STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225749	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee Healthcare	620 Laurel Street Lee, MA 01238

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that professional standards of practice were implemented relative to skin and wound care for one Resident (#19) of four applicable residents reviewed for wound care, out of a total sample of 26 residents.ˆ Specifically, for Resident #19, the facility failed to: -appropriately assess and implement skin care and diabetic foot care for the Resident with a history of Diabetes, Peripheral Vascular Disease and a right below knee amputation (BKA), resulting in left toe wounds not being identified and treated timely. -submit a referral to the Wound Care Provider timely for on-going wound care when diabetic wounds were identified on the toes of the Resident's left foot. -implement treatment orders for the Resident's left toe wounds timely, resulting in delayed treatment interventions when the Resident had suspected osteomyelitis, bone exposure of the left great toe, was subsequently hospitalized and administered intravenous (IV) antibiotics for confirmed osteomyelitis, and resulted in left great toe and left second toe amputations.ˆ -obtain accurate treatment orders relative to the left foot surgical sites on the Resident's re-admission from the hospital post left great and second toe amputations. -obtain treatment orders timely for open skin areas to the Resident's left shin. Findings include: The facility failed to assess and document the status of Resident #19's left foot diabetic wounds after the wounds were identified by the Podiatrist on 8/4/25. The Podiatrist recommended wound cultures, an x-ray of the ulcers to the Resident's left foot, daily dressings, antibiotic therapy and Wound Care team follow-up. From 8/5/25 until 8/20/25, there was no documented evidence of the status/condition of the Resident's left toe wounds. Resident #19 was observed with exposed bone of the left great toe by the Wound Care Provider on 8/21/25. The Wound Care Provider recommendations on 8/21/25 for treatments to the left great toe and left second toe, x-ray to evaluate bone involvement for suspicion of osteomyelitis, laboratory draws, wound cultures, surgical and/or vascular consult were not implemented as required. X-ray of the Resident's left foot completed on 8/26/25 (5 days after the Wound Care Provider recommendations) indicated suspected osteomyelitis. Resident #19 was subsequently transferred to the hospital for evaluation on 8/27/25 and treated with intravenous (IV) antibiotics for confirmed osteomyelitis (by MRI) and underwent left great toe and second toe amputations. The facility failed to implement the Podiatrist recommendation on 8/4/25 to have the Resident followed by the Wound Care Team and assess the status of the wound as required for a period of 17 days once the wound was identified on 8/4/25 resulting in the osteomyelitis and bone exposure not being identified timely due to the facility's lack of assessment and implementation of care. The facility further failed to obtain post-surgery Physician orders for NPWT (non-pressure wound therapy) as recommended in the hospital discharge summary and treatment orders for open areas on the Resident's left shin. Resident #19 was admitted to the facility in May 2023 with diagnoses including Type 2 Diabetes, acquired absence of the right leg below the knee amputation (BKA), and Peripheral Vascular Disease (PVD).ˆ Review of the Consultant Podiatrist Note, dated 8/4/25, indicated Resident #19 was examined and included the following: -presence of reddened, warm, discolored, and atrophy in the Resident's left foot. -No nails were on the left first, second and third toes, and there were signs of infection present. -Diabetic ulcers: >great left toe measuring 2.0 (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 0684 Level of Harm - Actual harm Residents Affected - Few	centimeter (cm) length by(x) 4.0 cm width x 0.2 cm depth which had presence of erythema, redness, edema, drainage and odor >left second toe measuring 2.5 cm length x 1.0 cm width x 0.2 cm depth which had presence of erythema, redness, edema, drainage and odor >third left toe measuring 1.0 cm length x 1.0 cm width x 0.1 cm depth which had presence of erythema, redness, edema -Betadine and dressings were applied to the ulcers. -findings were discussed with Resident #19 and Nurse #2. -recommended wound cultures, an x-ray of the ulcers to the Resident's left foot, daily dressings, antibiotic therapy and wound care team follow-up.ˆ Review of the Minimum Date Set (MDS) Assessment, dated 6/17/25, indicated Resident #19: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15 possible points -had behaviors including rejection of care 1-3 days of the 7-day reference period.