STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225718	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hancock Park Rehabiliation and Nursing Center	164 Parkingway Quincy, MA 02169

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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed:1. For Resident #48, who was diagnosed with Methicillin-resistant Staphylococcus aureus (MRSA), a bacterium that is resistant to several antibiotics, to ensure staff implemented precautions after entering and exiting a room identified as being on contact precautions, and2. To implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting of infections, communicable diseases and outbreaks among residents and staff.Findings include:1. Review of the facility's policy titled Infection Control- Personal Protective Equipment, dated as reviewed September 2025, indicated the following:This facility requires that all employees determined to have occupational exposure use appropriate personal protective equipment whenever risk of exposure is anticipated.-Gloves will be worn whenever it is reasonably anticipated that an employee may have hand contact with blood, other potentially infectious material, mucous membranes, non-intact skin, and when handling contaminated items or surfaces.-Disposable gloves will be replaced as soon as practical when contaminated or as soon as possible when torn, punctured, or when their ability to function as a barrier is compromised.-Masks and disposable face shields will be discarded after each patient contact or whenever soiled with blood or potential infectious material may be generated and the eye, nose or mouth contamination can be reasonably anticipated.-Protective body clothing, i.e., gowns and/or aprons, that will not permit blood or other potentially infectious material to reach an employee's work clothing, undergarments or skin will be worn whenever skin and/or clothing contamination is reasonably anticipated.Resident #48 was admitted to the facility in June 2024 with diagnoses including dementia, muscle weakness, morbid obesity, and repeated falls.Review of Resident #48's medical record indicated a physician's order for MRSA Precautions was started on 11/17/25.On 12/4/25 at 11:31 A.M., the surveyor observed a precaution bin located outside Resident #48's room. The precaution bin was filled with personal protection equipment (PPE) masks, gowns, and gloves. There was a contact precaution sign hanging on the door outside of the room. The door to the room was open and Housekeeping Staff #1 could be seen standing in the room. The staff member was not wearing any PPE. Housekeeping Staff #1 was observed touching items on the overbed table with her ungloved hand. Housekeeping Staff #1 was then observed exiting the room and picked up a box of gloves that were on top of the housekeeping cart located just outside Resident #48's room, with her bare contaminated hand, she then put on the gloves and re-entered room without additional PPE. The staff member was not wearing PPE aside from the gloves. Housekeeping Staff #1 was observed touching items on the overbed table, wiping a bureau with a towel and walking back to the housekeeping cart located outside the room. Using her contaminated gloved hands, she then picked up a spray bottle with pink liquid with her gloved hand and was observed touching the bathroom door handle and proceeded to clean the bathroom.On 12/4/25 at 11:35 A.M., Housekeeping Staff #1 used the same contaminated gloves to touch items on the overbed table and was observed exiting the room and touching items on the housekeeping cart outside the door. Housekeeping Staff #1 then removed (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	her contaminated gloves touching the outside surface of the contaminated gloves with her bare hands and proceeded to walk across the hall into room [ROOM NUMBER], without performing hand hygiene. Housekeeping Staff #1 was observed touching the door handle to the bathroom with her contaminated hand and touched items located in the bathroom. Housekeeping Staff #1 was then observed exiting room [ROOM NUMBER] without preforming hand hygiene and walked across the hall back into Resident #48's room without wearing PPE and was observed touching the bathroom door handle with her bare hand and then exited Resident #48's room and proceeded to touch items on the housekeeping cart including a box of gloves, spray bottles, and a mop.At 11:37 A.M., Housekeeping Staff #1 used her contaminated hands and picked up the mop and walked into Resident #48's room and proceeded to mop the floors and was observed touching items within the room with her bare contaminated hands. Housekeeping Staff #1 was not wearing PPE and did not perform hand hygiene during the observations. During an interview on 12/4/25 at 11:43 A.M., Housekeeping Staff #1 said she was sorry and pointed to the contact precaution sign and said she should have put on PPE because the Resident is on precautions. The staff member pointed to the PPE cart and said she should not have entered the room without wearing the PPE. When the surveyor asked about handwashing the Housekeeping Staff member said yes and proceeded to use the hand sanitizer located on the wall.During an interview on 12/4/25 at 2:28 P.M., the Infection Preventionist (IP) said she would expect staff to follow the appropriate precautions and wear PPE as indicated. The IP said hand hygiene must be done before and after glove use.During an interview on 12/4/25 at 2:41 P.M., the Director of Nurses (DON) said she expects all staff to follow infection control protocols and wear PPE when entering a precaution room. The DON said staff must perform hand hygiene appropriately and remove gloves correctly and wash hands when contaminated.2. Review of the facility's policy titled Surveillance Procedure, dated as reviewed September 2024, indicated the following:-The purpose of surveillance is to identify single cases of healthcare associated and/or cluster infections, occurring within the facility. Trending should be done for significant organisms and healthcare associated infections to guide appropriate interventions to prevent/reduce further transmissions.