Patient or Patient's Representative Signature. -the MOLST form requested Do Not Resuscitate and Do Not Intubate or Ventilate. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-no evidence that the MOLST form had been re-addressed with Resident #1's Guardian after his/her facility admission and before the surveyor brought it to the attention of the facility. During an interview on [DATE] at 11:50 A.M., Social Worker (SW) #1 said that Resident #1's MOLST form was not valid without a signature of the Resident's Responsible party. During an interview on [DATE] at 12:36 P.M., SW #2 said that she had reviewed Resident #1's MOLST form and believed it to be valid because it came from the hospital. 2. Review of the facility policy titled Advanced Directives, undated, included but was not limited to:*It is the policy of . to ensure that a resident's/responsible party's wishes are respected in regard to advance directives. -Upon admission, the resident, family or responsible party will be given a copy of the advanced directives. Resident #42 was admitted to the facility in [DATE] with diagnoses including unspecified dementia mild without behavioral disturbance, thrombocytopenia, dysphagia, venous embolism and thrombosis. Review of Resident #42's clinical record indicated a MOLST form which included:-Do not resuscitate (DNR), do not intubate (DNI) and ventilate (DNV), do not use non-invasive ventilation (NIV) and do not transfer to hospital.-The form was signed and dated by Resident #42's Healthcare Proxy (HCP) on [DATE].-The form was signed and dated by a Provider on [DATE]. Review of the Minimum Data Set (MDS) Assessment, dated [DATE], indicated Resident #42:-has severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of three out of a possible 15 points.-HCP was invoked.-Do not resuscitate (DNR), do not hospitalize (DNH), do not intubate (DNI) and feeding and other treatment restrictions were in place. Review of the February 2026 Physician's orders included the following relative to advanced directives for Resident #42:-Full code (attempt resuscitation, intubate and ventilate, transfer to the hospital and provide all other life saving measures) invoked (HCP), dated [DATE]. During an interview on [DATE] at 12:00 P.M., Social Worker (SW) #1 said that Resident #42's MOLST form must have been changed after the Resident was admitted to the facility. SW #1 said that Resident #42's Physician's order should have been changed to reflect the Resident's current wishes. SW #1 said the risk of inaccurate Physician orders would confuse nursing staff and does not reflect the Residents' current wishes. On [DATE] at 12:42 P.M., the surveyor and SW #2 reviewed a progress note entered by SW #2 in Resident #42's clinical record which indicated the Resident was a full code. During an interview at the time, SW #2 said that she had not reviewed Resident #42's clinical record prior to entering her notes and should have as it was an inaccurate record. During an interview on [DATE] at 2:13 P.M., the surveyor and Unit Manager (UM) #3 reviewed Resident #42's clinical record and UM #3 said when the Resident was admitted to the facility he/she had full code orders as there was no MOLST in his/her records at the time. UM #3 said the Resident's MOLST and Physician electronic medical records should both reflect the Resident wishes. During an interview on [DATE] at 3:00 P.M., UM #3 said that she placed a call to Resident #42's healthcare proxy (HCP), who said that the Resident's MOLST should indicate DNR/DNI/DNV/Do not (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer to hospital. During an interview on [DATE] at 3:56 P.M., SW #1 said that Resident #42 was originally admitted to Unit Two and then later transitioned to Unit Four. SW #1 said that she recalls that there was no MOLST in place at the time. SW #1 said that Resident #42's HCP brought the MOLST in sometime in [DATE]. SW #1 said that she made a copy of the MOLST and placed it in the Resident's records but failed to relay the information to the Physician and/or the UM's which was an oversight. SW #1 said she should have updated the records so that the Resident wishes could be honored.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews, and interviews, the facility failed to ensure that one Resident (#42) out of five applicable residents sampled for unnecessary medications, out of a total sample of 21 residents, was free from unnecessary psychotropic (any drug that affects behavior, mood, thoughts, or perception) medications. Specifically, for Resident #42, the facility failed to ensure that the Physician evaluated the Resident and documented the rationale for the continued use of as needed (PRN) Quetiapine (antipsychotic medication) as recommended by the Pharmacist.Findings include:Review of the facility policy titled Psychoactive Medication Protocol, undated, included but was not limited to: -The consultant pharmacist shall regularly review and assess the antipsychotic drug therapy of residents on these drugs using specific criteria established by Healthcare Financing Administration (HCFA) regulations. -Residents on antipsychotic drug therapy will be monitored for specific conditions, behavior both quantitively and objectively and side effects. Dosages reduction or discontinuation of antipsychotic drug recommendations will be appropriate according to Centers for Medicare Services (CMS) guidelines. The physician will then review the pharmacist's recommendations and write orders appropriate for the resident. -This medication regimen review and assessment monitor will be utilized throughout the resident's course of antipsychotic medication therapy. This assessment monitor is part of the resident's permanent record and will be retained within the facility. Review of the facility policy titled Psychoactive Medication, undated, included but was not limited to:*This facility supports the cooperative efforts of the physician, pharmacist, nursing staff, social worker and mental health professionals to establish specific goals and objectives to review the use of antipsychotic medications. -The Physician shall respond appropriately by changing or stopping problematic doses or medications or clearly document (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. Resident #42 was admitted to the facility in May 2025 with diagnoses including unspecified dementia, mild without behavioral disturbance, psychotic disturbance, anxiety disorder, and depression. Review of the Minimum Data Set (MDS) Assessment, dated 11/25/25, indicated Resident #42:-has severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of three out of a possible 15 points.-received an antipsychotic medication and the antipsychotic was administered on an as needed (PRN) basis. Review of Resident #42's February 2025 Physician orders indicated: -Quetiapine Fumarate (Seroquel) Oral Tablet. Give 50 Milligrams (mg) by mouth every 8 hours as needed (PRN) for Agitation, initiated 5/21/25, no stop date. Review of the Medication Administration Records (MAR) for October 2025 through December 2025 indicated:-Resident #42 was administered the PRN dose of Quetiapine Fumarate without a Physician assessment and documented rationale for continued use five times during the following months:-October: 10/30/25-November: 11/6/25, 11/20/25, 11/21/25-December: 12/25/25 Review of Resident #42's Psychiatric Behavioral Note, dated 8/8/25, indicated:-Discontinue Seroquel - cannot be on a PRN antipsychotic without a scheduled dose. Review of Resident #42's Psychiatric Behavioral Note, dated 9/19/25, indicated:-PRN Seroquel was not discontinued despite prior recommendations, will recommend again since patient is not on a scheduled antipsychotic and this goes against guidelines. -Discontinue PRN Seroquel. -A patient cannot be on a PRN antipsychotic without being on a scheduled antipsychotic. Review of Resident #42's Pharmacy Consultant Regimen indicated:-10/30/25: Resident is currently on the antipsychotic Quetiapine. Evaluate current diagnosis, behaviors and usage patterns and evaluate continued need. PRN antipsychotic orders cannot exceed 14 days and require direct prescriber evaluation for continuation. -11/25/25: Resident is currently on the antipsychotic Quetiapine. Evaluate current diagnosis, behaviors and usage patterns and evaluate continued need. PRN antipsychotic orders cannot exceed 14 days and require direct prescriber evaluation for continuation.