STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225630	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Navigator Homes of Martha's Vineyard	Navigator Way Building #1-5 Edgartown, MA 02539

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 observations and interviews the facility failed to maintain an environment free from accident hazards in 3 out of 3 occupied resident Houses. Specifically, the facility failed to ensure: 1. House 2a. secured and/or supervised kitchen sharps including chef knives (an all-purpose, versatile kitchen knife with a broad, 8 to 10-inch blade that curves toward a point, designed for chopping, slicing, dicing, and mincing), scissors and peelers,b. supervised accessible hot ovens, andc. secured cleaning chemicals. 2. House 3a. kitchen sharps including chef knives were secured and/or supervised, b. cleaning chemicals were secured, and c. potentially hazardous substances and items were not left unlocked and easily accessible to residents in the clean utility room and in one resident's room (#303). 3. House 4a. secured and/or supervised kitchen sharps including chef knives,b. secured cleaning chemicals, andc. potentially hazardous substances and items were not left unlocked and easily accessible to residents in the clean utility room. Findings include:Review of the facility's policy titled Hazardous Storage in the Home- Supporting Open Access to the Home, effective 1/1/26, indicated the following: To maintain the safety of the Elders but ensure a Real Home environment, most doors in the home will remain unlocked, with the exception of dangerous chemicals and sharp objects, will be secured in locked cabinets or rooms. -knives and other sharp objects will be stored in a locked drawer or cabinet in the home -clearly labeled/marked cleaning products will be stored in a locked utility/laundry room and locked cabinets in the kitchen when not in use -staff will not leave dangerous chemicals or sharp objects unattended 1. House 2 had a census of 13 residents, 10 of those residents had cognitive impairment. a. On 3/10/26 at 3:55 P.M., the surveyor observed the House 2 open concept kitchen area (directly open to dining area and accessible to residents). The kitchen island contained drawers, one with a broken child-safety latch and was able to be opened by the surveyor. The unsecured drawer contained two chef knives. Across from the island was counters with cabinets and drawers. One drawer contained kitchen scissors, a pizza cutter and a peeler. At this time there were two residents who were self-propelling in the dining area, one Resident was asking to leave the facility to catch the [NAME]. During an interview on 3/10/26 at 4:50 P.M., Certified Nursing Assistant (CNA) #7 said there were two CNAs on the 3:00 P.M. to 11:00 P.M. shift assigned to House 2 and one nurse that floated between House 2 and House 3. CNA #7 said she was usually assigned to the kitchen when she worked and was (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	assigned this evening. She said this meant she was responsible for cleaning the dishes after dinner. She said cutting knives were kept in the locked drawer and pointed to the drawer with the broken child-safety lock and said she believed the lock was broken and had noticed it was broken the day prior, but the cooks were responsible for knife storage. During an interview on 3/10/26 at 5:23 P.M., the Administrator said the knives were kept in the pantry (behind an unlocked door accessible from the resident hallway and the kitchen), but in a cabinet and on a high shelf. She said the staff were supposed keep the knives out of reach from residents and not in the kitchen in drawers. b. On 3/10/26 at 3:50 P.M., the surveyor observed the open concept kitchen stacked ovens, a lower oven at waist height and a second oven directly above that. The surveyor observed the lower oven set at 175 degrees Fahrenheit (F) with no food in it from 3:50 P.M. through 4:15 P.M. The open concept kitchen remained accessible to residents without staff in the kitchen. During an interview on 3/10/26 at 4:40 P.M., [NAME] #2 said the current two cooks were prepping and cooking dinner in House 4 this evening and would bring the dinners over to the other two Houses when ready. He said the cooks use the lower ovens as warming ovens and leave them at 175 F, even when there was not a cook in the kitchen. He said there was always a CNA in the kitchen, and the ovens were not left unattended. On 3/10/26 at 4:48 P.M., the surveyor observed the kitchen in House 2 unattended with the lower oven on 175 F and three residents in the dining area (directly adjacent to the open concept kitchen), there were no staff members in the kitchen, dining room, or living room. During an interview on 3/10/26 at 4:50 P.M., CNA #7 said the ovens were not left on unless there was food in them and if there was food in them the cooks were responsible for the ovens. She said the CNAs were not responsible for cooking on the 3:00 to 11:00 P.M. shift and did not check the ovens. On 3/11/26 at 11:04 A.M., the surveyor observed the open concept kitchen in House 2. The lower oven was set at 175 F and [NAME] #2 was observed to exit House 2 to the center courtyard and enter another House. There were five residents in a sitting area next to the kitchen with an outside vendor conducting chair yoga. There were no facility staff in the area. [NAME] #2 returned to House 2 at 11:07 A.M. with cooking materials. On 3/12/26 at 9:52 A.M., the surveyor observed the upper oven set at 350 F and CNA #9 was wiping down countertops. During an interview at this time, CNA #9 said she was done with breakfast and there was nothing in the oven. At 11:10 A.M., the surveyor observed the House 2 upper oven continue to be set at 350 F. There were no staff in the kitchen or dining area. During an interview at 11:13 A.M., CNA #9 said she was coming from providing care to one of the residents. She said she must have left the oven on this morning when heating up a muffin for a resident and forgot to shut it off. She said this was her first time assigned to the kitchen and as far as she knew the dietary staff did not leave the ovens on, so it was not something she would have checked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. On 3/10/26 at 12:38 P.M., the surveyor observed a 3-compartment sink in the open concept kitchen area. The cabinet below the sink had one half of a child-safety lock on the outside. Inside the cabinet was the other half of the child-safety lock and five one-gallon bottles of kitchen dish sanitizers, two of them were open with tubing directly to the compartment sinks. The cabinet below the 3-compartment sink continued to be unsecured for the following observations: 3/10/26 at 3:55 P.M., 3/11/26 at 8:05 A.M., and 3/12/26 at 11:13 A.M. On 3/10/26 at 3:51 P.M., the surveyor observed in a resident hall a door labeled closet. The closet contained housekeeping supplies including one gallon of glass cleaner and three 32-ounce bottles of bleach germicidal cleaner. The closet door did not have a mechanism to secure the door. On 3/11/26 at 11:54 A.M., the surveyor observed an outside vendor adding secure doorknobs to doors in House 2 and the vendor left House 2 at 12:30 P.M. On 3/11/26 at 12:30 P.M., the surveyor observed the Closet door to have no change in the doorknob, could not be secured and inside the closet there was one gallon of glass cleaner and three 32-ounce bottles of bleach germicidal cleaner. During an interview on 3/11/26 at 12:48 P.M., the Director of Environmental Services said the vendor was adding doorknobs with keypad only access to the Clean Utility closets and the Storage closets next to the Clean Utility Closet. He said there should not be bleach in any closet and it should be secured. 