ˆ -had lower range of motion impairment on one side -utilized a wheelchair and had a limb prosthesis -required partial to moderate assistance of staff with personal hygiene and dressing -had no venous or arterial ulcers or open lesions Review of the Resident's Comprehensive Care Plans included: -Potential for Skin Alteration Care Plan, initiated 5/28/23 and revised 2/9/24, that indicated the Resident had a history of fractures, Diabetes, decreased mobility, PVD and included the following interventions: >follow Physician orders for skin care and treatments (utilize best practice), revised 6/21/25 >inspect feet daily with care and moisturize, dated 2/9/24 -Diabetes Care Plan, initiated 6/11/23, included the following interventions: >Check all of body for breaks in skin and treat promptly as ordered by the doctor, initiated 6/11/23 >refer to the podiatrist/foot care nurse to monitor and document foot care needs ., initiated 6/11/23 >wash feet daily with mild soap and water. Dry thoroughly. May use a light dusting of power or lotion. Do not apply lotion or powder between the toes, initiated 6/11/23 >Monitor/document/report, as needed, any signs/symptoms of infection to any open areas: redness, pain, heat, swelling or pus formation, initiated 6/11/23 Review of the Weekly Skin Evaluations from July 2025 through 9/5/25, indicated: -no evidence of weekly skin checks from 7/6/25 through 7/12/25 -no evidence of weekly skin checks from 7/20/25 through 7/26/25 -Weekly Skin Evaluation, dated 7/28/25, indicated the Resident's skin was intact. -Weekly Skin Evaluation, signed on 8/8/25 by Director of Nursing (DON) #2, indicated: -the Resident's skin was not intact. -the left great toe and left second toe had cellulitis. -an X-ray was completed to rule out osteomyelitis and was negative for fracture/dislocation and osteomyelitis. -Under the section indicating to document the measurements of all new areas, DON #2 who completed the assessment indicated toe nails. -The Weekly Skin Evaluation completed by DON #2 failed to indicate measurements or descriptions of the areas noted on the assessment.ˆ ˆReview of theˆPhysician's orders from July 2025 through 9/5/25, included the following: -Wound Consult as indicated, initiated 5/27/23 -Consults: Podiatry ., initiated 6/5/23 -Diabetic foot care: wash foot with gentle soap and water, dry well. Monitor for any abnormalities, daily in the evening, initiated 6/8/23 -Behavior monitoring every shift . which included type of behavior, intervention and outcome, initiated 3/11/25 ˆ ˆ Review of the Wound Care Specialist Note, dated 8/21/25 (17 days after the initial identification of the wounds and recommendation made by the Podiatrist on 8/4/25 for wound care follow-up), indicated: -left great toe and second toe first evaluation. -Resident's lower extremity sensation was reduced. -Left great toe: >diabetic, measuring 1.0 cm by (x) 1.5 cm x 0.1 cm [wound].ˆ >wound base had hypergranulation (excessive growth of granulation tissue, a symptom of a dysfunctional wound environment). >bone was exposed, peri-wound was callous, and there was small amount of serous drainage. -Left second toe: >diabetic, measuring 1.0 cm x 1.0 cm x 0.1 cm [wound]. >hypergranulation was present. >peri-wound was normal, there was small amount of serous drainage. -the Wound Specialist recommended the following:ˆ >cleanse left great toe and left second toe with 0.125% (1/4 strength) Dakin's solution, apply Calcium Alginate to the base of the wound, secure with ABD pad, rolled gauze and change daily and as needed, to treat the hypergranular tissue. >X-ray to evaluate bone involvement. Osteo [sic] is suspected. >update lab work: Complete Blood Count (CBC), Complete Blood Profile (CBP), Erythrocyte Sedimentation Rate (ERP: measures inflammation levels in the body (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	and helps diagnose various inflammatory conditions) and C-Reactive Protein (CRP: measures inflammation in the body and helping to diagnose various conditions). >collect wound cultures and tailor to the results >surgical and/or vascular consult. Patient will likely warrant toe amputations.ˆ >no shoe to the left foot.ˆ ˆ Review of Resident #19's Clinical Record indicated the following: -8/5/25 at 4:27 P.M.: Nurse Progress Note by Nurse #2, indicated Doxycycline (antibiotic) 100 milligrams (mg) twice daily was ordered for ten days for the Resident's infected foot and an x-ray was ordered for a question of osteomyelitis. New dressing orders were obtained. -8/6/25: X-ray of the Resident's left foot was completed and failed to indicate fracture or bony changes to indicate osteomyelitis. -August 2025 MAR indicated Doxycycline 100 mg twice daily, was initiated on 8/5/25 and completed 8/15/25.