-12/25/25: Resident is currently on the antipsychotic (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Quetiapine. Evaluate current diagnosis, behaviors and usage patterns and evaluate continued need. PRN antipsychotic orders cannot exceed 14 days and require direct prescriber evaluation for continuation.Review of Resident #42's December 2025 Physician/Prescriber's Response indicated:-Disagree, no change, see progress note for detailed medical necessity. Review of the Physician/Prescriber's Response dated 1/7/26, indicated:-Psych input is requested. Review of Resident #42's medical records indicated a Psychiatry review, dated 1/21/26. During an interview on 2/19/26 at 12:30 P.M., the Director of Nursing (DON) said that she was responsible for reviewing all psych recommendations. The DON also said that she typically reviews the psych recommendations after the Resident has been seen and coordinate with the Physician to include the recommendations in the Resident plan of care. During an interview on 2/20/26 at 3:18 P.M., the Infection Preventionist (IP) said the PRN Seroquel was not assessed after the initial psych recommendations. The IP said she reviewed the Physician Progress Notes dated 8/24/25, that the PRN Seroquel should have been assessed within 14 days but was not re-assessed as required. The IP said the PRN antipsychotic should be assessed within 14 days to include a stop date. The IP also said that the PRN Seroquel was re-assessed by the Physician dated 2/7/26, and the order is now scheduled to Seroquel 50 mg three times a day. During an interview on 2/25/26 at 8:56 A.M., the Nurse Practitioner (NP) #1 said that she was not working in the facility August 2025 but was in the facility September 2025. The surveyor and NP #1 reviewed the psych recommendations for September 2025, and the NP said that she reviewed the recommendations and signed it. The NP also said signing the psych recommendations indicated that she agreed with the recommendations that a PRN antipsychotic should have a stop date and should be discontinued. The NP further said that the Resident was not on a scheduled antipsychotic and it was against guidelines to prescribe a PRN psychotropic medication without a scheduled psychotropic medication. During an interview on 2/25/26 at 9:00 A.M., Unit Manager (UM) #3 said that she was responsible for reviewing psych recommendations after the recommendations had been reviewed and signed by the Physician. UM #3 said she should have discontinued the PRN Seroquel signed by the Physician, but she did not.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, and interview, the facility failed to report allegations of abuse to the State Agency as required for one Resident (#3) out of a total sample of 21 residents. Specifically, for Resident #3, the facility failed to:1. report an allegation of abuse to the State Agency after allegations of abuse were reported on a Grievance Form dated 12/12/25.2. ensure that an allegation of abuse was reported to the Department of Public Health (DPH) within two hours as required, after the Director of Nursing (DON) was notified by the surveyor on 2/19/26 that the Resident said Nurse #2 was verbally abusive to him/her, and the verbal abuse allegation was not reported to DPH until 2/20/26 (24 hours later). Findings include:Review of the facility policy titled Abuse Prohibition Policies & Procedures dated 9/2021, indicated but was not limited to the following:*This facility has the responsibility to ensure that each resident has the right to be free from abuse, mistreatment, neglect and misappropriation of their personal property. To this end, this facility has developed and utilizes the following:-Screening of personnel for a past history of abuse.-Training of personnel regarding abuse through the orientation process and ongoing staff educational programs-Education to residents, families and staff on how to report incidents of potential or suspected abuse, and to whom they can report their concerns without fear of reprisal.-Identifying events, occurrences, patterns and trends of potential abuse for residents.-Performing internal facility investigations of alleged violations and identification of staff members responsible for investigating incidents and the reporting of same to proper authorities.-Protecting residents from harm during investigation of alleged abuse.-Reporting of all alleged violations of resident abuse to appropriate state agencies with the simultaneous development of corrective actions determined as part of the internal facility investigation to prevent further occurrences of abuse within 2 hours of alleged incident. The policy also included the following:*Resident abuse is defined as physically or emotionally harming residents or intentionally placing them in fear of being harmed. -Each resident has the right to be free from any physical or chemical restraints imposed for discipline or convenience. Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.-The facility must have and follow written polices and prohibit mistreatment, neglect, and abuse of resident of their property.-Alleged violations of these rights must be reported to the administration and other officials as required by state law. The facility must investigate thoroughly all alleged violations and report its findings. -All alleged violations of incidents included within the definition of abuses, mistreatment, neglect, involuntary seclusion or misappropriation or resident property shall be reported to the Department of Public Health, Division of Health Care Quality (DHCQ) immediately upon receipt of the facility's report of basis findings on the form established by DHCQ. The facility must then begin an internal investigation of the incident, and this investigation must be completed within 5 days or sooner. Review of the facility policy titled Resident Dignity and Respect Policy, dated 8/28/25, indicated but was not limited to the following:*To ensure all residents are treated with dignity, respect, compassion, and professionalism at all times in accordance with federal and state regulations governing skilled nursing facilities: -All residents have the right to be treated with dignity and respect regardless of age, diagnosis, cognitive status, background, religion, culture, gender, or disability. This facility is committed to person-centered care that promotes autonomy, privacy, safety, and emotional well-being. *Respectful communication:-Speak in a calm, courteous, and professional tone.-Never use demanding, dismissive, or infantilizing language. *Freedom from Abuse and Neglect:-Residents have the right to be free from abuse, neglect, exploitation, or mistreatment. -All suspected concerns must be reported immediately per facility policy and law.*Staff Responsibility:-All employees, contractors, and volunteers are required to:-Demonstrate professionalism and empathy in all interactions.-Report violations of this policy immediately. Resident #3 was admitted to the facility in September 2024 with diagnoses including Type 2 Diabetes Mellitus, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	major depressive disorder, anxiety disorder and mood disturbance. Review of the Minimum Data Set (MDS) Assessment, dated 1/15/26, indicated Resident #3:-was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of a possible 15 points.-has clear speech.