2. House 3 had a census of nine residents; eight of those residents had cognitive impairment. a. On 3/10/26 at 11:47 A.M., the surveyor observed the House 3 open kitchen area. The kitchen island contained drawers, one with an unfastened child-safety latch and was able to be opened by the surveyor. The unsecured drawer contained three chef's knives. An unsecured drawer below the chef's knives contained an unsheathed pizza cutter. At this time there was one resident who was self-propelling him/herself in the dining area and two residents sitting at the dining table unsupervised. During an interview on 3/10/26 at 5:34 P.M., [NAME] #1 said knives are kept in a locked drawer and he pointed out the small drawer on the center island. He said the lock was supposed to be fastened and it was not. [NAME] #1 said it is everyone's responsibility to ensure the drawer is locked. b. On 3/10/26 at 12:31 P.M., the surveyor observed a door labeled pantry in the kitchen area. The surveyor entered the unlocked pantry and observed a housekeeping cabinet with unlocked doors. The cabinet contained one 2.5-liter bottle of Pan-Clean Pot & Pan Detergent, two 1-quart bottles of Stainless-Steel Polish and three 1-quart bottles of Oven & Fryer Cleaner. During an interview with observation on 3/10/26 at 2:00 P.M., the surveyor observed a 3-compartment sink in the open concept kitchen area with an unfastened child-safety lock on the cabinet below. CNA #1 opened the unlocked cabinet doors below the sinks to reveal a one-gallon bottle of dish detergent and one-gallon bottle of dish sanitizer with tubing in each opened bottle leading to the compartment sinks. The cabinet below the 3-compartment sink continued to be unsecured for the following observations: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3/10/26 at 5:18 P.M. and 5:30 P.M. During an interview with observation on 3/10/26 at 5:34 P.M., [NAME] #1 said the cabinet under the 3-comparment sink contains chemicals and noted that it was unlocked. He said it is supposed to be locked, and it is everyone's responsibility to ensure the lock is secured. c. On 3/10/26 at 12:46 P.M. and 3/11/26 at 8:28 A.M., the surveyor entered the unlocked door of the clean utility room in the House 3 hallway. Inside the room were three unlocked cabinets with several hazardous items noted inside including: -Universal adhesive remover wipes -Hydrating Aqua Cream -Moisture Barrier Antifungal Cream -Body Wash and Shampoo -Mouthwash -Disposable razors On 3/10/26 at 12:52 P.M. and 3/11/26 at 8:15 A.M., the surveyor observed a plastic drinking cup with five diabetic glucometer lancets (small needle used to poke the skin) inside an unlocked compartment of the medication cabinet in room [ROOM NUMBER]. During an interview with observation on 3/11/26 at 12:54 P.M., the Director of Nursing (DON) and the surveyor entered the unlocked clean utility room and then room [ROOM NUMBER] and observed the above noted items that were unsecured. He said items in the clean utility room should be securely stored and not accessible to residents in any of the Houses. He said the items in the unlocked compartment of the medication cabinets should either be locked or the items stored in the locked medication room. 3. House 4 had a census of 10 residents, six of those residents had a cognitive impairment. a. On 3/10/26 at 4:05 P.M., the surveyor observed the House 4 open concept kitchen area (directly open to dining area and accessible to residents). On the countertop next to the refrigerator, the surveyor observed a personal knife pouch on the countertop. At the time, one resident was observed to be wandering in the dining room area and attempting to enter the kitchen area. The resident was redirected by staff to the lounge/TV area next to the kitchen. During an interview on 3/10/26 at 4:08 P.M., [NAME] #2 said the knife pouch on the countertop by the refrigerator was his personal set. [NAME] #2 said the pouch had a zipper and latch closure. On 3/10/26 at 4:14 P.M., the surveyor observed both [NAME] #1 and [NAME] #2 leave the kitchen area in House 4, with the personal knife pouch left on the countertop next to the refrigerator. The surveyor was able to zip/unzip and latch/unlatch the personal knife pouch and access the chef knives. [NAME] #1 did not return to the kitchen area in House 4 until 4:28 P.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. On 3/10/26 at 3:56 P.M., the surveyor observed in a resident hall a door labeled closet. The closet contained housekeeping supplies including 16 bottles of Simplex Crème-It Crème Cleanser and two bottles of Simplex Neutraquat Disinfectant/Detergent. On 3/11/26 at 8:17 A.M. and 12:32 P.M., the surveyor observed in a resident hall a door labeled closet. The closet contained housekeeping supplies including 16 bottles of Simplex Crème-It Crème Cleanser and two bottles of Simplex Neutraquat Disinfectant/Detergent. During an interview on 3/12/26 at 11:25 A.M., the Corporate Executive Chef (contracted with the facility for culinary services) said he had provided training to all facility staff on safety and hazards. He said the cooks at the facility were contracted through his company and there were no additional dietary staff. He said the facility had a hybrid culinary model where the CNAs were responsible for breakfast and the cooks were responsible for lunch and dinner. He said both the CNAs and the cooks know to secure sharps including knives and to secure sanitation products. He said the previous Food Service Director had decided to use child-safety locks and the locks had broken. He said the CNA staff were not trained to cook in the ovens and should only be using the stove tops. He said the cooks do leave the lower ovens on as warming ovens. He said the plan was to have a cook assigned to every house and that when the oven was on there were always staff around the facility. He said he had not thought about the CNA staff having other duties to do and having the oven unattended. He said this was important to look into because in one of the Houses there was a resident who often tried to enter the kitchen and he was not sure what the plan was when there was no cook assigned to a house. During an interview on 3/12/26 at 1:20 P.M., the Administrator said the facility plan for knives had not been followed by staff and they were not sure how the knives got moved to drawers in the kitchen and had not been communicated to management. She said the ovens were not used by the CNAs and they had not thought about the ovens being left on warm and being unattended. She said the under the sink chemicals should have been secured. She said the Clean Utility closets, Storage Closets and other Closets with supplies were not supposed to have any hazardous materials. She said the materials (cleaning supplies, treatment supplies, lancets) were stocked in the secure facility garage and only should have been taken out and put in secure areas when needed. c. On 3/10/26 at 1:26 P.M. and 3/11/26 at 8:25 A.M., the surveyor entered the unlocked door of the clean utility room in the House 4 hallway. Inside the room were three unlocked cabinets with several hazardous items noted inside including: -Universal adhesive remover wipes -Hydrating Aqua Cream -Moisture Barrier Antifungal Cream -Body Wash and Shampoo -Mouthwash -Disposable razors During an interview with observation on 3/11/26 at 12:54 P.M., the DON said items in the clean utility room should be securely stored and not accessible to residents in any of the Houses.