STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225619	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alliance Health at Marie Esther	720 Boston Post Road Marlborough, MA 01752

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review, and interview, the facility failed to provide the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week as required, placing all facility residents at risk for not having their clinical needs met either directly by the RN or indirectly by the Licensed Practical Nurse (LPN) or Certified Nurse's Aides (CNA) that the RN was responsible for overseeing with provision of resident care.Specifically, the facility failed to have an RN working at least eight consecutive hours over a 24-hour period on three days (8/16/25, 8/30/25, and 8/31/25). Findings include:Review of the Facility Assessment Tool, last updated 7/23/25 and reviewed by the facilities Quality Assurance and Performance Improvement (QAPI) committee on 8/27/25, indicated:-How do we determine if we have sufficient staffing? Consider the following:>Review expectations for minimum staffing requirements at the federal and state level. >Federal law requires nursing homes to have sufficient staff to meet the needs of the Residents, to use the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week. Review of the As Worked Nursing Schedule provided by the facility, failed to indicate that a Registered Nurse worked in the building for eight consecutive hours on 8/16/25, 8/30/25 and 8/31/25. During an interview on 9/4/25 at 2:20 P.M., the Assistant Administrator said that the Director of Nursing (DON) was providing RN coverage but was unable to provide evidence that the DON was in the building and providing eight consecutive hours of RN coverage on 8/16/25, 8/30/15 and 8/31/25. During an interview on 9/5/25 at 7:14 A.M., the Administrator said that the facility follows the federal regulation on RN coverage and that the facility does not have a policy pertaining to RN staffing.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure that respiratory care and services consistent with professional standards of practice were provided for one Resident (#1) out of a total sample of 12 residents.Specifically, for Resident #1, the facility failed to provide portable oxygen as ordered by the Physician when the Resident was out of bed (OOB) and participating in activities away from the stationary oxygen source. Findings include: Review of facility policy, titled Physician Orders, effective 11/22/16 and revised 11/14/22, include but are not limited to:>it is the policy of the facility that a physician personally approves in writing a recommendation that an individual be admitted to the facility. Each resident will remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist can provide orders for the resident's immediate care and needs.-Medical Doctor (MD) orders will be followed by staff as appropriate until the order has been discontinued or changed. Resident #1 was admitted to the facility in April 2022 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Bronchitis, not specified as Acute or Chronic, and Chronic Respiratory Failure with Hypoxia. Review of the Minimum Data Set (MDS) Assessment, dated 7/11/25, indicated Resident #1:-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of total possible score of 15. -was prescribed continuous oxygen therapy. Review of Resident #1's Physician's orders indicated:-O2 (oxygen) at 2 LPM (liters per minute) via Nasal Cannula (NC) continuously for COPD every shift: Days (7:00 A.M.- 3:00 P.M.) Evening (3:00 P.M.-11:00 P.M.), Nights (11:00 P.M. - 7:00 A.M.), initiated 7/8/25.-Portable O2 use while OOB (out of bed) via Nasal Cannula every shift, initiated 7/8/25. Review of Resident #1's Comprehensive Person-Centered Care Plan revised 7/8/25, indicated:-the Resident has potential for respiratory distress related to a dx (diagnosis) of COPD and requires the use of oxygen.-intervention for oxygen as ordered. On 9/3/25 at 4:28 P.M., the surveyor observed Resident #1 lying in bed with the head of the bed elevated, with O2 via NC set to 2 LPM in use. During an interview at the time, Resident #1 said that he/she always uses oxygen. On 9/4/25 at 8:33 A.M., the surveyor observed Resident #1 in the main dining room on the unit eating his/her breakfast. The surveyor failed to observe that portable oxygen was observed being administered to the Resident at the time. On 9/4/25 at 8:50 A.M., the surveyor observed Resident #1 in the main dining room sitting in a wheelchair and participating in an activity. The surveyor observed that Resident #1 was not being administered portable oxygen as ordered during the activity session. On 9/4/25 at 10:19 A.M., the surveyor observed Resident #1 seated in a wheelchair in the main dining room without portable oxygen being administered. During an interview at the