-Surveillance will be performed by the Infection Control Coordinator, for healthcare associated infections within the facility.-Infection reports/information will be completed/collected on affected resident/patients.-Infection control coordinator will collect and coordinate data from nursing personnel. Repots of any resident suspected of having an infection according to infection criteria and by developing computerized reports of MD orders, antibiotic reviews, lab data, conducting rounds with nursing staff.-The Infection Control Coordinator will collect reports/information, review daily logs, and make rounds on regular basis to ensure complete data collection.-The Infection Control Coordinator will keep a running log of residents with a positive Mantoux, a positive MRSA, a positive C.difficile and other multiple-resistant organisms.-The facility routinely audits (monitors and documents) adherence to HH (hand hygiene) and PPE (personal protective equipment). Hand Hygiene and PPE surveillance goal will consistent of minimum, of once per month on each shift will be required. During outbreak situation, the unit will need a minimum of once per week per shift surveillance.Review of the facility's infection control line listings failed to indicate the monitoring, tracking, and analyzing of current infections in the facility and failed to have an ongoing system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility.Review of the December 2025 line listing failed to include current infections within the facility including one resident with confirmed MRSA, one resident with confirmed C. difficile infection (an infection from a bacterium that causes colitis, an inflammation of the colon, causing diarrhea), and one case of active eye infection.During an interview on 12/4/25 at 2:20 P.M., the surveyor asked the IP to provide her with the facility's infection control line listings. The IP said she has line listings that she reviews at the end of the month, and she will review reports for new antibiotics, but she does not track clinical signs, symptoms or trending of infections unless antibiotics are prescribed. The IP said she does not evaluate the infections until the end of the month when she counts the antibiotics (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	prescribed. The IP was unable to provide documentation of current ongoing infection control surveillance, including a system for recording infections, monitoring and any actions taken by the facility.During an interview on 12/4/25 at 2:44 P.M., the DON said she expects the facility to follow infection control guidelines for tracking and evaluating infections as well as document surveillance of signs and symptoms of communicable diseases. The DON said the facility should be aware of the infection control rates in the facility and should be identifying clusters and monitoring for increases in infections.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, the facility failed to maintain comfortable and safe temperature levels on the third floor of the East Dining Room.Comfortable and safe temperature levels means that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia, or hyperthermia, or and is comfortable for the residents. Findings include:The following observations were made on the third-floor dining room:12/2/25 at 9:18 A.M., two out of four residents reported feeling cold and one resident had his/her jacket on. 12/3/25 8:41 A.M., three out of five residents reported feeling cold and one resident had his/her jacket on.12/3/25 at 8:49 A.M., one resident left the dining room and said, I need to go get my coat, it's freezing and wheeled him/herself out of the dining room and returned with a winter coat on.During an observation and interview on 12/3/25 at 9:07 A.M., the surveyor and the Assistant Maintenance Director observed the third-floor dining room, and the following thermal temperatures were taken by the Assistant Maintenance Director: Room temperature had a low of 60 degrees and a high of 67 degrees. Areas scanned/checked included center of the room, above the floor, interior walls. Thermal temperatures did not go above 67 during the observation. The Assistant Maintenance Director said the two vents located in the dining room are turned off and the switches to turn them on were removed over two years ago so residents would not adjust the air flow. He also said that the thermostat on the fourth floor controls the heat to the third-floor dining room but will not blow heat in if the vents are closed. The surveyor and Assistant Maintenance Director then observed the fourth-floor dining room, and the vents were open, and thermal readings were between 71 degrees and 76 degrees.During an interview on 12/4/25 at 1:02 P.M., the Administrator said we addressed it and opened the vents to allow for the heat and added in a vent system as the temperature should remain above 71 degrees.During an interview on 12/4/25 at 1:17 P.M., the Corporate Nurse #1 said she would expect the heat to be functioning and warm in the dining areas and said we are checking the temperatures now and we have put in heaters in the dining areas.During an interview on 12/4/25 at 2:03 P.M., Maintenance Technician said the ceiling roof opens and closes to allow outside air in because the outside roof had a gap it was letting in cold air blowing above window into room. He said the two vents in the dining room should be open and not in the off position to allow for warm heat to blow into the room.