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on record review and interview, the facility failed to designate a person who met the minimum qualifications to serve as the Food Service Director (FSD). Specifically, the facility did not employ a full-time dietitian or have a qualified dietary employee who met the minimum qualifications to serve as the FSD. Findings include:During an interview at the entrance conference on 3/10/26 at 12:16 P.M., the Administrator said there was not a FSD and the dietitian worked 20 hours per week at the facility. The Administrator said food services for the facility were contracted and overseen by a Regional Chef. During an interview on 3/11/26 at 10:45 A.M., [NAME] #1 said the FSD for the facility was the Regional Chef and he was on vacation. [NAME] #3 was in charge while he was gone. During an interview on 3/11/26 at 11:00 A.M., the Corporate Executive Chef said he was at the facility to support the kitchen staff during the survey process. The Corporate Executive Chef said he was not in charge of the kitchens at the facility but did support the dietitian and the Regional Chef in specializing menus for the facility. During an interview on 3/11/26 at 2:34 P.M., [NAME] #3 said he was the senior cook at the facility and was filling in for the Regional Chef while he was on vacation. [NAME] #3 said he was not the FSD. During an interview on 3/12/26 at 8:27 A.M., the Administrator brought the surveyor certifications for [NAME] #2 and the Corporate Executive Chef. The Administrator said the Regional Chef, who was on vacation, oversees the whole food service program at the facility. The Administrator said they did not have a FSD at this time. During an interview on 3/12/26 at 9:43 A.M., the Dietitian was not responsible for overseeing the kitchen staff or the running of the kitchen. The Dietitian said she is only at the facility 20 hours per week and is not responsible for the running of the food service program. During an interview on 3/12/26 at 9:45 A.M., the Administrator said the facility currently had no one in charge of the food service program with a certification. The Administrator said the Regional Chef was overseeing the program, but he is not the FSD and does not have credentials. The Administrator said the facility had a FSD, but they left in the past month and are awaiting a new hire to start. The Administrator said [NAME] #3 was overseeing the other cooks at the facility. The facility failed to provide any additional certifications for [NAME] #1, [NAME] #3 or the Regional Chef during the survey process.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to:1. Ensure staff wore beard restraints in the main kitchen during meal preparation and service; and2. Handle ready-to-eat food (food which does not require cooking or further preparation prior to consumption) utilizing proper hand hygiene to prevent cross contamination (transfer of pathogens from one surface to another).Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated but was not limited to:-2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following:- 3-301.11 Preventing Contamination from Hands. (A) FOOD EMPLOYEES shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT.- 3-304.15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. 1. On 3/10/26 at 12:28 P.M., in House 4's kitchen area, the surveyor observed [NAME] #2 plating food items for the lunch meal service without a beard covering donned (on). On 3/10/26 at 3:55 P.M., in House 4's kitchen area, the surveyor observed [NAME] #1 and [NAME] #2 preparing food items for the dinner meal service. Both [NAME] #1 and [NAME] #2 did not have a beard covering donned. On 3/10/26 at 5:18 P.M., in House 3's kitchen area, the surveyor observed [NAME] #2 bringing food items into the kitchen area and placing the food items into the oven. [NAME] #2 did not have a beard covering donned. On 3/10/26 at 5:34 P.M., in House 3's kitchen area, the surveyor observed [NAME] #1 enter the kitchen area and remove food items from the oven. The surveyor observed [NAME] #1 retrieve plates and dishware from the kitchen and place them on the countertop. [NAME] #1 did not have a beard covering donned. On 3/11/26 at 8:17 A.M., in House #4's kitchen area, the surveyor observed [NAME] #1 preparing food items for the breakfast meal service. [NAME] #1 did not have a beard covering donned. On 3/11/26 at 10:45 A.M., in House 4's kitchen area, the surveyor observed [NAME] #1 peeling potatoes in the kitchen area. [NAME] #1 did not have a beard covering donned. On 3/11/26 at 10:45 A.M., in House 2's kitchen area, the surveyor observed [NAME] #2 preparing food items for lunch in the kitchen area. [NAME] #2 did not have a beard covering donned. On 3/11/26 at 12:15 P.M., in House 2's kitchen area, the surveyor observed [NAME] #2 slicing food items in the kitchen area. [NAME] #2 did not have a beard covering donned. During an interview on 3/11/26 at 2:34 P.M., the Corporate Executive Chef said beard coverings and hairnets should be worn at all times during preparation of food and serving of food items. 2. On 3/10/26 at 12:59 P.M., the surveyor made the following observations in House 4's kitchen area:- Certified Nursing Assistant (CNA) #1 delivered a resident's meal with gloved hands to the dining room table. CNA #1 then walked away from the resident, returned and began serving the resident their meal. CNA #1 did not change their gloves or perform hand hygiene prior to returning to the resident to assist with feeding.- CNA #1 moved the trash bin on wheels in the kitchen area with gloved hands. CNA #1 then, with the same gloved hands, began placing fruit into a dish and serve it to a resident. CNA #1, with the same gloved hands, then returned to the kitchen area to grab an ice cream cup from the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CNA #1 then grabbed a spoon from a drawer in the kitchen area with the same gloved hands and delivered the spoon and ice cream to a resident seated at the dining room table. CNA #1 then doffed (removed) her gloves but never performed hand hygiene. During an interview on 3/10/26 at 1:13 P.M., CNA #1 said hand hygiene should be performed each time gloves are removed. On 3/10/26 at 3:55 P.M., the surveyor made the following observations in House 4's kitchen area:- [NAME] #2 took the temperature of food items prior to dinner service. [NAME] #2 cleaned the thermometer between food items with a dishcloth.- [NAME] #2 used the used the same dishcloth to wipe down the countertop of the prep island. [NAME] #2 also used the dishcloth as a potholder as he placed food items back into the oven.- [NAME] #2 touched his gloved hands to his face and hat. [NAME] #2 continued to complete food preparation without changing his gloves or performing hand hygiene. On 3/11/26 at 8:57 A.M., the surveyor made the following observations in House 4's kitchen area:- [NAME] #3 entered House 4 from House 3 with gloved hands, grabbing the door handle to enter. [NAME] #3 said he needed to grab eggs from House 4. [NAME] #3 did not change his gloves and opened the refrigerator in House 4's kitchen to grab a carton of liquid eggs. [NAME] #3 exited House 4 with the same gloved hands and carton of liquid eggs, touching the door handle while exiting. On 3/11/26 at 10:45 A.M., the surveyor made the following observations in House 4's kitchen area:- [NAME] #1 was peeling potatoes over a trash can next to the prep island in the kitchen area. [NAME] #1 was noted to stop peeling potatoes, touch a cell phone with his gloved hands and return to peeling potatoes without changing gloves or performing hand hygiene.