STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225650	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at New Bedford	221 Fitzgerald Drive New Bedford, MA 02745

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessments for two Residents (#13 and #7), out of seven residents reviewed. Specifically, the facility failed: 1. For Resident #13, to accurately reflect if the Resident was utilizing a restraint on the most recent quarterly MDS and;2. For Resident #7, to accurately reflect if the Resident was being administered insulin on the two most recent quarterly MDSs.Findings include:1. Resident #13 was admitted to the facility in August 2022. Review of the facility provided Matrix (Form CMS-802) on 7/30/25 indicated Resident #13 had a physical restraint.Review of the MDS assessment, dated 5/15/25, indicated Resident #13 had a restraint of a bed rail, used less than daily.During an interview with observation on 7/30/25 at 8:30 A.M., Resident #13 said he/she had limited range of motion on their left upper extremity. The surveyor observed Resident #13 in bed with bilateral bed rails on the upper portion of the bed only, which did not restrict movement.During an interview on 8/5/25 at 9:51 A.M., the MDS Coordinator said the MDS for Resident #13 was inaccurate as Resident #13 had never had a restraint and the bed rails were not a restraint for the Resident. 2. Resident #7 was admitted to the facility in August 2024. Review of the MDSs, dated 6/13/25 and 3/14/25, indicated Resident #7 received insulin during the look back period. Review of the medical record failed to indicate Resident #7 had received insulin in March 2025 or June 2025. During an interview on 8/5/25 at 10:10 A.M., the MDS Coordinator said she had completed the medication section on the March and June 2025 MDSs and based the information on the assessment of Resident #7 taking Victoza (an injection used to treat diabetes). During an interview on 8/5/25 at 10:53 A.M., the MDS Coordinator said she reviewed the information and found that Victoza is not an insulin and the MDSs were inaccurate.

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

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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 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop, implement and individualize a comprehensive care plan for one Resident (#137), out of a total sample of 27 residents. Specifically, the facility failed to ensure a comprehensive care plan related to Resident #137's right hand contracture (shortening/tightness to the muscle, tendons, ligaments, skin and other tissues resulting in difficulty moving the affected joint) was developed and implemented.Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, dated March 2022, indicated but was not limited to the following:- A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.- The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.- Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.Review of the facility's policy titled Resident Mobility and Range of Motion, dated July 2017, indicated but was not limited to the following:- Residents with limited range of motion (ROM) will receive treatment and services to increase and/or prevent a further decrease in ROM.- The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed.- The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion.- The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. The resident and representative will be included in determining these goals and objectives.Resident #137 was admitted to the facility in December 2022 with diagnoses including right hand contracture, cerebral infarction and muscle weakness.Review of Resident #137's Minimum Data Set (MDS) assessment, dated 6/12/25, indicated he/she had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Furthermore, the MDS assessment indicated Resident #137 had a range of motion impairment to his/her upper extremity and he/she was dependent for functional mobility tasks.On 7/30/25 at 9:30 A.M., the surveyor observed Resident #137 in bed turned onto their left side. Resident #137 was noted to have a contracture to his/her right hand.Review of Resident #137's Occupational Therapy (OT) Discharge summary, dated [DATE], indicated but was not limited to:- Resident #137 received skilled OT services from 4/17/25 to 6/10/25.- Skilled Intervention: Skilled OT focused on PROM (passive range of motion) to bilateral hands/wrists in order to prevent contracture. Addressed splint fit, tolerance and training.- Patient Progress: Resident tolerates right resting hand splint up to six hours. Recommend wear schedule on with A.M. care and off with P.M. care. Left palm pillow to be worn as tolerated. Resident agreeable with POC (plan of care) and will prevent further contracture.