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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. Based on observation, record review and interview, the facility failed to implement the plan of care for one Resident (#121) out of a total of 28 sampled Residents. Specifically, the facility failed to ensure Resident #121's call light was within reach and accessible per his/her fall care plan. Findings include:Resident #121 was admitted to the facility in March 2022 with diagnoses including cerebral infarction (stroke) and aphasia. Review of the Minimum Data Set (MDS) Assessment, dated 9/3/25, indicated Resident #121 is severely cognitively impaired as evidenced by a score of 00 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). On 12/3/25 at 7:34 A.M., the surveyor observed Resident #121 resting in bed. Resident #121 did not respond to the surveyor's questions. The surveyor observed Resident #121's call light out of reach and inaccessible on his/her bedside table. Review of Resident #121's Fall Care Plan, dated 3/6/22, indicated: Problem: Resident #121 is at risk for fallsIntervention: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. During an observation with interview on 12/4/25 at 9:12 A.M. and 10:53 A.M., the surveyor observed Resident #121's call light on the floor and out of reach and inaccessible to Resident #121. When asked how he/she calls for help when he/she needs assistance, Resident #121 said, I don't need help right now and was unable to engage in further conversation. During an interview on 12/4/25 at 10:53 A.M., Nurse #1 said that Resident #121 does utilize his/her call light and it should be within reach. Nurse #1 said she was unaware that Resident #121's call light was inaccessible and out of reach. During an interview on 12/4/25 at 12:58 P.M., the Director of Nursing said resident call lights should be within reach and accessible.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to ensure nursing staff provided assistance with Activities of Daily Living (ADLs) for one Resident (#15), out of a total sample of 28 residents. Specifically, for Resident #15, the facility failed to provide assistance and/or supervision with meals as per the plan of care.Findings include:Review of the facility's policy titled Activities of Daily Living (ADLs), Supporting, dated 9/22, indicated the following:-Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).-Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.Policy Interpretation and Implementation-Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: Dining (meals and snacks).Resident #15 was admitted to the facility in November 2015 with diagnoses that included adult failure to thrive, unintentional weight loss, gastro-esophageal reflux, and vascular dementia. Review of the Minimum Data Set (MDS) assessment, dated 9/10/25, indicated the Resident was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #15 is dependent for all self-care activities and requires substantial/maximal assistance for self-feeding.On 12/2/25 at 9:25 A.M., 9:31 A.M., and 9:35 A.M., and 12/3/25 at 8:52 A.M., 8:54 A.M., 9:04 A.M., 9:17 A.M and 9:27 A.M., the surveyor observed Resident #15 seated upright in his/her bed eating breakfast. There was no staff observed providing supervision or assistance, the Resident was not visible from the hallway, and the Resident ate less than 50% of his/her breakfast. During these observations, the surveyor observed Resident #15 coughing while eating his/her breakfast and no staff passed by the Resident's room or stopped to check on or assist Resident #15.During a record review on 12/4/25 at 7:23 A.M., Resident #15's activities of daily living and nutrition care plans indicated the following:-Eating: Resident #15 is dependent of 1 for meals. Last revised 9/25/25.-Nutrition: Monitor/document/report PRN any s/sx (signs and symptoms) of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Last revised 8/21/25.During an interview on 12/4/25 at 9:37 A.M., Nurse #3 said we setup Resident #15's meal and he/she can feed him/herself and we will check on him/her and if assistance is needed, we will provide it. Nurse #3 said Resident #15 does not normally refuse care.During an interview on 12/4/25 at 9:43 A.M., the Director of Nursing said she would expect Resident #15 would be provided with the level of assistance and/or supervision indicated on his/her care plan for self-feeding and any refusals should be documented. Review of the medical record failed to indicate Resident #15 refused assistance with self-feeding.