ˆ -August 2025 TAR indicated: >no documented refusals of care or other behaviors by the Resident from 8/5/25 through 8/31/25. -no documented evidence that the Wound Care Specialist recommendations from 8/21/25 for wound treatment to the Resident's left great toe and left second toe were implemented.ˆ -Non-Pressure Ulcer Evaluations, dated 8/22/25 which indicated: >Diabetic area to the Resident's left great toe that was: facility acquired, had an onset date of 8/5/25, and required weekly evaluation. The left great toe area measured 1.0 cm in length x 1.0 cm in width x 0.1 cm in depth.ˆ >Diabetic ulcer to the Resident's left second toe that was: facility acquired, had an onset date of 8/5/25 and required weekly evaluation. The left second toe area measured 1.0 cm in length x 1.5 cm in width x 0.1 cm in depth.ˆ -8/25/25: Nurse Practitioner (NP) Note (dated four days after the Wound Care Specialist Evaluation Note), indicated the Resident was evaluated for new left toe ulcers. Left great toe had bone exposure. Wound care ordered labs, wound cultures and X-ray, but this was not transcribed (not completed). Case was discussed with nursing and re-ordered CBC, Complete Metabolic Panel (CMP), CRP and ESR, X-ray of the left foot and wound cultures. Will refer to the vascular surgeon for evaluation.ˆ -8/26/25: X-ray of the Resident's left foot, completed and reported, indicated findings suggest osteomyelitis, recommend MRI.ˆ -no documented evidence that lab work and cultures were obtained on 8/21/25 (Wound Care Specialist) and 8/25/25 (NP) as ordered. ˆ-The Clinical Record failed to indicate documented evidence of the status/condition of the Resident's left toe wounds from 8/5/25 until 8/20/25. -8/27/25: Discharge/Transfer Evaluation indicated Resident #19 was sent to the emergency room for question of osteomyelitis to the left foot wound.ˆ ˆ-8/29/25: Social Worker (SW) Progress Note indicated the SW received a call from Resident #19's Representative who reported the hospital informed him/her that the Resident was having his/her first and second toes removed and was currently receiving IV antibiotics. -9/1/25: Nursing Evaluation which indicated under Skin Integrity: left first and second toes removed. Skin tear to left lower leg . -September 2025 Physician's Orders included the following: >Left first and second toe: cleanse with Normal Saline, blot dry, apply Baza AF to periwound, apply 1/4 Dakins soaked gauze to wound bed. Cover with double layer Xeroform, cover with ABD with rolled gauze and tape. Change BID and as needed (PRN), every day and evening shift for wound care, ordered 9/1/25.ˆ >Calcium Alginate to the toes on the left foot. Place in-between toes and on tope place ABD on wrap with kling. Clean the wound with saline daily and as needed, ordered 8/6/25.ˆ -The September 2025 Physician's orders failed to indicate post-surgery orders for the NPWT and treatment orders for the open areas on the Resident's left shin. Review of the Hospital Discharge summary, dated [DATE], indicated the following relative to Resident #19: -admitted to the hospital for worsening left foot infection involving the first and second toes ongoing for two weeks.ˆ -Lab work improved with IV fluids. -Physical exam revealed two 1 x 2 cm wounds on the Resident's left shin and a 1 cm wound on the first and second toes (of left foot) with surrounding erythema and edema. -Doralis pedis pulse was intact. -X-ray showed destructive changes to the distal phalanx of the left hallux (bony bump at the base of the great toe). -MRI confirmed acute osteomyelitis of the first distal/proximal phalanges and second distal/middle phalanges with marrow edema and osseous destruction. -Resident was started on IV Zosyn and Vancomycin (antibiotics). -Underwent surgical amputation of left first and second toes without complication.ˆ -Resident was safe for discharge, will (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	continue with antibiotics regimen for a total of 14 days upon discharge, and follow-up with wound care clinic in two weeks.ˆ -Wound Care Instructions upon discharge: ˆ >left first and second toe amputation site: cleanse with normal saline, pat dry. Apply Adaptec over exposed bone. Apply granufoam to area, cover with drape. Apply ACE wrap for circulatory support. Non-Pressure Wound Therapy (NPWT also referred to as a wound vac) set at 125 mmHg (millimeters of Mercury: pressure measurement), continuous, to be changed Monday/Wednesday/Fridays. If dressing becomes dislodged or NPWT fails for more than two hours, remove the dressing and perform the following: Apply saline soaked gauze to wound bed, cover with Xeroform, gauze, ABD, secure with Kling. Change every eight (8) hours until NPWT can be resumed.ˆ >Please do the following dressing twice daily to the left first and second toe amputation sites until the NPWT system arrives: Cleanse with normal saline, blot dry. Baza AF to the periwound. Apply a gauze that is moistened with quarter -strength (1/4) Dakin's solution to the wound. Cover with double layer Xeroform or Vaseline gauze cut to fit. Cover with ABD and secure with rolled gauze and tape. Please avoid tight wraps.