- [NAME] #1 touched the side of the trash can and did not change gloves or perform hand hygiene prior to returning to peeling potatoes. On 3/11/26 at 12:29 P.M., the surveyor made the following observations in House 4's kitchen area:- [NAME] #2 entered House 4 from House 2 with gloved hands, touching the door handle when entering. [NAME] #2 entered House 4's kitchen pantry and grabbed a bag of salad mix. [NAME] #2 exited House 4 and returned to House 2 with gloved hands, touching the door handles of each on his entrance/exit. During an interview on 3/11/26 at 3:23 P.M., the Corporate Executive Chef said gloves should be changed when moving between tasks when working in the kitchen. The Corporate Executive Chef said staff should not be touching drawers, in/out of pantry, touching multiple surfaces, or going between Houses with gloved hands. The Corporate Executive Chef said staff should perform hand hygiene between glove changes.

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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 interview and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to maintain a water management program which included an assessment to identify where Legionella (a type of bacteria naturally found in water and soil that causes serious, sometimes fatal, pneumonia known as Legionnaires' Disease) and other opportunistic waterborne pathogens could grow and spread and failed to implement measures to prevent the growth of opportunistic waterborne pathogens (also known as control measures), and how to monitor them. Findings include: During the entrance conference on 3/10/26 at 12:15 P.M., the Administrator said the new facility had five separated Houses (numbered 1 through 5) and residents had moved into Houses 2, 3 and 4 on 2/4/26. On 3/11/26 at 2:15 P.M. the surveyor requested to review the facility water management program. During an interview on 3/11/26 at 2:20 P.M., the Director of Environmental Services said the previous location had a comprehensive water management program and that the water management program for the new, current location will be comprehensive but was not currently in place. He said there was previously a contract with a water management company for the previous location. He said the current facility location did not have any water management program in place. He said the facility was contracting with a water management company and provided a copy of the contract, dated 12/22/25, that the Administrator had signed with no date of signature and a blank section of signature for the water management company. No additional information was provided prior to the exit on 3/12/26.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure monthly medication regimen reviews were maintained as part of the permanent medical record and failed to ensure recommendations made by the pharmacy consultant were addressed timely for three Residents (#4, #7, and #3), out of a total sample of 12 residents. Findings include:Review of the facility's policy titled Medication Regimen Review, dated last revised 6/1/24, indicated but was not limited to the following: - The consultant pharmacist will provide the resident's Medication Regimen Review (MRR) to facility identified personnel who will ensure that the attending physician, medical director, director of nursing and other necessary facility staff receive the recommendations. - For those issues that require physician/prescriber intervention, facility should encourage physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected, as outlined in the State Operations Manual Appendix PP. - The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. - The attending physician/prescriber should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident per facility policy, or applicable state and federal regulations. - If the attending physician/prescriber has decided to make no change in the medication, the attending physician should document the rationale in the residents' health record. - The facility should maintain readily available copies of the consultant pharmacist reports on file in the facility, and as a part of the resident's permanent health record. 1. Resident #4 was admitted to the facility in January 2025 with diagnoses including type II diabetes, chronic pain, and depression. Review of the medical record indicated Resident #4 had a monthly pharmacy MRR and recommendations were made by the consultant pharmacist regarding medications on 9/25/25, 11/6/25, 12/19/25, and 1/26/26. During an interview on 3/12/26 at 8:34 A.M., the Administrator said the facility was working with the pharmacy to obtain the recommendations because the recommendations were made prior to the move to the new location on 2/4/26. During an interview on 3/12/26 at 8:52 A.M., the Director of Nurses (DON) said he was unable to find the original pharmacy recommendations. He said the process was that the pharmacy emailed him the recommendations, he distributed them to the physicians, the physicians would address the recommendations, sign the forms, then changes to the orders would be made as indicated and the forms would be uploaded to the electronic medical record. The DON provided the surveyor with copies of the recommendations for Resident #4 and said he would provide any documentation to indicate the physician had addressed the recommendations in the medical record. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Consultant Pharmacy Report, dated 9/25/25, indicated the following: - Resident may benefit from deprescribing and receives the following medications: Multivitamin Injection (MVI) daily, Ocuvite Adult Plus 50 (eye vitamin and mineral supplement) daily and Coenzyme Q10 (antioxidant) 100 mg (milligrams) daily. - Please consider discontinuing MVI, Ocuvite and Coenzyme Q10 daily doses, monitor for any change in symptoms and periodically reevaluate. Review of the medical record failed to indicate the attending physician had reviewed the consultant recommendation for MVI, Ocuvite and Coenzyme Q10 and what, if any actions had been taken. Review of the medical record indicated as of 3/12/26 Resident #4 continued to receive the medications daily. Review of the Consultant Pharmacy Reports, dated 11/6/25 and 12/19/25, indicated the following: - Resident #4 receives a basal insulin analog twice daily for diabetes (Lantus 24 units in the morning and 40 units at bedtime). Basal insulin analogs typically exhibit a relatively constant serum concentration over 24 hours which permits once daily dosing up to 80 units. - Please change the administration of Lantus to 64 units once daily. Close monitoring (e.g., glucose) should accompany any change in diabetic therapy and guide further adjustments. Review of the medical record failed to indicate the attending physician had reviewed the consultant recommendation for Lantus and what, if any actions had been taken. Review of the medical record indicated as of 3/12/26 Resident #4 continued to receive the medications daily. Review of the Consultant Pharmacy Report, dated 1/26/26, indicated the following: - Resident #4 frequently receives PRN Motrin and Tylenol for pain but is not attaining adequate pain control according to documentation in the medical record. - Please evaluate pain status if pain is inadequately controlled, please consider adjustments to the current regimen scheduling a routine analgesic, Tylenol ES (extra strength) 500 MG three times daily. Review of the medical record failed to indicate the attending physician had reviewed the consultant recommendation for Motrin and Tylenol and what, if any actions had been taken. Review of the medical record indicated as of 3/12/26 Resident #4 continued to receive the medications daily. During an interview on 3/12/26 at 11:54 A.M., the DON said there was no documentation to indicate the physician specifically addressed the recommendations for MVI, Ocuvite, Coenzyme Q10, Lantus, Motrin and Tylenol. 