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure one Resident (#43) with limited range of motion (ROM) received appropriate treatment and services to prevent further decrease in ROM, out of a total of 28 sampled residents. Specifically, the facility failed to implement the discharge plan of care made by rehab services for daily ROM with care and the use of a carrot (a device utilized to position the fingers away from the palm to protect the skin from excessive moisture, pressure, and the risk of nail puncture injuries while helping to prevent bacteria build up and protect against increased spasticity).Findings include:Review of the facility's Restorative Nursing Policy, dated September 2025, indicated: 3. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care. 3. Restorative goals and objectives are individualized and resident centered and are outlined in the resident's plan of care.Review of the facility's Range of Motion (ROM) policy, dated September 2025, indicated: Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM as much as possible. Residents with limited mobility will receive services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. 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. Resident #43 was admitted to the facility in February 2022 with diagnoses including unspecified dementia and legal blindness.Review of the Minimum Data Set (MDS) Assessment, dated 11/19/25, indicated he/she was unable to participate in the Brief Interview for Mental Status exam (BIMS) and is cognitively impaired. The MDS also indicated Resident #43 is dependent on staff for all activities of daily living and has no functional limitation in range of motion in his/her upper extremities. A diagnosis of contracture, unspecified joint was added to his/her diagnosis list on 6/5/25. On 12/2/25 at 8:28 A.M., the surveyor observed Resident #43 asleep in bed and his/her right hand was balled into a fisted position. A hand carrot was observed on his/her nightstand.Review of the nurse progress note, dated 5/3/25, indicated: OT consult for possible carrot that pt (patient) can hold in his/her right hand to help with contractures. Review of the Occupational Therapy (OT) Discharge summary, dated [DATE], indicated: Progress & Response to TX (treatment): Pt made gains with skilled OT services since eval (evaluation) with orthotic use and ROM program.Pt has demonstrated ability to use carrot orthotic up to 5 hours per day to prevent further loss of ROM and maintain skin integrity. Staff ed (education) provided on ROM during care and utilization of carrot orthotic as tolerated throughout the day. Review of Resident #43's physician's orders failed to indicate the use of a hand carrot.Resident #43's care plans failed to indicate the presence of a contracture or methods and means for facility staff to monitor Resident #43's hand contracture.During an interview on 12/3/25 at 7:48 A.M., certified nurse aide (CNA) #1 said she was unsure how long Resident #43's hand had been contracted and that the rehab department works with Resident #43 and is responsible for placing the carrot in Resident #43's hand. CNA #1 then attempted to range Resident #43's hand, and he/she grimaced in pain and pulled his/her hand away.During an interview on 12/3/25 at 7:53 A.M., Nurse #1 said that Resident #43 was working with rehab services, but they ended the use of the carrot.During an interview on 12/3/25 at 8:21 A.M., CNA #2 said that Resident #43 wears the hand carrot every day.During an interview on 12/3/25 at 12:22 P.M., Occupational Therapist (OT) #1 said that he had worked with Resident #43 to assess his/her range of motion and use of the carrot orthotic. OT #1 said that at the end of services, Resident #43 could tolerate the use of the carrot for up to five hours with no redness or skin irritation. OT #1 said that the expectation is for staff to follow the education provided by the OT to implement the recommendations, obtain (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's orders and update the care plan. OT #1 said he spoke with nursing staff about utilizing the hand carrot and performing range of motion with Resident #43.On 12/3/25 at 12:27 P.M., the surveyor observed Resident #43 in his/her wheelchair resting and the hand carrot was placed on his/her side, not in his/her hand.During an interview on 12/3/25 at 12:41 P.M., CNA #1 said she was not sure who was responsible for placing the carrot in Resident #43's hand and the surveyor should ask Nurse #1. During an interview on 12/3/25 at 12:42 P.M., Nurse #1 said that OT was working with Resident #43 and it would be nursing or the CNA's responsibility to implement the use of orthotics, like the hand carrot. Nurse #1 said she was not aware that Resident #43 had not received rehab services since 11/18/25 and there should be orders and a care plan in place related to Resident #43's contracture management and use of a hand carrot. During an interview on 12/3/25 at 1:30 P.M., Unit Manager #1 said that when a resident comes off rehab services, the rehab staff will communicate with the nursing staff what interventions need to be implemented. Unit Manager #1 said nursing staff are responsible for obtaining physician's orders for recommended equipment and updating resident care plans. Unit Manager #1 said she was not aware there were no physician's orders related to the use of the hand carrot or performing ROM with Resident #43 per his/her OT discharge summary.Review of the equipment logbook indicated an in-service regarding the use of a hand carrot and performing ROM care took place with nursing staff on 12/3/25, approximately 15 days after Resident #43 had been discharged from rehab services. During an interview on 12/4/25 at 12:58 P.M., the Director of Nursing (DON) and Regional Nurse #1 said that residents with contractures should have a care plan indicating his/her contracture and methods of managing and monitoring the resident's range of motion. The DON said that when residents come off rehab services, an in-service with the nursing team is provided and placed in the red binder on the unit and that nursing staff updates the care plans and obtains physicians orders. The DON and Regional Nurse #1 said they were made aware upon the surveyor's inquiries on 12/3/25 that Resident #43 was missed and interventions related to the hand carrot and ROM as tolerated were not implemented upon his/her discharge from rehab services on 11/18/25.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to maintain accurate medical records for two Residents (#45, #43), out of a total of 28 sampled residents. Specifically, the facility failed:1. For Resident #45, to accurately document the presence of three new skin areas during weekly skin evaluations; and 2. For Resident #43, to accurately document the onset of a contracture. Findings include: 1. Review of the facility's policy titled Skin Integrity Guideline, revised 2019, indicated the following: -Purpose: To provide a systemic approach and monitoring process for skin. -Residents will be observed by the CNA (Certified Nurse Assistant) daily for reddened/open areas, edema of feet or sacrum. Changes will be reported to the licensed nurse and documented. -The facility develops a routine to review residents with wounds or at risk on a weekly basis and will document as needed. -Newly identified skin areas will have a skin event report completed. -If identified risk present, the interventions will be documented in the Care Plan. -Documentation of Weekly skin Evaluation/Observations: Licensed nurse will be responsible for performing this skin evaluation/observation. Review of the facility's policy titled Health Information Management, dated September 2025, indicated the following: -Policy: The clinical record shall serve as a tool in the planning for resident care and provide a means of communication among all members of the health team. -Procedure: All records shall be complete, accurate, current, available, and shall be maintained in an approved manner. Resident #45 was admitted to the facility in July 2024 with diagnoses including vascular dementia and major depressive disorder. Review of the Minimum Data Set (MDS) assessment, dated 10/16/25, indicated Resident #45 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15. This MDS also indicated that Resident #45 was at risk for pressure ulcers/injuries and had no presence of any ulcers, wounds, skin problems or pressure ulcers. On 12/2/25 at 8:28 A.M., the surveyor observed Resident #45 sleeping in his/her bed with both lower legs visible. Resident #45's left lateral (to the side, away from the middle) leg was noted with a raised area that was purple/black in color. The area appeared to look like a hematoma (a collection of blood outside of a blood vessel that appears as a swollen area of blood). Review of Resident #45's active Physician's Orders indicated the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hancock Park Rehabiliation and Nursing Center	164 Parkingway Quincy, MA 02169