time, Resident #1 said he/she always uses oxygen. Resident #1 said he/she was dressed up by the Certified Nurse Aide (CNA) and the CNA took off the oxygen tubing/nasal cannula and did not put it back on. Resident #1 asked the surveyor to find out where his/her oxygen was and to get his/her oxygen for him/her. During an interview on 9/4/25 at 10:21 A.M., Nurse #1 said Resident #1 should always have his/her portable oxygen administered via NC as ordered by the Physician. Nurse #1 said Resident #1's oxygen had been removed when the CNA assisted him/her with getting dressed. Nurse #1 said Resident #1 should have his/her portable oxygen on continuously when out of his/her room. Nurse #1 said the risk of Resident #1 not having access to his/her oxygen as ordered was shortness of breath as the oxygen ensures that Resident #1 was able to breathe. During an interview on 9/4/25 at 10:49 A.M., the Director of Nursing (DON) said Resident #1 required his/her oxygen to be applied continuously as ordered by the Physician. The DON said she had seen Resident #1 with his/her oxygen in use on previous days. The DON said the risk of Resident #1 not having his/her oxygen applied as ordered would cause the Resident's oxygen levels to desaturate (decrease in the oxygen saturation) leading to shortness of breath for Resident #1.

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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, interview, and record review, the facility failed to ensure that medications were stored in a safe and secure manner for one Resident (#22) out of a total sample of 12 residents.Specifically, for Resident #22, the facility failed to ensure that:-One over-the-counter medication was secured and was not left at the Resident's bedside table and readily accessible to other residents on the unit.-One prescribed medication was secured and was not left at the Resident's bedside table and readily accessible to other residents on the unit.- A Physician's order was obtained for the use of one over-the-counter and one prescribed medication.- A self-assessment of medication was completed to ensure the Resident was capable of self-administering medications. Findings include: Review of the facility policy titled Medication Storage in the Facility, undated, indicated:-Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. -Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications.-Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. Review of the facility policy titled Medication: Self Administration, revised 5/22/19, included but was not limited to:>Residents may administer their own medications, if requested, once the interdisciplinary team (IDT) determines that this practice is safe.>The resident must meet the following criteria:-The resident must be able to read the administration label on all medications.-The resident must be able to demonstrate an ability to dispense the medication from the receptable.-The resident must pass the Self-Administration Medication Assessment.-The resident must request the desire to self-administer medications.-Once the request is obtained, the above assessment must be completed with results documented in the medical record. This assessment is updated on a Qtrly (quarterly) basis.-Documentation of the administered drugs, and location of the administered drugs will be noted in the resident's care plan.-If the results indicate the person is capable of self-administration, the physician must be notified to obtain an order for such.-Medication must remain secured at the nursing station except for limited medications, i.e. (that is) respiratory (handheld) inhalers, nitroglycerin sublingual tablets or sprays. Medications must be stored under proper conditions of sanitation, temperature, light, moisture and ventilation.>Nursing remains responsible for:-Assuring the medication is taken.-Signing off medication order,-Monitoring for effects and side effects; and,-Notifying the physician of any changes in condition that might necessitate medication adjustment.>Self-administration of medication should be addressed in the care plan with an established plan for continuing to monitor ability to self-administer drugs and needs for continued education on an ongoing basis, including reliability in following the program and a reassessment of functional ability. Education includes the resident's and family's responsibilities in the resident care and how to safely and effectively use medication. The interdisciplinary team may withdraw right to self-administration if resident becomes unable to carry out safely. Resident #22 was admitted to the facility in July 2024 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), and Age-Related Cognitive Decline. Review of Resident #22's Minimum Data Set (MDS) assessment, dated 7/7/25, indicated that the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 9/4/25 at 