2. Resident #7 was admitted to the facility in January 2025 with diagnoses including pulmonary embolism (blood clot in the lungs), hypertension, and heart failure. Review of the medical record indicated Resident #7 had a monthly pharmacy MRR and recommendations were made by the consultant pharmacist regarding medications on 12/22/25. During an interview on 3/12/26 at 8:34 A.M., the Administrator said the facility was working with the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pharmacy to obtain the recommendations because the recommendations were made prior to the move to the new location on 2/4/26. During an interview on 3/12/26 at 8:52 A.M., the DON said he was unable to find the original pharmacy recommendations. He said the process was that the pharmacy emailed him the recommendations, he distributed them to the physicians, the physicians would address the recommendations, sign the forms, then changes to the orders would be made as indicated and the forms would be uploaded to the electronic medical record. The DON provided the surveyor with copies of the recommendations for Resident #7 and said he would provide any documentation to indicate the physician had addressed the recommendations in the medical record. Review of the Consultant Pharmacy Report, dated 12/22/25, indicated the following: - Clinical Priority Recommendation: Prompt Response Required - Resident #7 receives aspirin and Eliquis. - Concomitant use of apixaban or edoxaban and select medications may further increase the risk for serious, potentially fatal bleedings. Combination therapy with an antiplatelet agent may be an appropriate choice in select high risk individuals. - If concomitant therapy is to continue, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensures ongoing monitoring for effectiveness and potential adverse consequences (e.g., unusual bruising, bloody or black tarry stools, red or dark brown urine, abdominal pain or swelling, bleeding gums or nose). Any of these symptoms should be reported to the prescriber immediately. Review of the medical record failed to indicate the attending physician had reviewed the consultant recommendation for aspirin and Eliquis and what, if any actions had been taken. Review of the medical record indicated Resident #7 received the medications daily from 12/20/25 through 1/3/26. During an interview on 3/12/26 at 1:47 P.M., the DON said there was no documentation to indicate the physician specifically addressed the recommendations for aspirin and Eliquis. The DON said because the recommendation came over as a clinical priority, the physician should have been faxed and called immediately to address the recommendation. During an interview on 3/12/26 at 3:21 P.M., the Consultant Pharmacist said a prompt clinical recommendation should have a response within 30 days. The Consultant Pharmacist said the recommendation should be reviewed by the physician somewhat timely to ensure additional monitoring is being completed. 3. Resident #3 was admitted to the facility in September 2025 with diagnoses of dementia with agitation, allergies, and chronic pain. Review of the medical record indicated Resident #3 had a monthly pharmacy MRR. Review of the medication record indicated the pharmacist had made recommendations regarding medications on 10/20/25 and 1/26/26. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the paper and electronic medical records failed to include what the pharmacist recommendations were on 10/20/25 and 1/26/26. During an interview on 3/12/26 at 8:34 A.M., the Administrator said the facility was working with the pharmacy to obtain the recommendations because the recommendations were made prior to the move to the new location on 2/4/26. During an interview on 3/12/26 at 8:52 A.M., the DON said he was unable to find the original pharmacy recommendations. He said the process was that the pharmacy emailed him the recommendations, he distributed them to the physicians, the physicians would address the recommendations, sign the forms, then changes to orders would be made as indicated and the forms would be uploaded to the electronic medical record. The DON provided the surveyor with copies of the recommendations for Resident #3 and said he would provide any documentation to indicate the physician had addressed the recommendations in the medical record. Review of the pharmacy Consultation Report indicated the following recommendations for Resident #3:10/20/25: order for acetaminophen (Tylenol) 1000 mg every six hours: document the maximum daily dose of acetaminophen from all sources. If maximum dose is 3 grams daily, reduce acetaminophen to three times per day.1/26/26: order for acetaminophen 1000 mg every six hours: document the maximum daily dose of acetaminophen from all sources. If maximum dose is 3 grams daily, reduce acetaminophen to three times per day. Review of the medical record failed to indicate the attending physician had reviewed the recommendation for acetaminophen and what, if any actions had been taken. The medical record indicated as of 3/12/26 Resident #3 continued to receive acetaminophen 1000 mg every six hours. Review of the pharmacy Consultation Report, dated 10/20/25, indicated the following:Consider a trial dose reduction of Seroquel (an antipsychotic) to 25 mg at bedtime Review of the medical record failed to indicate the attending physician had reviewed the recommendation for a trial dose reduction of Seroquel and what, if any actions had been taken. The medical record indicated as of 3/12/26 Resident #3 continued to receive Seroquel 37.5 mg every day. Review of the pharmacy Consultation Report, dated 1/26/26, indicated the following:Reduce the dose of loratadine (a medication for allergy symptom relief) 10 mg to every other day or consider a trial discontinuation Review of the medical record failed to indicate the attending physician had reviewed the recommendation for a dose reduction of loratadine and what, if any actions had been taken. The medical record indicated as of 3/12/26 Resident #3 continued to receive loratadine 10 mg daily. During an interview on 3/12/26 at 10:56 A.M., the DON said there was no documentation to indicate the physician had addressed the recommendations regarding acetaminophen, Seroquel, or loratadine.