- Communication: Functional skills reviewed with team members and reviewed resident's plan of treatment and treatment services with interdisciplinary team members.Review of Resident #137's comprehensive care plans failed to indicate a contracture or limited ROM care plan was developed or implemented. During an interview on 8/4/25 at 2:29 P.M., Certified Nursing Assistant (CNA) #2 said Resident #137 wears a splint on her right and left hands due to contractures.During an interview on 8/4/25 at 2:30 P.M., Nurse #5 said she believed Resident #137 had contractures to his/her right hand and left hand. Nurse #5 said she was not sure if Resident #137 had a care plan related to his/her contractures. Nurse #5 said she believed the Unit Manager was responsible for updating resident care plans.During an interview on 8/4/25 at 2:37 P.M., Unit Manager (UM) #3 said care plans are minimally updated on a quarterly basis but also when a resident has a change in condition/status. UM #3 reviewed Resident #137's comprehensive care plans and said Resident #137 did not have a care plan related to his/her contractures and limited range of motion.During an interview on 8/4/25 at 4:50 P.M., the Director of Nursing (DON) said Resident #137 should have a care plan related to his/her contractures and limited ROM.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure one Resident (#94) was administered medications in accordance with professional standards of quality, in a total sample of 27 residents. Specifically, the facility failed to ensure that nurses administering medications ensured Resident #94 had taken the medications.Findings include:Review of the facility's policy titled Administering Medications, dated as revised in April 2019, indicated the following:-only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so-medications are administered in accordance with prescriber orders, including any required time frameResident #94 was admitted to the facility in September 2024.Review of the Minimum Data Set (MDS) assessment, dated 6/24/25, indicated Resident #94 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident was cognitively intact.Review of the medical record indicated Resident #94 was advised of their right to self-administer medication on 9/13/24 and indicated they wished for the nursing staff to administer their medications.During an interview with observation on 7/30/25 at 11:50 A.M., the surveyor observed Resident #94 in bed and on the overbed table there was a medication cup containing at least seven medications (two red and blue capsules, two oblong tablets and three round tablets). Resident #94 said he\she was not sure what time they were provided the medication because he/she gets confused sometimes.Review of the paper and electronic medical record failed to indicate Resident #94 had been assessed to administer his/her own medications.Review of the Medication Administration Record indicated Resident #94 had an order to be administered the following medications at 9:00 A.M. (almost three hours earlier):-Lactobacillus capsule (a probiotic)-Potassium Chloride extended release 20 milliequivalent (mEq); give 2 tablets (a potassium supplement)-Sertraline 50 milligram (mg) tablet-Vitamin D3; give 2 tablets-Acetaminophen 500 mg; give 2 tablets During an interview with observation on 8/1/25 at 9:21 A.M., Resident #94 said the nurse had recently brought him/her their medication and he/she still had to take them. The surveyor observed a medication cup with five pills on the overbed table (two oblong tablets and three round tablets). During an interview on 8/1/25 at 11:25 A.M., Nurse #2 said she was normally assigned to work the unit and was familiar with the residents. She said none of the residents on her assignment were able to self-administer medications. She said Resident #94 did not have an assessment to self-administer medications. She said when she had left the Resident's room this morning the Resident was in the process of taking their medication and she had not waited until the medications had all been taken. During an interview on 8/1/25 at 11:30 A.M., Unit Manager #2 said there was a list of four residents on the unit who were able to self-administer medications and Resident #94 was not one of them. She said she would have to review the information and follow up with the surveyor. During an interview on 8/5/25 at 8:22 A.M., Unit Manager #2 said Resident #94 was not capable of self-administering medications and nurses should ensure the Resident has taken all of the medications prior to leaving the Resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interviews and records reviewed, the facility failed to ensure one Resident (#57), out of a total sample of 27 residents, received care and treatment to promote healing of a pressure ulcer. Specifically, the facility failed for Resident #57, to implement treatments from the wound consultant physician for an unstageable pressure ulcer (wound covered with necrotic (dead) tissue making it difficult to determine stage) of the coccyx.Findings include:Resident #57 was admitted to the facility in September 2024 with diagnoses including Parkinson's Disease and muscle weakness.Review of Resident #57's Minimum Data Set (MDS) assessment, dated 7/4/25, indicated he/she had an unhealed unstageable pressure ulcer and was receiving pressure ulcer/injury care.On 7/30/25 at 9:32 A.M., Resident #57 said he/she had a wound on their buttock region and said it had been present since last fall.Review of Resident #57's care plans indicated he/she had actual skin breakdown related to an unstageable coccyx wound. The care plan interventions included but were not limited to: wound consult as needed, administer treatment per physician orders and follow-up care with physician as ordered.Review of the Consultant Wound Physician's note, dated 2/4/25, indicated the following treatment plan: cleanse with normal saline, apply calcium alginate, honey gel to base of wound, secure with superabsorbent pad and