-understands others and is understood. 1.On 2/20/26 at 10:30 A.M., the surveyor reviewed a Grievance Form for Resident #3 dated 12/12/25. The Grievance Form indicated:-Name of Person filing the grievance/complaint was the Resident.-Signature of person filing the grievance/complaint was the Social Worker (SW).-Director of Nursing (DNS) reported that Resident did not like the way he/she was handled/touched when Certified Nurse Aide (CNA) was providing care.-what actions or recommendations do you feel need to be taken, indicated the following:---Met with Resident who would not provide information verbally.---Wrote his/her own statement which he/she later retracted and stated, he/she wished to forgive the CNA. -Grievance form was signed and dated on 12/12/25 by the Social Worker, as reviewed and resolved. During an interview on 2/20/26 at 10:55 A.M., the Administrator said that Resident #3's grievance entered on 12/12/25 was reviewed and investigated by the DON. The Administrator said that the Resident retracted his/her statement relative to the statement made by CNA #2. During an interview on 2/20/26 at 11:00 A.M., with the Administrator, the DON and the Infection Preventionist (IP), the DON said that she spoke with Resident #3 and CNA #2 immediately after the incident on 12/12/25. The DON said that she did not report the allegations made by Resident #3 because the Resident retracted the statement he/she made regarding CNA #2 on 12/12/25. The DON said that she spoke with the Resident and the Resident forgave CNA #2. The IP said that both incidents were reportable and should have been reported to the Massachusetts Health Care Facility Reporting System (HCFRS) within two hours. During an interview on 2/20/26 at 12:06 P.M., with the DON and the Administrator, the DON said that there was no investigation file relative to the allegation of mistreatment grievance by Resident #3 on 12/12/25. The DON said that the Resident redacted his/her complaint of being mishandled by CNA #2, and that the Resident wanted to forgive CNA #2. 2. During an interview on 2/19/26 at 2:10 P.M., Resident #3 said that Nurse #2 told him/her yesterday that if he/she did not like it here in the facility, he/she could leave. Resident #3 said that he/she reported the incident to the Unit Manager (UM) on 2/18/26. On 2/19/26 at 2:33 P.M., the surveyor notified the Director of Nursing (DON) of the alleged incident where Nurse #2 told Resident #3 that he/she could leave if he/she did not like it here. The DON said that she would check with the Resident, get more information about the incident and report as necessary. During an interview on 2/19/26 at 3:40 P.M., UM #3 said she did not recall any concerns raised by Resident #3 relative to Nurse #2 acting rudely towards the Resident the previous day (2/18/26). During an interview on 2/19/26 at 3:45 P.M., the DON said that Nurse #2 should not have told Resident #3 to leave the facility if he/she did not like it here. The DON said that the type of statement could be indicative of verbal abuse. During an interview on 2/20/26 at 10:00 A.M., Resident #3 said that he/she felt very hurt when Nurse #2 told him/her to leave the facility if he/she did not like it here. Resident #3 said that he/she felt unwanted. During an interview on 2/20/26 at 12:06 P.M., with the DON and the Administrator, the DON said that Nurse #2 had used profane language directed at Resident #3 and that if he/she did not like it here, he/she could leave on 2/18/26. The Administrator said that the facility probably should have reported the event to the DPH HCFRS system. During an interview on 2/25/26 at 12:25 P.M., the DON said that the risk of not reporting the incident on 12/12/25 and 2/19/26 was risk of further abuse. During an interview on 2/25/26 at 12:31 P.M., with the Administrator, the DON and the IP, the Administrator and the IP both said that they were not made aware of the (reportable) incidents on 12/12/25 and 2/19/26.

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Waterview Lodge Llc, Rehabilitation & Healthcare	250 West Union Street Ashland, MA 01721

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observations, interviews, and record review, for one Resident (#69) out of a total sample of 21 residents, the facility failed to provide treatment and services consistent with the needs of the Resident relative to communication which increased the Resident's risk for diminished activities of daily living (ADL) abilities.Specifically, for Resident #69, the facility failed to use methods such as the Resident's preferred language to communicate with the Resident regarding ADL care when:-the Resident's preferred language was [specific non-English language].-none of the staff at the facility spoke the Resident's preferred language.-the Resident demonstrated frequent refusal of ADL care. Findings include:Review of the facility's policy titled ADL Policy, undated, indicated:-The facility will provide assistance with ADLs based on each resident's assessed needs and individualized care plan.-Staff will provide assistance according to the care plan.-Cultural preferences and personal routines will Resident #69 was admitted to the facility in April 2011 with diagnoses including Dementia, Anxiety, and Depression. Review of Resident #69's Social Service Note, dated 2/1/12, indicated:-information was obtained from the Resident with the help of an interpreter.-Resident came to the United States of America (USA) from another country.-Resident stated that he/she did not need to know how to speak English; he she worked in the USA, was shown how to and did his/her job. Review of the MDS Assessment, dated 1/17/26, indicated Resident #69:-preferred language was [specific non-English language].-did not need or want an interpreter to communicate with . healthcare staff.-had unclear speech, rarely/never understood others, and rarely/never made him/herself understood.-the Brief Interview for Mental Status (BIMS) Assessment should not be conducted with the Resident due to the Resident being rarely/never understood.-staff assessment of the Resident's cognitive skills for daily decision-making was completed in place of the BIMS Assessment being completed with the Resident and indicated the Resident had moderately impaired skills for daily decision-making.-required partial/moderate assistance for bathing/showering and supervision/touching assistance for dressing.-triggered for care planning of cognitive loss/dementia, functional abilities, and communication.-demonstrated rejection of care four to six days during the MDS observation period. Review of Resident #69's Active Care Plan indicated:-has an ADL deficit related to Dementia (1/26/21).-has a communication problem related to a language barrier. He/she speaks [specific non-English language] (10/22/25).-monitor effectiveness of communication strategies and assistive devices daily (10/22/25).-prefers communicating face to face, while family is present to translate, . (10/22/25).