9:06 A.M., the surveyor observed Resident #22 was awake and seated at the edge of his/bed. The surveyor further observed the following medications located on the Resident's nightstand table:-Antifungal Powder with Miconazole Nitrate 2%-Thera Breath Dentist Formulated Fresh Breath Oral RinseDuring an interview at the time, Resident #22 said the Antifungal Powder with Miconazole Nitrate 2% and the Thera Breath Dentist Formulated (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fresh Breath Oral Rinse were medications he/she had been using for over a year. Resident #22 said that he/she could administer the medications on his/her own and does not require nursing assistance to administer. Review of Resident #22's Physician orders failed to indicate any evidence that an antifungal powder and oral rinse had been ordered by the Physician for Resident #22. On 9/4/25 at 10:32 A.M., the surveyor and Nurse #1 observed the antifungal and oral rinse medications on Resident #22's nightstand table. During an interview at the time, Resident #22 said he/she uses the antifungal powder on a cut on top of his/her right thigh and that the antifungal powder was given to him/her by the wound doctor and he/she had been using it for a year without staff saying anything to him/her. Resident #22 said he/she did not believe a Doctor's order was required to have the oral rinse by his/her bedside. During an interview following the observation, Nurse #1 said Resident #22 was not allowed to keep/or have prescription medications at his/her bedside. Nurse #1 said she does not know the risk of Resident #22 having medications at the bedside as it was not a practice that was allowed in the facility. During an interview on 9/4/25 at 10:47 A.M., the Director of Nursing (DON) said Resident #22 was not allowed to have prescribed medications on his/her nightstand table for safety reasons. The DON said the facility should have obtained a Physician's order to administer the antifungal powder and oral rinse medications. The DON also said that a self-assessment for medication should have been completed for Resident #22 to determine if the Resident was capable of self-administering medications for him/herself. The surveyor and the DON reviewed Resident #22 clinical records and failed to find evidence that a medication self-assessment was completed for Resident #22. During an interview on 9/4/25 at 11:11 A.M., Nurse #2 said Resident #22's Oral Rinse was an over-the-counter medication, and the Resident does not require a Doctor's order to administer the oral rinse. When the surveyor asked Nurse #2 if the facility policy requires a Resident to have over-the-counter oral rinse at their bedside without a Physician order and/or self-administration medication assessment, Nurse #2 said no.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow professional standards of practice for food safety to prevent the potential of foodborne illness to residents who are at high risk. Specifically, the facility failed to utilize pasteurized eggs in the preparation of over easy (eggs fried on both sides with a runny yolk) eggs to safely accommodate the resident's choice during the breakfast meals and ensure that the unpasteurized eggs being used were cooked until all parts of the egg are completely firm to prevent the potential spread of foodborne illness. Findings include:Review of the facility's policy titled Food Purchasing, dated 9/1/25, indicated:-It is the policy.that all food be purchased from sources approved by Federal, State and local authorities. -Be knowledgeable of all the approved vendors. All food should adhere to the following standards.-Only Grade A eggs should be purchased. Frozen and packaged egg products shall be pasteurized. Review of the facility invoices from the facility vendor dated 6/24/25, 7/1/25, and 8/14/25, indicated that the eggs purchased to make the over easy eggs in the facility were not pasteurized. On 9/4/25 at 7:49 A.M., the surveyor observed the staff in the main kitchen serving breakfast onto nursing facility meal trays which included eggs cooked over easy. When the surveyor asked the Food Service Director (FSD) to observe the eggs that were being used to cook the over easy eggs, the eggs were observed to not be pasteurized. During an interview at the time, the FSD said that there were three Residents who typically request over easy eggs for breakfast. The FSD said that he was not aware that the eggs were required to be pasteurized for egg dishes that are not fully cooked.