change daily and as needed (PRN) for soiling, saturation, or accidental removal.Review of the February 2025 Treatment Administration Record (TAR) indicated the following treatment was applied to Resident #57's wound from 2/4/25 through 2/11/25:- Cleanse with normal saline, pat dry, apply Santyl, calcium alginate and cover with foam dressing.Review of Resident #57's medical record failed to indicate why the Consultant Wound Physician's treatment for honey gel from 2/4/25 was not implemented.Review of the Consultant Wound Physician's note, dated 2/25/25, indicated the following treatment plan: cleanse with normal saline, apply calcium alginate, honey gel and collagen to base of the wound, secure with superabsorbent pad and change daily and PRN.Review of the February 2025 TAR indicated the following treatment was applied to Resident #57's wound from 2/25/25 through 2/28/25:- Cleanse with normal saline, apply calcium alginate, honey gel to base of the wound, secure with superabsorbent pad.Review of Resident #57's medical record failed to indicate documentation on why the treatment order from 2/25/25 through 2/28/25 did not include the Consultant Wound Physician's treatment of collagen to the base of the wound.Review of the Consultant Wound Physician's notes, dated 3/4/25, 3/11/25, 3/20/25, and 3/25/25, indicated the following treatment recommendation: cleanse with normal saline, apply calcium alginate, collagen, Santyl (honey gel ok until Santyl arrives) to base of wound, secure with superabsorbent pad and change daily and PRN.Review of the March 2025 TAR indicated the following treatments were applied to Resident #57's wound from 3/6/25 through 3/31/25:- Cleanse with normal saline, apply Santyl, followed by calcium alginate and cover with foam dressing every day shift; and- Cleanse with normal saline, pat dry, apply Santyl, calcium alginate, collagen and cover with superabsorbent dressing, may use Medi honey if Santyl is unavailable.- Both of above treatments were signed off daily.Review of Resident #57's medical record failed to indicate documentation stating the Consultant Wound Physician's treatments were clarified and/or changed as well as failed to indicate why the collagen was removed from the treatment order. Furthermore, the medical record failed to include documentation indicating the nursing staff only completed one of the coccyx treatment orders.Review of the Consultant Wound Physician's note, dated 4/15/25, indicated the following treatment recommendation: cleanse with normal saline, apply calcium alginate, crushed Flagyl to the base of the wound, secure with superabsorbent pad and change daily/PRN. This order was discontinued by the Consultant Wound Physician on 4/22/25.Review of the Consultant Wound Physician notes, dated 4/22/25 and 4/29/25, indicated the following treatment recommendation: cleanse with normal saline, apply calcium alginate, Santyl, collagen to the base of the wound, secure with superabsorbent pad and change daily and PRN.Review of the April 2025 TAR indicated the following treatment was applied to Resident #57's wound from 4/16/25 through 4/29/25:- Cleanse with normal saline, apply calcium alginate, crushed Flagyl to base of the wound, secure with superabsorbent pad.Review of Resident #57's medical record failed to indicate documentation stating why the Consultant Wound Physician's treatment was not implemented on 4/22/25 and/or 4/29/25. Furthermore, the medical record failed to indicate documentation regarding the continuation of the Flagyl treatment order.Review of the Consultant Wound Physician's note, dated 5/13/25, indicated the following treatment recommendation: cleanse with normal saline, apply calcium alginate, Gentamycin to base of the wound, secure with superabsorbent pad and change daily and PRN.Review of the May 2025 TAR indicated the following

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential of foodborne illness to residents who are at high risk. Specifically, the facility failed to:1. Properly label and date food products and maintain safe/clean equipment in three nourishment kitchenettes; 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). Findings include:1. Review of the facility's policy titled Foods Brought by Family/Visitors, dated October 2017, indicated but was not limited to the following:- Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents.- Food brought by family/visitors that is left with resident to consume later will labeled (sic) and stored in a manner that is clearly distinguishable from facility-prepared food.- Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the use by date.- The nursing staff will discard perishable foods on or before the use by date.- The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). On 7/30/25 at 1:02 P.M., the surveyor made the following observations in the Acushnet Unit Kitchenette:- The freezer contained a brown paper bag dated 7/30/25 to 8/9/25 containing individual [NAME]-Dazs ice cream cups. The bag was not labeled with resident identification. On 7/30/25 at 1:12 P.M., the surveyor made the following observations in the Fairhaven Unit Kitchenette:- An individual container of Profeel Protein Pudding was located on the door of the refrigerator and had no resident identification.