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure all drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. Specifically, the facility failed to:1. Ensure the clean utility room, which contained topical treatments, was locked when not in direct supervision of a licensed nurse in two (#3 and #4) of three Houses; and2. Ensure for rooms #302, #303 and #306, that topical treatments were not left unsecured and unattended in the residents' rooms. Findings include:Review of the facility's policy titled Medication Storage and Transport, last revised 1/16/26, indicated but was not limited to:-Medications shall be stored, handled and administered in accordance with 105 CMR 150.008, and in a manner that ensures the security, integrity, and proper control of all medications, including controlled substances.-Medications will remain secured at all times unless directly under the supervision of a licensed nurse.-All medication preparation and storage will occur in the designated secured medication storage areas, including the Home Office and locked medication cabinets within each Elder's room, in alignment with Department of Public Health expectations for security and supervision.-Each Elder's room contains a dedicated, locking medication cabinet for storage of non-controlled prescribed and over-the-counter medication ordered by the physician and specific to that Elder. 1a. On 3/10/26 at 12:46 P.M. and 3/11/26 at 8:28 A.M., the surveyor entered the unlocked door of the clean utility room in the nursing unit hallway of House #3. Inside the room were three unlocked cabinets with several items noted inside including:-Vasche wound cleanser-Bacitracin Ointment USP (topical antibiotic)-Triple antibiotic ointment-Hydrocortisone cream 1% (topical steroid)-Calmoseptine Ointment (topical ointment and paste that contains menthol and zinc oxide)-Silicone Skin Guard Skin protectantb. On 3/10/26 at 1:25 P.M. and 3/11/26 at 8:25 A.M., the surveyor entered the unlocked door of the clean utility room in the nursing unit hallway of House #4. Inside the room were unlocked cabinets with several items noted inside including:-Bacitracin Ointment USP-Hydrogen Peroxide 3% (chemical compound used as a disinfectant)-Hydrocortisone cream-Anit-Itch cream-Wound cleanser2. On 3/10/26 at 12:52 P.M. and 3/11/26 at 8:15 A.M., the surveyor observed the following:-room [ROOM NUMBER] (door wide open): two bottles of Nystatin powder (topical antifungal used to treat fungal skin infections) unsecured and easily accessible to residents in an unlocked medication cabinet compartment.-room [ROOM NUMBER] (door wide open): one packet of triple antibiotic ointment (topical treatment to prevent infections in minor skin injuries).On 3/11/26 at 12:07 P.M., the surveyor and Nurse #3 observed a box containing multiple packets of skin prep wipes in the unlocked medication cabinet compartment in room [ROOM NUMBER]'s room (door wide open). Nurse #3 said chemicals and dressing supplies are not to be kept in residents' rooms or in any area where other residents could access them.During an interview with observation on 3/11/26 at 12:54 P.M., the Director of Nursing and the surveyor entered the unlocked clean utility room and rooms #303 and #306 and observed the above noted items that were unsecured. He said items in the clean utility room should be securely stored in the medication room and not accessible to residents in any of the Houses, and the items in the unlocked compartment of the medication cabinets should either be locked in the cabinet or stored in the locked medication room.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview, the facility failed to notify Resident #35's Healthcare proxy (HCP) timely of ongoing changes to the Resident's care and condition for one of two discharged records reviewed. Findings include: Review of the facility's policy titled Change in Condition (Significant) and Notification of Change, dated [DATE], indicated but was not limited to the following: - it is the policy to inform the elder and to notify the elder's legal representative/family member when there is a change in status in a timely manner- significant change in status includes changes in an elder's status such as physical, mental, psychosocial, life threatening, clinical complications, need to discontinue treatment, commencement of new treatment- when there is a change in condition there is timely notification of the elder's legal representative/family and the appropriate observations/assessments are performed and documented- staff nurse will notify the family member/legal representative of the change in status in a timely manner; there may be occasions when it is appropriate for the social worker to contact the family; the specific date, time and name of the person notified and the details of what the person was notified of will be clearly documented in the elder's record Resident #35 was admitted to the facility in [DATE] and had diagnoses including: acute respiratory failure, chronic obstructive pulmonary disease (progressive irreversible lung disease that restricts air flow making it difficult to breathe - COPD), and peripheral vascular disease. The Resident was on hospice services and expired on [DATE]. Review of the Healthcare Facility Reporting System (HCFRS) indicated that the facility self-reported a family allegation of neglect on [DATE] regarding Resident #35, which the facility also investigated. Review of the family concern received by the facility on [DATE], indicated, but was not limited to, the family did not feel informed of changes in the Resident's care or condition following the facility's move to a new physical address on [DATE]. Review of the medical record for Resident #35 indicated but was not limited to the following:- Healthcare proxy (HCP) activation form was completed on [DATE], indicating the Resident no longer had the capacity to make or communicate healthcare decisions. Review of the progress notes from [DATE] through [DATE], indicated but were not limited to the following: - [DATE]: Resident very weak with unlabored breathing- [DATE]: New order for chest x-ray, nurse called physician to indicate time frame for completion and was informed not urgent- [DATE]: discontinue chest x-ray; Augmentin (an antibiotic) 875/125 milligrams by mouth twice a day for seven days- [DATE]: Resident had two nausea/vomiting [sic], Compazine (a medication to help eliminate nausea) administered as ordered, wet cough with no sputum or phlegm, very poor appetite despite encouragement- [DATE]: Resident had episode of COPD exacerbation [sic], as needed Morphine administered with some result, couple hours later, Ativan (antianxiety medication) administered with positive result, Resident calmer had some rest - [DATE]: complaint of dull pain in the left flank region, hospice contacted and notified, respirations shallow, Resident's feet show signs of minor mottling (a patchy discoloration of the skin, common in the final hours or days of life indicating circulatory slowdown) The progress notes and medical record failed to indicate Resident #35's HCP or family were notified of the ongoing changes in his/her condition and/or changes in the plan of care timely. During an interview on [DATE] at 12:37 P.M., the Director of Nurses (DON) said Resident #35 had a daughter, who was not the HCP, come to visit in February 2026 requesting a lot of medical information and he informed her that he could not release any information to her and he felt doing so would violate HIPAA (healthcare information portability and accountability). He said the Resident's HCP was activated, was a different daughter, and that person also lived out of state. He said the Resident had a small decline in January and then in February the Resident's condition continued to deteriorate. He said the HCP, who lived out of state, was informed of changes and made aware of the Resident's