-has impaired cognitive functioning related to Dementia (10/22/25). On 2/18/26 at 8:33 A.M., the surveyor observed Resident #69 in his/her room, wearing two hospital gowns with a shirt over the two hospital gowns, and a pair of shoes. The surveyor approached the Resident and spoke to him/her. The Resident did not respond to the surveyor and muttered in a language that was not English. During an interview on 2/19/26 at 10:07 A.M., Unit Manager (UM) #2 said he thought Resident #69 understood more English than he/she spoke and that the Resident spoke in broken English. UM #2 said Resident #69 frequently refused care. On 2/19/26, between 10:24 A.M. and 12:44 P.M., the surveyor observed the following:-Resident #69 sitting in the hallway outside of his/her room. Resident #69 was observed wearing a pair of green pants, no socks and his/her shoes were on the wrong feet. Resident #69 was also observed wearing a hospital gown, a light blue designed pajama top over the hospital gown, and a black jacket over the pajama top. The surveyor further observed that the Resident's pants and black jacket had small spots of dried, tannish colored debris. -At 10:31 A.M., the surveyor observed UM #2 and a Nurse standing at the medication cart positioned diagonally across the hallway from where Resident #69 sat. -At 10:39 A.M. a Certified Nurse Aide (CNA) walked down the hallway pushing a mechanical lift and traveled between where Resident #69 sat and where the surveyor was standing across from the Resident. The CNA looked down at the ground as he steered the mechanical lift through the hallway between the surveyor's and (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Resident's feet. -At 12:00 P.M., 12:41 P.M., and 12:43 P.M., the surveyor observed Resident #69 in his/her room, remained wearing the same clothing items that he/she wore that morning, and the Resident's shoes were on the wrong feet. During an interview on 2/19/26 at 12:40 P.M., CNA #4 said Resident #69's hygiene was not good and the Resident was independent with dressing. CNA #4 said whenever she approached Resident #69 for ADL care, the Resident just said no. When the surveyor asked what interventions had been implemented in an attempt to engage Resident #69 in ADL care, CNA #4 said when the Resident said no, that was it. CNA #4 said Resident #69 refused care all day. The surveyor alerted CNA #4 that Resident #69's shoes were on the wrong feet. The surveyor and CNA #4 entered Resident #69's room and observed the Resident wearing his/her shoes on the wrong feet, CNA #4 said it was fine and exited the room. On 2/19/26 at 12:44 P.M., the surveyor observed CNA #4 enter Resident #69's room and approach the Resident and say, It is dressing time. Dress it up. The surveyor observed Resident #69 look at CNA #4 and did not respond. CNA #4 was observed asking Resident #69 if he/she wanted a sandwich and the Resident said no. CNA #4 then exited the Resident's room and the Resident stood up and began walking in the room. On 2/19/26 at 12:45 P.M., the surveyor notified UM #2 that Resident #69 was wearing his/her shoes on the wrong feet and that the Resident was walking in his/her room. UM #2 was observed entering Resident #69's room and the Resident was sitting in his/her bedside chair. The surveyor observed UM #2 approach the Resident, kneel on the floor, and reach toward the Resident while saying he was going to fix his/her shoes and the Resident said no. UM #2 stood up and left the room, and said to the surveyor the Resident refused for him to fix his/her shoes. During a telephone interview on 2/19/26 at 1:24 P.M., Resident #69's Legal Guardian said that he/she was appointed as Legal Guardian for Resident #69 due to his/her ability to speak the Resident's preferred language and communicate with the Resident. Resident #69's Legal Guardian said he/she has only communicated with the Resident using the Resident's preferred language and although some of their conversations were circular (repetitive), it is easy for him/her to communicate with the Resident. Resident #69's Legal Guardian said the Resident understands and speaks to him/her using the Resident's preferred language. Resident #69's Legal Guardian said he/she attends the Resident's interdisciplinary team (IDT) care plan meetings, either in-person or over the phone and that he/she is aware the Resident has refusal of care. Resident #69's Legal Guardian said that he/she did not recall interventions to attempt to engage Resident #69 in ADL care having been discussed during the IDT care plan meetings. During an interview on 2/19/26 at 2:53 P.M., UM #2 said Resident #69's cognition seemed to be getting worse and that the Resident was demonstrating more refusals of care. UM #2 said when residents demonstrated refusal of care, staff would talk with the residents to identify why they were refusing care. UM #2 said no one had really talked with Resident #69 regarding why he/she was refusing care because that would require an in-depth conversation with the Resident in his/her preferred language which had not been done. During an interview on 2/19/26 at 3:05 P.M., Activities Assistant (AA) #1 said Resident #69's English is very limited and that the use of visuals is the key to communicate with the Resident. AA #1 said if you just approach the Resident abruptly and want the Resident to do something, he/she is not going to do it for you. AA #1 said as an example, if she wanted to know whether the Resident wanted hot chocolate, she would present the Resident with a packet of hot chocolate mix and a mug while asking if the Resident wanted a hot chocolate. AA #1 said providing this kind of visual was helpful for the Resident to communicate whether or not he/she wanted the hot chocolate. AA #1 said facility staff had previously discussed obtaining assistance from the Resident's Legal Guardian to develop a visual communication tool, using words in the Resident's preferred language paired with pictures, in order to communicate more effectively with the Resident. AA #1 said the visual communication tool had not been developed. During an interview on 2/20/26 at 7:58 A.M., MDS Nurse #1 said Resident #69 has Dementia and that individuals with Dementia often lose language abilities when their Dementia progresses. MDS Nurse #1 said Residents with Dementia whose preferred language is not English but have learned some English often forget the English they learned when their Dementia progresses. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS Nurse #1 said Resident #69's preferred language is [specific non-English language]. MDS Nurse #1 said Resident #69 is the only Resident at the facility who speaks this [specific non-English language] and that no one at the facility seemed to be able to communicate with the Resident. During an interview on 2/20/26 at 8:50 A.M., AA #1 said she developed a visual communication tool to trial with Resident #69, using pictures and words in the Resident's preferred language after the surveyor's inquiry about the Resident's communication abilities on 2/19/26. AA #1 said she used the communication tool with the Resident that morning (2/20/26) in an attempt to engage the Resident in his/her breakfast meal and that she thought the communication tool was helpful for the Resident. During an interview on 2/20/26 at 10:25 A.M., the Speech Language Pathologist (SLP) said she works weekly at the facility and that if there were changes in a resident's cognition or communication status, facility staff would refer the resident to her to be assessed. The SLP said she had never received a referral to assess Resident #69 for cognition or for communication. On 2/25/26 at 8:27 A.M., the surveyor observed AA #1 sitting with Resident #69 and talking to the Resident. AA #1 provided pictures in combination with spoken and written English and non-English (Resident's preferred language) words. The surveyor observed Resident #69 leaning forward toward the communication tool, use his/her finger to point and respond to AA #1 with some spoken language. During an interview on 2/25/26 at 8:32 A.M., AA #1 said she used the newly developed communication tool with Resident #69 and that she thought the Resident was responding well to the combined use of pictures, words, and gestures. AA #1 said the Resident understands some English and that there are some things the Resident is not able to understand in English. AA #1 said she thought the Resident was starting to get used to using the visual communication tool as demonstrated by the Resident looking at the pictures and attentive to AA #1 when she spoke to him/her. AA #1 said that the more facility staff try to communicate with the Resident in his/her preferred language, the more the Resident may appreciate the staff and respond more positively to what the staff offer. Please refer to F842.