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Document weekly skin check in the weekly skin check assessment every day shift every Mon, dated 7/15/24. -Monitor right side hematoma every shift, dated 11/21/25. Review of the most recent skin assessments for Resident #45 indicated the following: -An assessment, dated 11/21/25, indicating a new skin issue to the Resident's right side of head described as a hematoma. -An assessment, dated 11/25/25, that failed to indicate Resident #45 had any skin issues. Further review of Resident #45's recent skin assessments indicated an assessment, dated 12/2/25 at 12:13 P.M., documented by staff after the surveyor's observation. This entry failed to indicate the Resident had a skin injury on the left lower leg. Review of Resident #45's plan of care related to skin, dated 7/16/24, indicated the Resident had potential for pressure ulcer development and required weekly skin inspection for redness, open areas, scratches, cuts and bruises. The plan of care failed to indicate the Resident had any open areas or skin injuries. Review of Resident #45's progress notes failed to indicate any documentation regarding an open area or skin injuries to Resident #45's left lower leg. On 12/4/25 at 10:22 A.M., the surveyor observed Resident #45 sitting up on the side of his/her bed with both lower legs visible. The left lower leg looked as though fluid inside had been drained. An open area was present, the surrounding skin yellowish in color, with a pink wound bed (the base of a wound, consisting of tissue exposed after an injury). During an interview on 12/4/25 at 12:11 P.M., Certified Nurse Assistant (CNA) #3 said she was assigned to Resident #45 and if she noticed any new skin areas, redness, scratches or bruises during resident care, she would notify the nurse. During an interview and observation on 12/4/25 at 12:14 P.M., the surveyor and CNA #3 observed Resident #45 sitting on his/her bed. CNA #3 observed with the surveyor the open area on Resident #45's left lower leg. CNA #3 said that she did not notice the area on the Resident's left lower leg this morning during care. CNA #3 said she did know that Resident #45 had swelling to her legs but did not know about the open area, and if she noticed the area she would have reported it to the nurse. During an interview on 12/4/25 at 12:19 P.M., Nurse #4 said she would expect the CNAs to report any new areas on a resident during ADL (activities of daily living) care. Nurse #4 said when a new area is noted, the area should be accurately documented in the skin assessment. During an interview and observation on 12/4/25 at 12:23 P.M., the surveyor and Nurse #4 observed Resident #45 sitting on the side of his/her bed. Nurse #4 observed with the surveyor the open area on Resident #45's left lower leg. Nurse #4 said the area looked new and the Resident could have scratched the area because it was open. Nurse #4 lifted Resident #45's pant leg, exposing the front and upper part of Resident #45's left leg. The surveyor and Nurse #4 observed two additional open areas that were similar in appearance to the open area on the Resident's left lower leg. Nurse #4 said (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225718	A. Building B. Wing	12/04/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #45 had a total of three open areas and she was going to notify the doctor and consult the wound doctor. During an interview on 12/4/25 at 12:36 P.M., the Director of Nursing (DON) said she expects the CNAs to report to the nurses with any new skin concerns regarding all residents. The DON said when a new area is noted, it is the nurse's responsibility to go assess the new area. The DON said she expects nurses to accurately document findings on the weekly skin assessments and notify the physician of findings. During an interview on 12/4/25 at 3:06 P.M., the DON said she expects medical records to be accurately documented. 2. Resident #43 was admitted to the facility in February 2022 with diagnoses including unspecified dementia and legal blindness. Review of the MDS Assessment, dated 11/19/25, indicated he/she was unable to participate in the BIMS exam and is cognitively impaired. The MDS also indicated Resident #43 is dependent on staff for all activities of daily living and has no functional limitation in range of motion in his/her upper extremities. A diagnosis of contracture, unspecified joint was added to his/her diagnosis list on 6/5/25, however the diagnosis was listed as present upon admission. Review of Resident #43's admission paperwork failed to indicate the presence of a contracture upon admission. Review of the OT Discharge summary, dated [DATE], indicated an onset of a contracture to Resident #43's right hand on 8/13/23, and that he/she was unable to tolerate the use of a splint at that time. During an interview on 12/4/25 at 3:06 P.M., the DON said she expects medical records to be accurately documented.