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record reviews, the facility failed to offer the Pneumococcal Vaccination as recommended to two Residents (#2 and #22) of five applicable residents, out of a total sample of 12 residents, putting the Residents at risk for developing facility acquired Pneumonia.Specifically, the facility failed to ensure that:1. Resident #2 had no medical contraindication to, or had been offered, received, or declined any Pneumococcal Vaccination after admission to the facility.2. Resident #22 did not have medical contraindication to, or had been offered, received, or declined any Pneumococcal Vaccination after admission to the facility. Findings include: Review of the CDC guidance titled Pneumococcal Vaccine Recommendations, dated 10/26/24, indicated the following for individuals [AGE] years of age and older:-Administer PCV (Pneumococcal Conjugate Vaccine) 15 (Pneumococcal immunization that protects against 15 types of Pneumococcal disease), PCV20 (Pneumococcal immunization that protects against 20 types of Pneumococcal disease), or PCV21 (Pneumococcal immunization that protects against 21 types of Pneumococcal disease), for all adults 50 years or older:-Who have never received any Pneumococcal Conjugate Vaccine.-Whose previous vaccination history is unknown.-Give one dose of PCV20 or PCV21 at least 1 year after PCV13. Review of the facility policy titled Influenza and Pneumococcal Immunization, revised 3/28/25, indicated the following:-On admission, the resident and/or legal representative will be provided with written information regarding Pneumonia and Influenza Immunization.Residents will be encouraged to receive the vaccine.-Based on assessment and practitioner recommendation, adults aged 65 or older who have not previously received the pneumococcal vaccine or whose previous vaccination history is unknown should receive the appropriate pneumococcal vaccine based on the MD's assessment/order.-Subsequent documentation will be placed on the resident's individual Immunization Record. 1. Resident #2 was admitted to the facility in January 2023 and was over the age of 50. Review of Resident #2's Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident:-Was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of possible 15.-Resident's Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself) was invoked (put into effect).-Pneumococcal vaccination was up-to-date. Review of the Massachusetts Immunization Information System (MIIS) indicated Resident #2 received the Prevnar-13 (PCV13) Pneumococcal Vaccine on 5/25/16. Review of the CDC PneumoRecs VaxAdvisor online calculator indicated the following recommendation for Resident #2:-Give one dose of PCV20 or PCV21 at least 1 year after PCV13. During a telephone interview on 9/5/25 at 2:40 P.M., Resident Representative (RR) #1 said that he/she could not recall if the facility had offered a Pneumonia Vaccine for Resident #2, but that he/she would want an updated vaccine for the Resident if it were offered. Further review of Resident #2's medical record failed to indicate that the Resident had a medical contraindication to or had been offered, received, or declined a Pneumococcal Vaccination since admission to the facility in January 2023. 2. Resident #22 was admitted to the facility in July 2024 and was over the age of 50. Review of Resident #22's Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident:-Was cognitively intact as evidenced by a BIMS score of 15 out of possible 15.-Pneumococcal vaccination was not up-to-date and had not been offered. Review of the Massachusetts Immunization Information System (MIIS) Vaccine Administration Record, provided by the facility indicated Resident #22 had a history of receiving an unspecified Pneumococcal Vaccine on 2/1/15. Review of the CDC PneumoRecs VaxAdvisor online calculator indicated the following recommendation for Resident #22:-Give one dose of PCV15, PCV20, or PCV21. If PCV20 or PCV21 is used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV23 to complete their pneumococcal vaccinations. The recommended interval between PCV15 and PPSV23 is at least 1 year. During an interview on 9/5/25 at 1:18 P.M., Resident #22 said that he/she did not recall having (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any conversation with staff about Pneumonia Vaccination, that no staff had approached him/her to offer an updated vaccination, and he/she would want to receive an updated vaccine, if offered. Further review of Resident #22's medical record failed to indicate that the Resident had a medical contraindication to or had been offered, received, or declined a Pneumococcal Vaccination since his/her admission to the facility in July 2024. During an interview on 9/5/25 at 10:46 A.M., the Infection Preventionist (IP) said the facility process is to review resident's immunization history on admission to the facility and utilize the MIIS to review vaccination history, including Pneumococcal Vaccines, and then staff will offer updated vaccination consent forms which are kept in residents' medical record. During an interview on 9/5/25 at 2:21 P.M., the IP said she was unable to provide evidence that updated Pneumococcal Vaccinations were offered to Resident #2 or #22.