ˆ On 9/3/25 at 10:16 A.M., the surveyor observed: -Resident #19 was dressed in shorts and seated in a wheelchair in the hallway and wearing a right leg prosthetic. -the Resident's left leg had a large irregularly shaped reddened area on the front left shin and a square, undated bandage in the middle of the Resident's left shin. A yellow scab was observed below the bandage.ˆ -the Resident's left foot was wrapped in Kling wrap, that was undated, and he/she was wearing a surgical shoe. During an interview at the time, Resident #19 said he/she had just returned from the hospital where the toes on his/her left foot were amputated.ˆ ˆ On 9/4/25 at 8:38 A.M., the surveyor observed the following: -Resident #19 was up, dressed in shorts and seated in a wheelchair in the hallway. -An undated wrap was observed on the Resident's left foot, and he/she was wearing a surgical shoe. -The left shin was deep red in color, there were no bandages on the left leg, and a round dime sized open area was observed on the middle front of the left shin. A clear colored fluid was observed from the red colored wound bed.ˆ During an interview at the time, Resident #19 said he/she never had pain in his/her left leg and was not aware of any treatment to the shin area. Resident #19 said that the Nurse was supposed to change his/her dressing to the left foot twice daily, but it was only changed once since he/she had been re-admitted to the facility.ˆThe surveyor observed Resident #19 touching the fluid located in the exposed open area on the left shin with his/her fingers during the interview. ˆ Review of the Medication Administration Records (MARs) and Treatment Administration Records (TARs) from July 2025 through 8/4/25 indicated: -7/13/25: one episode of screaming/cursing -7/17/25: one episode of refusal of care -No other documented behaviors. -Diabetic foot care was administered daily from 7/1/25 through 7/31/25. -No behaviors or refusals of care were documented for 8/1/25 through 8/4/25. -Diabetic foot care was administered daily from 8/1/25 through 8/5/25. Review of the September 2025 TAR indicated both treatments to the Resident's left toes (dated 8/6/25 and 9/1/25) were documented (indicated with a check mark) as administered to Resident #19 from 9/2/25 through 9/4/25. Further review of the September 2025 TAR indicated: -the treatment started on 9/1/25, was ordered twice daily -9/2/25: checked off as administered twice -9/3/25 and 9/4/25: checked off as administered once ˆ On 9/5/25 at 7:26 A.M., the surveyor observed the following: -Resident #19 was lying in bed on his/her right side.ˆ -black surgical shoe was on the bed (not on the Resident's foot). -the Resident's left foot was bare, and Kling wrap was observed around his/her left ankle. -the Resident's left foot was laying on the bed, the first and second toes on the Resident's left foot were absent and the first and second toe amputated areas on the top of the foot were open, red and exposed. -the left lower front leg was red in color and had a dime sized circular area that was not covered.ˆˆ During an interview at the time, Resident #19 said he/she very upset because the Nurse who worked the previous night had completed the dressing to his/her left foot late and the wound dressing was incorrectly done. On 9/5/25 at 9:00 A.M., the surveyor reviewed the Resident's Clinical Record with the Assistant Director of Nurses (ADON), Administrator, and Director of Nursing (DON). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview at the time, the ADON said the following: -there were two treatment orders for the Resident's left foot dated 8/6/25 and 9/1/25 that were both supposed to be in place. The ADON said the treatment order dated 8/6/25 was the treatment prior to the Resident's hospitalization, and the treatment dated 9/1/25 was the ordered treatment after the Resident's surgical amputation. -the documentation in the September 2025 TAR indicated both treatments were being administered by the Nurses. -the Hospital Discharge Summary indicated a NPWT was ordered and there had been no NPWT utilized for Resident #19's wound since he/she was re-admitted to the facility. -the orders for the Resident's wound care outlined in the Hospital Discharge Summary should be reviewed with the Provider upon re-admission.ˆ The Administrator said the facility had utilized NPWT previously and had the equipment available previously in the facility. ˆ During an interview on 9/5/25 at 10:09 A.M., the NP said the following: -Resident #19 had a history of left lower leg cellulitis which required treatment with multiple antibiotics.