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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. Based on observation, interview, and record review, the facility failed to ensure that activities of daily living (ADL's) were provided as required for one Resident (#48) out of a total sample of 21 residents. Specifically, for Resident #48, the facility failed to assist with facial hair removal per Resident preference when the Resident required assistance from staff with personal care and grooming. Findings include: Review of the facility policy titled Activities of Daily Living (ADL) Policy, undated, included the following: -It is the purpose to ensure residents receive appropriate assistance with Activities of Daily Living (ADL's) in a manner that promotes dignity ., and quality of life. The facility will provide assistance with ADL's based on each resident's needs and individual care plan. -ADL's include but are not limited to Bathing and personal hygiene .grooming. -Assessment: Care plans will reflect the resident's current level of assistance required. -Assistance: Staff will provide assistance according to the care plan. -Dignity and Respect: Cultural preferences and personal routines will be honored whenever possible. -Quality Assurance; ADL care will be monitored through routine audits and care plan reviews to ensure compliance with quality of care. Resident #48 was admitted to the facility in September 2022 with diagnoses including Alzheimer's Disease and muscle weakness. Review of the Minimum Data Det Set (MDS) Assessment, dated 12/5/25 indicated Resident #48:-was rarely/never understood. -required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with personal hygiene. Review of the Resident's active, person-centered ADL Deficit Care Plan indicated: -Personal hygiene: Resident requires 1-2 staff assistance with personal hygiene, effective 9/15/22. Review of Resident #48's active Care Kardex (an individualized document that identifies basic resident needs relative to daily care) indicated: -required assistance from 1-2 staff for personal hygiene, undated. On 2/18/26 at 8:00 A.M., the surveyor observed Resident #48 seated at his/her bedside with five, dime sized patches of thick, stubbled, gray hair on his/her chin. During an interview at the time, Resident #48 said he/she needed some help for facial hair removal and that the Certified Nurse Aide (CNA) had all the razors. On 2/19/26 at 9:01 A.M., the surveyor observed Resident #48 seated at his/her bedside and remained with five, dime sized patches of thick, stubbled, gray hair on his/her chin. During an interview at the time, Resident #48 said he/she liked to have the hair removed from his/her chin but needed help from the staff with a razor. During an interview on 2/20/26 at 8:18 A.M., Resident #48 said the staff did not offer to assist with a razor yesterday to remove his/her facial hair. The surveyor observed that the Resident remained with the five, dime sized patches of thick, stubbled, gray hair on his/her chin. On 2/25/26 at 8:41 A.M., the surveyor observed five, dime sized patches of thick, curling, gray hair on Resident #48's chin. During an interview at the time, the Resident said no one had offered, assisted or provided a razor to remove his/her facial hair. Resident #48 said he/she liked the hair to be removed because it made him/her feel better when the hair was not there. During an interview on 2/25/26 at 8:45 A.M., CNA #7 said he/she was assigned to Resident #48. CNA #7 said Resident #48 had already been assisted with morning care, needed assistance from the CNA for most care, does not refuse care, and can make his/her needs known. CNA #7 said Resident #48 required assistance from the CNA to remove facial hair. CNA #7 said that he had not offered to assist Resident #48 with facial hair removal, but facial hair removal should be offered every morning for both men and women. During an interview on 2/25/26 at 8:57 A.M., Nurse #6 said he was assigned to Resident #48. Nurse #6 said that as a Charge Nurse he watches to make sure that ADL care was done for all residents and makes sure the residents look clean, neat and have no odors. Nurse #6 said facial hair should be removed by the CNAs for men and women during morning care or later in the day if refused. Nurse #6 said that personal grooming and hygiene were important so that the Resident presents well and feels good for themselves. The surveyor and Nurse #6 observed Resident #48's facial hair and Nurse #6 said that the Resident's facial hair looked long and to be more than just a few days of growth. Nurse #6 said he would speak to the Resident's CNA because the facial hair should be (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed. During an interview on 2/25/26 at 9:20 A.M., Nursing Supervisor (NS) #1 said she conducts walking rounds in the facility several times a day to look and see that things are done the right way. NS #1 said that she looks around to evaluate all the residents for comfort, grooming and appropriate clothing. NS #1 said that male and female residents should be offered and assisted to shave facial hair off during morning care each day. NS #1 said that not removing facial hair for Resident #48 could cause the Resident to feel undignified about themself.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one Resident (#46) out of a total sample of 21 residents, was free from potential accidental hazards relative to the accessibility of an opioid medication. Specifically, for Resident #46, the facility failed to ensure:-that a prescribed medication, Ultram (Tramadol: an opioid medication) was kept in a secured medication cart and not in the unlocked drawer of the Resident's bedside table.-that the Tramadol medication was not easily accessible to the Resident, other residents, visitors and staff when the medication was left to be administered without Licensed Staff supervision and the Resident was not assessed to safely self-administer the Tramadol medication. Findings include:Review of the facility policy titled Medication Administration Policy, undated, indicated the following:-Purpose: To ensure safe medication administration and reduce medication errors by requiring strict adherence to the Five Rights of medication administration.-Right Time: Administer (medications) within ordered time frames and facility approved windows; document and report late, missed, or refused medications. Resident #46 was admitted to the facility in December 2021 with diagnoses including low back pain, unspecified osteoarthritis and Paranoid Schizophrenia. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #46 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15. Review of Resident #46's active Physician orders dated 2/18/26, indicated:-Ultram Oral Tablet 50 milligrams (mg). Give one tablet by mouth three times a day for pain, initiated 9/3/25 Review of the February 2026 Medication Administration Record (MAR) indicated Ultram/Tramadol oral tablet 50 mg was administered to Resident #46 on 2/18/26 at 6:00 A.M. During an interview on 2/18/26 at 9:10 A.M., Resident #46 said that he/she receives Tramadol three times a day which helps with his/her low back pain. Resident #46 then opened the top drawer of his/her bedside table and removed a clear medicine cup containing one white tablet. Resident #46 said that the tablet in the medicine cup was the Tramadol that the Nurse had brought to him/her earlier that morning around 5:00 A.M. Resident #46 said he/she doesn't like to take the medication when he/she was not hungry and waits until after breakfast to take the Tramadol. Review of the Self Administration of Medication assessment dated [DATE], did not indicate Resident #46 was assessed as being capable of storing the Tramadol medication at his/her bedside. On 2/18/26 at 9:13 A.M., the surveyor and Unit Manager (UM) #2 observed the white tablet in the clear medicine cup that Resident #46 had removed from the bedside table. During an interview at the time, UM #2 said the white tablet was Tramadol and that Resident #46 should not have been allowed to store the medication in the bedside table drawer. UM #2 said Tramadol is a narcotic pain medication that Resident #46 received three times a day for back pain and the Nurse that administered the Tramadol earlier in the morning should have ensured Resident #46 had taken the medication prior to leaving the Resident's room. During an interview on 2/18/26 at 3:28 P.M., the Director of Nursing (DON) said Resident #46 should not have been allowed to store the Tramadol medication in his/her bedside table and the Nurse who administered the Tramadol medication should have watched Resident #46 take the medication before leaving the Resident's room.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview, and record review, the facility failed to ensure pharmacy recommendations from medication regimen reviews (MRR) were reviewed and addressed timely for two Residents (#8 and #42) out of a total sample of 21 residents. Specifically:1. For Resident #8, the facility failed to ensure that the Pharmacist's recommendation to evaluate the use of Flonase (corticosteroid nasal spray) was addressed in a timely manner by the Physician.2. For Resident #42, the facility failed to ensure that the Pharmacist recommendation for an Abnormal Involuntary Movement Scale (AIMS) assessment (rating scale used to measure involuntary movements of the face, mouth, trunk, or limbs known as tardive dyskinesia (TD) in a resident taking antipsychotic medications) was addressed timely by the Physician. Findings include:Review of the facility policy titled Pharmacy Recommendations and Medication Order Changes Policy, undated, indicated the following: -all medication recommendations and order changes must be reviewed, clarified as soon as possible, documented accurately, and implemented promptly to ensure resident safety and regulatory compliance. >Procedure -Recommendations (dose changes, discontinuations, Gradual Dose Reductions, lab monitoring, duplicate therapy, drug interactions, etc.) are documented in writing or electronically. -The Director of Nursing (DON) or designee reviews all recommendations. -The attending Physician or authorized Provider is notified. -Provider response (approved, modified, or declined) must be documented in the medical record, or in a separate binder kept at the nursing supervisor's office. -Urgent concerns are addressed immediately; routine recommendations within 24-72 hours. 1. Resident #8 was admitted to the facility in July 2024 with diagnoses including insomnia and acute respiratory failure with hypoxia. Review of Resident #8's Consultant Pharmacist Recommendation to the Prescriber Form dated 11/25/25, indicated: -Pharmacist recommended changing the Resident's prescription for Flonase to PRN (pro re nata- [as needed]) to see if it was still necessary. -the recommendation had not been reviewed, signed or dated by the Physician or Prescriber. During an interview on 2/25/26 at 4:08 P.M., the Chief Executive Officer (CEO) said that she was unable to locate any documentation to indicate the Physician had reviewed the Pharmacist's recommendation to change the Flonase medication for Resident #8 made in November 2025. 2. Resident #42 was admitted to the facility in May 2025 with diagnoses including unspecified dementia, mild without behavioral disturbance, psychotic disturbance, anxiety disorder, and (continued on next page)

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	225598	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Lodge Llc, Rehabilitation & Healthcare	250 West Union Street Ashland, MA 01721

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	depression. Review of the Minimum Data Set (MDS) Assessment, dated 11/25/25, indicated Resident #42:-has severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of three out of a possible 15 points.-received an antipsychotic (psychotropic medication primarily used to manage psychosis) and the antipsychotic was administered on as need (PRN) basis. Review of Resident #42's Care Plan dated 5/22/25, included but was limited to: -an approach to monitor, document and report PRN any adverse reactions of psychotropic medications, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking). Review of Resident #42's February 2025 Physician orders indicated:-Quetiapine Fumarate (Seroquel - antipsychotic medication) Oral Tablet. Give 50 Milligrams (mg) by mouth every 8 hours as needed for Agitation, initiated 5/21/25, no stop date. Review of the Medication Administration Records (MAR) for October 2025 through December 2025 indicated Resident #42 was administered the PRN dose of Quetiapine Fumarate as follows:-October: 10/30/25-November: 11/6/25, 11/20/25, 11/21/25-December: 12/25/25 Review of the Pharmacist Consultant Medication Regimen dated 1/27/26, indicated:-Recommendation categories: AIMS-Ensure that an AIMS assessment has been completed within 6 months. Review of Resident #42's clinical record did not indicate that an AIMS assessment was completed in the last six months (8/8/25). During an interview on 2/25/26 at 3:48 P.M., the Infection Preventionist (IP) said that the pharmacy recommendation was to complete an AIMS assessment within 6 months. The IP said that the AIMS was not done and it should have been completed for the residents receiving an antipsychotic medication. The IP also said that AIMS assessment should be completed every six months.