condition to the best of his knowledge. During an interview on [DATE] at 1:31 P.M., Nurse (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 said she regularly provided care to Resident #35 and is aware that the Resident had an activated HCP and was on hospice services. She said the Resident started having more complications with his/her respiratory status a month or so prior to him/her passing away. She said the family should always be notified of changes, especially since the Resident had an activated HCP. She reviewed the progress notes for Resident #35 from February 2026 and said it appeared there were multiple opportunities in which the family/HCP should have been updated, and weren't documented as being at bedside, but she could not find any evidence that that notification occurred. She said perhaps the Hospice Nurse had updated the family on all the ongoing changes since the Resident was on hospice. She said the standard expectation of care is to notify the HCP or family of any changes in orders, or a residents' condition to keep them informed of any progress or decline. She said she recalls speaking to the HCP a few times but cannot recall what those talks entailed and said she did not document any of those notifications/communications. During an interview on [DATE] at 2:27 P.M., the Hospice Nurse said the staff reached out to hospice as needed with changes in condition and for recommendations. She said when that occurs and recommendations are given, she would expect that the nurses at the facility would reach out to the family and update them on any changes. She said she was in the facility about twice a week visiting the Resident and would update the family at bedside at those times, but if she was offsite and providing recommendations, she would expect the facility staff to update the family with any changes. During a follow up interview on [DATE] at 1:58 P.M., the DON said his expectation is that the HCP/families are made aware of any new orders or recommendations and any change in condition and the staff should have been keeping Resident #35's family updated on the ongoing changes and documenting that in the medical record. He said if that is not documented in the medical record then he would assume it did not occur. During an interview on [DATE] at 2:07 P.M., the Administrator said she completed the investigations into the family's concerns. She said she did notice that during the investigation that although staff would tell her they felt they were communicating with the family and notifying them of changes in the Resident's condition or plan of care she could not find any documentation to support that was happening routinely and timely in an ongoing manner. She said timely would be right away, but never more than 48 hours. She said during her investigation she learned that the facility needs to do a better job of documenting notification of changes to the families/HCP. A telephone call was placed to Resident #35's HCP on [DATE] at 10:33 A.M., but no return call had been received.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans for one Resident (#21), out of a sample of 12 residents. Specifically, the facility failed for Resident #21, to develop and implement a care plan related to a history of leaving the residential area and expressing a desire to leave the facility. Findings include:Review of the facility's policy titled Elopement, revised on 1/8/26, indicated all Elders with any history, past or present, of wandering or confusion with associated wandering and especially those with a history of elopement will be identified. All instances of wandering will be documented and reviewed periodically to identify behavior patterns. All identified wandering Elders will have a care plan developed and implemented with specific approaches and time-measured goals. Resident #21 was admitted to the facility in June 2023 with a diagnosis of dementia. Review of the Minimum Data Set (MDS) assessment, dated 3/3/26, indicated Resident #21 scored 0 out of 15 on the Brief Interview for Mental Status, indicating a severe cognitive impairment. Review of Section E for behaviors indicated Resident #21 did not exhibit a behavior of wandering. On 3/10/26 at 1:00 P.M., the surveyor observed Resident #21 self-propelling in their wheelchair towards the front door. The Resident said they were upset because their son was missing. The Resident was observed seated in front of the vertical window that framed the front door, looking outside. Review of the nursing progress notes indicated the following:1/9/26: Resident with increased confusion and was anxious to catch the [NAME] because his/her mother was waiting for them and asking which town the [NAME] was going to.1/19/26: Resident exited their unit, went through another unit, into the elevator and down to the employee lounge. The Resident was found by the custodian on duty. Resident had said he/she was looking for their mom.2/4/26: Resident moved to the new facility location. Review of the medical record failed to include a care plan with interventions for wandering/elopement. Review of the Elopement Risk assessment, dated 3/6/26, indicated Resident #21 did not exhibit any contributing factors including elopement attempts in the past or verbalizing statements about leaving. In addition, the assessment indicated the Resident had not experienced any contributing factors including recent move to facility, recent room change or wandering. The Outcomes section indicated no interventions were necessary. On 3/11/26 at 12:06 P.M., the surveyor observed Resident #21 self-propelling in their wheelchair from their room towards the front door. During an interview on 3/11/26 at 12:08 P.M., Certified Nursing Assistant (CNA) #5 said she was a new employee at the new location as of February 2026. She said Resident #21 was often asking to go home and gravitated towards the front doors, like now. She said the doors were unable to be opened without a keycard or a master key. She said the master key was previously located in the keyhole until Resident #21 started to fidget with the keys and they were removed. She said staff attempt to sit outside with the Resident for a couple minutes or try to redirect the Resident to an activity. During an interview on 3/11/26 at 12:10 P.M., CNA #4 said she had been working at the previous facility and had not heard anything about Resident #21 leaving the residential units and going in the elevator. She said the Resident would not have been able to do this because staff were always around. During an interview on 3/12/26 at 9:42 A.M., Nurse #1 said she was working at the previous facility when Resident #21 exited the units and took the elevator downstairs. She said Resident #21 does wander, more often in the afternoons and mostly heads towards the exit door. She said she did not know if the Resident had a care plan and did not enter care plans into the electronic medical record. During an interview on 3/12/26 at 10:10 A.M., the Assistant Director of Nurses said Resident #21 had left the residential units at the previous facility and a wander guard was implemented at that time. She said this new facility had secure doors and there was no wander guard system. She said she was unable to find a care plan to indicate Resident #21 wandered or what the interventions were. During an interview on 3/12/26 at 10:35 A.M., the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225630	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Navigator Homes of Martha's Vineyard	Navigator Way Building #1-5 Edgartown, MA 02539