- A Sargento Balance Break Cheese and Cracker Snack container was located on the door of the refrigerator and had no resident identification. On 7/30/25 at 1:21 P. M., the surveyor made the following observations in the Dartmouth Unit Kitchenette:- The microwave had food splatter and residue on the top and sides. The top inside portion of the microwave had peeling/bubbling of the white plastic lining.- A package of prunes was opened and unsealed on the door of the refrigerator with a use by date of 7/31/25. There was no resident identification on the package.- The refrigerator contained an opened Thick and Easy Thickened Orange Juice (Nectar Consistency) bottle. The bottle was dated received on 6/27/25. There was no open or use by date indicated on the bottle. The manufacturer label on the bottle indicates to dispose of the bottle 10 days after being opened. On 7/31/25 at 7:28 A.M., the surveyor made the following observations in the Dartmouth Unit Kitchenette:- The microwave had food splatter and residue on the top and sides. The top inside portion of the microwave had peeling/bubbling of the white plastic lining. - A package of prunes was opened and unsealed on the door of the refrigerator with a use by date of 7/31/25. There was no resident identification on the package. On 8/4/25 at 1:12 P.M., the surveyor made the following observations in the Fairhaven Unit Kitchenette:- An individual container of Profeel Protein Pudding was located on the door of the refrigerator and had no resident identification. On 8/4/35 at 8:38 A.M., the surveyor made the following observations in the Acushnet Unit Kitchenette:- The freezer contained a brown paper bag dated 7/30/25 to 8/9/25 containing individual [NAME]-Dazs ice cream cups. The bag was not labeled with resident identification. On 8/4/25 at 8:46 A.M., the surveyor made the following observations in the Dartmouth Unit Kitchenette:- The microwave had food splatter and residue on the top and sides. The top inside portion of the microwave had peeling/bubbling of the white plastic lining. During an interview on 8/5/25 at 10:16 A.M., the Food Service Director (FSD) said the unit kitchenettes in the facility are cleaned and stocked by the dietary staff daily. The FSD said the dietary staff make sure microwaves and refrigerators/freezers are clean. The FSD and the surveyor reviewed the observations made in the unit kitchenettes throughout the survey. The FSD said all items should have proper labels including resident identification and use by dates. The FSD said the microwave on the Dartmouth Unit needed to be replaced due to the peeling/bubbling on the top inside. 2. 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

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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 observation, document review, and interview, the facility failed to maintain complete and accurate medical records for two Residents (#2 and #10), out of a total sample of 27 residents. Specifically the facility failed to:1. Ensure Resident #2 had documentation in their medical record of their full diagnoses and psychiatric history, including a historical diagnosis of Schizoaffective disorder; and2. Ensure Resident #10's medical record contained only his/her health information.Findings include:1. Resident #2 was admitted to the facility in April 2025 with diagnoses including: Metabolic encephalopathy, bipolar disorder, anxiety disorder, and major depressive disorder recurrent. Review of the Minimum Data Set (MDS) assessment, dated 6/3/25, indicated the Resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Further review of the MDS indicated diagnoses of other neurological conditions, and anxiety, depression, and bipolar disorder under the psychiatric/mood disorder diagnoses section. Review of the diagnoses list for Resident #2 indicated a diagnosis of schizoaffective disorder was added to the Resident's record on 6/16/25. During an interview on 7/31/25 at 8:42 A.M., the Resident said he/she has a long history of mood and psychiatric disorders, and he/she takes medications to help him/her manage those diagnoses. The Resident said they were bipolar and said he/she does not recall anyone ever telling him/her that they had any type of schizoaffective disorder. Review of the progress notes from the Psychiatric Nurse practitioner (Psych NP) at the facility, from 5/5/25 through 6/25/25, failed to indicate the Resident was being seen or monitored for schizoaffective disorder. A telephonic follow up note, dated 5/7/25, indicated the Psych NP had received and reviewed the Resident's records from their outpatient psychiatrist but did not include any information on the schizoaffective disorder. During an interview on 7/31/25 at 4:35 P.M., the MDS Nurse said she added the diagnosis of schizoaffective disorder following a hospitalization in which it appeared the Resident had a diagnosis of schizoaffective disorder, bipolar type. She said she is aware that prior to adding a diagnosis of schizoaffective disorder the facility should do their due diligence to ensure the diagnosis is accurate, but she did not have any other information on the Resident and would have to look for some documentation to determine if it was a onetime episodic diagnosis or a long-standing history. During an interview on 8/1/25 at 12:33 P.M., the Director of Nursing (DON) said the facility found a document, that was not in the medical record, that indicated from the Resident's community provider a historic diagnosis of schizoaffective disorder, after the surveyor inquired about the new diagnosis. She said the document and the diagnosis for schizoaffective disorder should have been in the medical record to ensure the record was complete and accurate and it was not. During an interview on 8/1/25 at 1:03 P.M., the Social Worker said she found Resident #2's behavioral health document regarding their history in the community on a clipboard for the Psych NP in her office. She said the document was not in the medical record where it should have been. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/25 at 1:49 P.M., the Psych NP said she reached out to Resident #2's community psychiatric provider in May 2025 and received a copy of their history and records at that time. She said the documents indicated the Resident had a long history of schizoaffective disorder. She said she did not put the document in the medical record at the facility and did not update her progress notes to reflect the diagnosis for the Resident. She said the medical record did not reflect the diagnosis for the Resident or the Resident's history accurately, as it should. During an interview on 8/5/25 at 1:17 P.M., the Administrator said his expectation is that the medical records are complete and accurate at all times. 2. Resident #10 was admitted to the facility in October 2024 with diagnoses which included: heart failure and hypertension. Review of Resident #10’s electronic medical record, documents tab, indicated but was not limited to: -Inpatient Order (IPO), dated 10/9/24, for Resident #169, and -Provider Progress Note, dated 4/29/25, for Resident #170 During an interview on 8/5/25 at 9:29 A.M., the Director of Admissions said the liaison had uploaded the IPO for Resident #169 and it should not have been uploaded into Resident #10’s medical record. During an interview on 8/5/25 at 9:46 A.M., the Director of Nurses (DON) said she reviewed Resident #10's electronic medical record and said the documents for Residents #169 and #170 should have been uploaded into the correct residents' medical record and not Resident #10's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225650	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at New Bedford	221 Fitzgerald Drive New Bedford, MA 02745

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 to prevent the growth of Legionella (bacteria that can cause legionellosis (illness caused by Legionella) including a pneumonia-type illness called Legionnaires' disease) and other opportunistic waterborne pathogens.Findings include: Review of the facility's policy titled Legionella Water Management Program, dated as revised September 2022, indicated but was not limited to:-As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team-The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease-The water management program includes the following elements:a. An interdisciplinary water management teamb. A detailed description and diagram of the water system in the facility, including the following1. Receiving;2. Cold water distribution;3. Heating;4. Hot water distribution; and5. Wastec. The identification of areas in the water system that could encourage the growth and spread of Legionella of other waterborne bacteriad. The identification of situations that can lead to Legionella growthe. Specific measures used to control the introduction and/or spread of Legionellaf. The control limits or parameters that are acceptable and that are monitoredg. A diagram of whether control measures are appliedh. A system to monitor control limits and the effectiveness of control measuresi. A plan for when control limits are not met and/or control measures are not effective andj. Documentation of the programReview of the Water Management Program, dated 1/6/25, indicated but was not limited to:1. Written description of building water system and devices (page 2 of 5)-Cold water systems: the cold water is dead headed at all units. It is pumped by 70-pound pressure that is supplied by the town of [NAME].-Back flow devices: All backflow devices are checked by the town of [NAME] twice a year and all necessary repairs are handled by [Name of Plumbing Company].2. Water System Flow Diagram (page 3 of 5)-includes trellis fountain-unable to distinguish areas that have been identified/classified as hazardous concerns: conditions for bacterial spread, stagnation, temperature permissive, no disinfectant, external hazardsFurther review of the Water Management Program indicated the facility failed to describe the building water systems using text and flow diagrams specific to their building and identify areas where Legionella could grow and spread. During an interview on 8/4/25 at 4:34 P.M., the Director of Maintenance said the Water Management Program and assessment is reviewed and updated annually and was last completed in January 2025. The Director of Maintenance reviewed the water management program documentation and said the written description of building water system and devices was not specific to the facility and the Water System Flow Diagram did not clearly depict the hazardous concerns. The Director of Maintenance said the facility did not receive its water from the town of [NAME] and had no trellis fountains.During an interview on 8/5/25 at 10:12 A.M., the Administrator said the Water Management Program and assessment should have been specific to the facility and should meet all criteria.