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, and interview, the facility failed to ensure that drugs and biologicals were stored in accordance with State and Federal requirements on two nursing units (Unit Four and Unit Three) out of three total nursing units, and that expired medications were removed from use in a shared medication storage room for three (Unit Two, Unit Three and Unit Four) out of three medication storage rooms observed. Specifically, the facility failed to:1. ensure that medication carts on Unit Four and Unit Three were locked when the medication carts were unattended, to prevent unauthorized personnel and residents access to medications on and in the medication carts.2. ensure for Unit Two, Unit Three, and Unit Four medication storage rooms, that expired over-the-counter medications were removed from the medication storage cabinet to mitigate potential administration to the facility residents. Findings include: Review of the facility policy titled Policy and Procedure for Medications Storage, dated 6/23/18, included but was not limited to:*All drugs and biologicals will be stored in locked compartments (i.e. [that is] medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.-Only authorized personnel will have access to the keys to locked compartments. -During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. -Unused medications: All medications rooms are routinely inspected by the consultant pharmacist and nursing staff for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. 1.On 2/19/26 at 7:46 A.M. to 8:15 A.M., the surveyor observed the following during medication pass being done by Nurse #2 on Unit Four:-Nurse #2 poured two tablets of Tylenol in a medication cup and said that she needed to assess the resident's temperature prior to administering the Tylenol. Nurse #2 took the medication cup with the two tablets of Tylenol and walked away from the medication cart that was in the hallway into the nursing station. The surveyor observed a large bottle of Tylenol containing 325 milligrams (mg) tablets was left on top of the medication cart and Nurse #2's back was turned away from the medication cart. -a resident approached the medication cart and asked the surveyor who was standing at the cart for his/her medication. Nurse #2 was not present at the time, and the large bottle of Tylenol remained unsecured on top of the medication cart. The resident waited at the medication cart for Nurse #2 to return to the cart. -Nurse #2 returned to the medication cart and was observed to place the bottle of Tylenol back into the medication cart drawer. -Nurse #2 removed medications from the cart, poured the medications and then entered a resident's room. Nurse #2 left the blister packs of Haloperidol, Omeprazole, Aspirin and Vitamin D3 medications on top of the medication cart and also left the second drawer of the medication cart open while in the resident's room. During an interview on 2/19/26 at 8:32 A.M., Nurse #2 said she should not leave any medications on top of the medication cart. Nurse #2 said that medications should be in the locked medication cart to prevent unauthorized personnel and resident access to the medications. Nurse #2 further said that a resident could have walked by and taken the medication when her back was turned and the medication cart was not visible to her. On 2/19/26 from 8:58 A.M. to 9:16 A.M., the surveyor observed the following during medication pass done by Nurse #3 on Unit Three:-Nurse #3 walked away from the medication cart located in the hallway and into the nurse's station with her back to the medication cart. Residents and other staff members were observed walking around the area where the medication cart was positioned in the hallway. -Nurse #3 returned to the medication cart and prepared medication to be administered. Nurse #3 walked away from the medication cart with the medication cart unlocked and medication cart keys on top of the medication cart. Nurse #3 and the surveyor walked together to a resident room to administer medications. The surveyor observed from the hallway other staff members walking by the medication cart that was left unattended in the hallway.-Nurse #3 returned to the medication cart and locked the medication cart. During an interview (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 2/19/26 at 9:19 A.M., Nurse #3 said that medication carts should always be locked and the medication cart keys should always be in her possession when she stepped away from the medication cart. Nurse #3 said that it was unsafe to leave the medication cart unlocked because other staff members and residents who were not authorized could have access to the medication when she was not present. During an interview on 2/19/26 at 9:28 A.M., Unit Manager (UM) #2 on Unit Three said that medication carts should be always locked for safety when the Nurse walked away from the medication cart. During an interview on 2/19/26 at 10:10 A.M., the Director of Nursing (DON) said that medication carts should be always locked to prevent resident and other unauthorized staff access to the medications inside the cart for safety. 2. On 2/19/26 at 1:23 P.M., the surveyor and UM #1 observed the following in the Unit Two medication storage room cabinet:-One expired bottle of nasal spray, expiration date 1/26. -One expired bottle of nasal spray, expiration date 8/24. During an interview at the time, UM #1 said that the nasal sprays should not be in the cabinet because they had expired. UM #1 was observed removing the two expired nasal sprays from the cabinet. 2a. On 2/19/26 at 1:47 P.M., the surveyor and Nurse #3 observed the following in the Unit Three medication storage room cabinet: -One expired bottle of nasal spray, expiration date 1/26. -One expired bottle of nasal spray, expiration date 8/24.During an interview at the time, Nurse #3 said that the nasal sprays should not be in the cabinet because they had expired. 2b. On 2/19/26 at 2:00 P.M., the surveyor and Nurse #2 observed the following in the Unit Four medication storage room: -Two expired bottles of Aspirin 325 mg (milligrams), expiration date 7/25.-One expired bottle of Aspirin 325 mg, expiration date 1/24.-One expired bottle Aspirin 325 mg, expiration date 3/23.-Two expired bottles of Aspirin enteric coated, expiration date 10/25.-One expired bottle of Docusate Sodium, expiration date 5/24.-One expired bottle of nasal spray, expiration date 1/26. -One expired bottle of nasal spray, expiration date 8/24.During an interview at the time, Nurse #2 said that central supply stocks the cabinets for the over-the-counter medications. Nurse #2 said that the use of the cabinets for the storage of over-the-counter medications was a new project the facility implemented three weeks ago. Nurse #2 also said that the expired medications should not have been in the cabinets. Nurse #2 further said that nursing staff also has the responsibility of checking the dates of the over-the- counter medications when they remove medications from the cabinets. During an interview on 2/19/26 at 2:04 P.M., UM #3 said that the storage of over-the-counter medication storage rooms was implemented three weeks ago and the expired medications should not have been in the storage cabinets. UM #3 also said that nursing staff should be checking the medications to ensure that all expired over-the-counter medications were removed. UM #3 further said that central supply stock the cabinets and typically checks for expired medications and removes them. During an interview on 2/19/26 at 2:13 P.M., the Director of Nursing (DON) said that the use of the medication storage cabinets was implemented three weeks ago to give the nursing staff access to medications during the off hours. The DON said that the expired medications should not have been in the building at all and should not have been stocked up in the cabinets if expired.