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nurses said Resident #21 liked to hover around the exit doors and would attempt to use the door handles and that this should have been reflected on the assessment and the care plans.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one Resident (#1) from a sample of 12 residents, the facility failed to ensure Comprehensive Care Plans were reviewed and revised by the interdisciplinary team (IDT) after each assessment, including both the comprehensive and quarterly assessments to reflect the Resident's needs as required.Findings include:Review of the facility's policy titled Comprehensive Care Plan, dated 1/11/26, indicated but was not limited to:-Each Elder will have an individualized Comprehensive Care Plan that is developed, updated, and implemented by the interdisciplinary team with input from the Elder and family.Resident #1 was admitted to the facility in July 2025 and had diagnoses including adjustment disorder and a history of falls.Review of the Minimum Data Set (MDS) assessment, dated 10/7/25, indicated Resident #1 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and had an invoked health care proxy (HCP-health care agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions).Review of a Physician's progress note, dated 12/16/25, indicated that he performed an assessment and in his medical opinion, Resident #1 demonstrated capacity to make his/her own healthcare related decisions and therefore revoked his/her healthcare proxy activation.Review of the MDS assessment, dated 1/6/26, indicated Resident #1 was cognitively intact as evidenced by a BIMS score of 13 out of 15. The assessment indicated that the Resident did not have an invoked HCP. Review of comprehensive care plans indicated:-Problem: Cognitive Loss / Dementia. Resident (sic) has impaired decision making related to (sic) acute mental status changes (delirium), alcoholism, recent urinary tract infections (sic) (7/11/25)-Approach: Activated HCP (7/11/25)-Goal: Resident's (sic) needs will be anticipated and met by staff daily. He/she will be encouraged to participate in his/her care as much as he/she accepts (Target Date 1/1/26)Further review of the comprehensive care plans failed to indicate the care plan was reviewed and revised by the IDT to reflect the revocation of the Resident's HCP activation after the MDS assessment dated [DATE] as required.During an interview on 3/12/26 at 11:52 A.M., the Director of Nursing (DON) reviewed Resident #1's medical record and said he could not find any documentation to indicate the Resident's plan of care was reviewed or revised by the IDT following the last MDS assessment, dated 1/6/26, to reflect the revocation of the Resident's HCP activation on 12/16/25.During an interview on 3/12/26 at 3:20 P.M., the Assistant Director of Nursing reviewed Resident #1's medical record and said she could not find any documentation to indicate the Resident's plan of care was reviewed by the IDT following the last MDS assessment and the care plan was not reviewed and revised to reflect the revocation of the Resident's HCP activation on 12/16/25.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and interview, the facility failed to ensure mechanical equipment, specifically a refrigerator, in one of three pantry kitchens was maintained in safe operating condition. Findings include:Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following:4-5 Maintenance and Operation 4-501 Equipment 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. Review of the facility's policy titled Safety and Equipment Maintenance, dated revised 1/2025, indicated but was not limited to the following:- If unsafe conditions are seen in the kitchen, report them immediately to your supervisor so they can be corrected. On 3/10/26 at 3:55 P.M., in House 4's kitchen pantry, the surveyor observed the pantry refrigerator door held shut by a plastic bin of oranges on the ground in front of the door. The refrigerator contained honeydew melons, salted butter, prepared desserts, dated 3/10/26, and packages of meat products. On 3/11/26 at 8:35 A.M., in House 4's kitchen pantry, the surveyor observed the pantry refrigerator door held shut by a plastic bin of oranges on the ground in front of the door. In addition, tape was placed on the top and sides of the refrigerator in an attempt to keep the door closed. The refrigerator contained honeydew melons, salted butter, prepared desserts, and packages of meat products. During an interview on 3/11/26 at 10:45 A.M., [NAME] #1 said the pantry refrigerator door in House 4 has not been closing all the way since yesterday. [NAME] #1 said he placed a plastic bin full of oranges on the ground in front of the door to make sure the door stayed closed. [NAME] #1 said he was not sure when someone was coming to take a look at the refrigerator door. On 3/11/26 at 12:35 P.M., in House 4's kitchen pantry, the surveyor observed the pantry refrigerator door held shut by a plastic bin of oranges on the ground in front of the door. In addition, tape was placed on the top and sides of the refrigerator in an attempt to keep the door closed. The refrigerator contained honeydew melons, salted butter, prepared desserts, dated 3/10/26, and packages of meat products. During an interview on 3/11/26 at 2:34 P.M., [NAME] #3 said he was the senior cook and in charge of overseeing all the House kitchens while the Regional Chef was on vacation. [NAME] #3 said he was told the pantry refrigerator in House 4 was not shutting appropriately this morning, but he had not assessed or done anything about it yet. During an interview on 3/11/26 at 2:35 P.M., the Corporate Executive Chef said he and [NAME] #3 would assess the pantry refrigerator in House 4. On 3/11/26 at 2:54 P.M., in House 4's kitchen pantry, the surveyor observed the pantry refrigerator door was held shut by a plastic bin of oranges on the ground in front of the door. In addition, tape was placed on the top and sides of the refrigerator in an attempt to keep the door closed. The internal thermometer of the refrigerator read 52 degrees Fahrenheit (F). The refrigerator contained meat products, butter, and prepared desserts dated 3/11/26. On 3/11/26 at 3:05 P.M., in House 4's kitchen pantry, the surveyor observed the pantry refrigerator door was held shut by a plastic bin of oranges on the ground in front of the door. In addition, tape was placed on the top and sides of the refrigerator in an attempt to keep the door closed. The internal thermometer of the refrigerator read 53 degrees F. The refrigerator contained meat products, butter, and prepared desserts dated 3/11/26. During an interview on 3/11/26 at 3:23 P.M., the Corporate Executive Chef and the surveyor reviewed the observations made of House 4's kitchen pantry refrigerator. The Corporate Executive Chef said he just put a work order into the system but had not gotten a chance to head over to House 4 to assess the refrigerator. The Corporate Executive Chef said temperatures in the refrigerators should be 41 F or below. The Corporate Executive Chef said all food items in the pantry refrigerator in House 4 would need to be discarded. During an interview on 3/11/26 at 4:56 P.M., the Administrator said kitchen staff should report any equipment malfunctions to the Plant Manager or herself. The Administrator said she should be notified immediately when equipment is not functioning so it can be assessed and fixed.