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, interviews, and record review, the facility failed to maintain an accurate medical record for one Resident (#69) out of a total sample of 21 residents, relative to Resident behaviors for refusal of care, increasing the Resident's risk for ineffective behavior monitoring, behavior assessment, and the implementation of interventions to address the Resident's behavioral needs.Specifically, facility staff failed to document instances of Resident #69's refusal of care when:-Facility staff identified Resident #69 had frequent refusal of care.-The surveyor observed Resident #69 refuse care from facility staff when care was offered to the Resident. Findings include:Resident #69 was admitted to the facility in April 2011 with diagnoses including Dementia, Depression, and Schizophrenia. Review of Resident #69's Behavior Nursing Note, dated 10/15/25, indicated:- .resistive to care-gets angry when staff approach for hygiene and care- . anger is exhibited by screaming loudly at staff- . no effect on verbal redirection- . sometimes responds to reapproach. Review of Resident #69's Active Care Plan indicated:-has an ADL performance deficit related to Dementia (1/26/21).-has impaired cognitive function related to Dementia (10/22/25)-has a behavioral problem (yelling, screaming, cursing) related to Dementia with psychotic features (10/22/25).-Monitor behavior episodes . Document behavior and potential causes (10/22/25). Review of Resident #69's Minimum Data Set (MDS) Assessment, dated 1/17/26, indicated:-required partial/moderate assistance for bathing.-required supervision/touching assistance for dressing.-demonstrated four to six days of rejection of care during the Assessment's seven-day observation period.-cognition was moderately impaired for daily decision-making.-triggered for care planning for cognitive loss/dementia, behavior, functional abilities, and communication. During an interview on 2/19/26 at 10:07 A.M., Unit Manager (UM) #2 said Resident #69 demonstrated frequent refusals of care. On 2/19/26 at 10:24 A.M., the surveyor observed Resident #69 sitting in the hallway, outside his/her bedroom. Resident #69 was wearing a hospital gown, a light blue designed pajama top over the hospital gown, and a black jacket over the pajama top, a pair of green pants, no socks and wore his/her shoes on the wrong feet. The Resident's pants and black jacket were observed to have small spots of dried, tannish colored debris on them. On 2/19/26 at 12:00 P.M., 12:41 P.M., and 12:43 P.M., the surveyor observed Resident #69 in his/her room, wearing the same clothing items he/she wore that morning, and the Resident's shoes remained on the wrong feet. During an interview on 2/19/26 at 12:40 P.M., Certified Nurse Aide (CNA) #4 said Resident #69's hygiene was not good and that whenever she approached Resident #69 for ADL care, the Resident just said no. CNA #4 said Resident #69 refused care all day. On 2/19/26 at 12:44 P.M., the surveyor observed CNA #4 enter Resident #69's room, approach the Resident and say, It is dressing time. Dress it up. The surveyor observed Resident #69 look at CNA #4 and did not respond. CNA #4 then asked Resident #69 if he/she wanted a sandwich and the Resident responded, no. CNA #4 then exited the Resident's room. On 2/19/26 at 12:45 P.M., the surveyor observed UM #2 enter Resident #69's room where the Resident was sitting in his/her bedside chair. The surveyor observed UM #2 approach the Resident, kneel on the floor, and reach toward the Resident while saying he was going to fix his/her shoes and the Resident said, no. UM #2 then stood up and exited the room. During an interview at the time, UM #2 said the Resident refused to allow for him to fix his/her shoes. During an interview on 2/19/26 at 2:53 P.M., UM #2 said Resident #69's cognition seemed to be getting worse and that the Resident has been demonstrating more refusals of care. During an interview on 2/19/26 at 2:53 P.M., UM #2 said Resident #69's cognition had been getting worse and that the Resident was demonstrating more frequent refusals of care. UM #2 said staff would just keep approaching the Resident if the Resident refused care. Review of Resident #69's February 2026 CNA Flowsheet indicated:-Documentation for bathing performance was not recorded for nine shifts.-Documentation for upper body dressing performance was not recorded for three shifts.-Documentation for lower body dressing performance was not recorded for (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seven shifts.-Documentation was not recorded to indicate refusal of care anytime during the month relative to bathing and dressing. Review of Resident #69's February 2026 Medication Administration Record (MAR) indicated:-Facility staff were to monitor the Resident for rejection of care.-Monitoring for rejection of care included: frequency, interventions, outcome, and whether or not rejection of care occurred.-The Resident's rejection of care that occurred on the 2/19/26 day shift was recorded as 0 for frequency, interventions, outcome, and whether or not rejection of care had occurred. During an interview on 2/25/26 at 8:20 A.M., CNA #5 said that CNAs were required to alert the Nurse when a Resident rejects care and that the CNAs were responsible to record the rejection of care on the CNA flowsheet. During an interview on 2/25/26 at 8:25 A.M., UM #2 said the CNAs were responsible to tell the Nurses when a Resident rejects care and then the Nurses were responsible to record the rejection of care on the Resident's MAR. The surveyor and UM #2 reviewed Resident #69's February 2026 MAR and UM #2 said the MAR did not include any documentation that the Resident's rejection of care on 2/19/26 was recorded as required. UM #2 said rejection of care should have been recorded for several attempts to provide care for Resident #69 that were made on 2/19/26. UM #2 said it was important to record the Resident's frequency for rejection of care, interventions used, and outcomes of interventions used to ensure the Resident was properly monitored for changes in behavior, effectiveness of interventions provided, and implementation of new interventions if needed.