ˆ -The NP could not recall being notified of any concerns about Resident #19's toes prior to being contacted by the Wound Care Provider, who at the time of notification had requested an x-ray of the Resident's left foot, lab work and cultures to be completed which were ordered.ˆ -The NP returned to the facility the following week and the x-ray of the Resident's left foot, lab work and cultures of the wound had not been completed, so she reordered them to be completed. It was her expectation that when the Wound Care Provider made recommendations, those recommendations would be ordered/completed on the same day.ˆ -The results from the x-ray of the Resident's left foot completed on 8/26/25, suggested possible osteomyelitis and recommended an MRI, so the Resident was transferred out to the hospital for evaluation.ˆ -If there were any concerns about the Resident's skin or if an area on the Resident's skin was worsening, the NP would expect the facility to notify her.ˆ -The NP was not made aware of any areas on the Resident's left lower extremities since he/she was re-admitted back to the facility.ˆ ˆ During an interview on 9/5/25 at 10:38 A.M., the Wound Care Provider said the following: -She conducted wound rounds for residents in the facility weekly on Thursdays with the ADON. -The facility staff would provide a list of residents with wounds for her to evaluate. -She was not made aware of Resident #19's left foot wounds until 8/21/25. -When she evaluated the Resident on 8/21/25, she had concerns for osteomyelitis due to the bone exposure and hypergranulation that was observed. At that time, she ordered an x-ray, lab work and wound cultures to be completed.ˆ ˆ During interviews on 9/5/25 at 9:00 A.M., 11:30 A.M., and 12:59 P.M., the DON said the following: -all residents should have weekly skin checks completed and if they were not completed, there should be documentation in the clinical record as to why the skin assessment was not done.ˆ -Resident #19 was at increased risk of skin issues because of his/her diagnoses of Diabetes, PVD and history of non-compliance, so it was important to complete the weekly skin evaluations.ˆ -The DON was unable to find evidence that lab work and wound cultures were completed for Resident #19. -The DON reviewed the Resident's clinical record, saw the two treatment orders which were in place and still active for the Resident's left foot wounds and said that the treatment ordered for 8/6/25 was not an appropriate order and should have been discontinued.ˆ -there were no current policies relative to non-pressure areas for the facility and that the Nurses would refer to professional standards for wound care. -If a resident was identified with a skin issue/area, the Wound Care Provider would be notified so they would be monitored during weekly wound rounds with the ADON. During those wound rounds, measurement of the wounds would be obtained. -In addition to the weekly wound rounds, the Nurses should be completing the treatments as ordered by the Provider and be notifying the Provider if there were any changes. The Nurses should also be completing a weekly Non-Pressure Ulcer Evaluation for Resident #19 since the wounds were identified on 8/4/25. The DON reviewed the Resident's clinical record, and found this evaluation was not completed until 8/22/25.ˆ ˆ During a follow-up interview on 9/5/25 at 1:47 P.M., the DON said it appears that the Podiatrist identified the Resident's left toe wounds on 8/4/25. The DON said when a resident was admitted , a skin check would be completed and if a skin area/wound was identified, it would be documented, Physicians orders for treatment of the area would be obtained and then the (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure three Nurses (Nurse #2, #3 and #4), of five Nurses reviewed, had been evaluated upon hire and/or annually to ensure skills and competencies were met relative to wound care.Specifically, for one Resident (#19) who had diabetic wounds, the facility failed to ensure Nurses #2, #3, and #4, who provided care to Resident #19, were evaluated upon hire and/or annually to ensure they had the skill sets and competencies when providing wound care. Finding include: Review of the Facility Assessment, last reviewed on 8/29/25, indicated the facility had the capability to care for the residents who had:-skin ulcers and injuries-skin and soft tissue infections-advanced wound care needs In addition, the Facility Assessment indicated the following relative to Staff Training/Education and Competencies:-facility utilizes a computer-based program for various training modules which are assigned and completed throughout the year. -an annual competency fair is conducted, allowing staff to practice and demonstrate required competencies.-yearly education for all staff included:>Nutrition and Skin/Wound care Resident #19 was admitted to the facility in May 2023 with diagnoses including Type 2 Diabetes, acquired absence of the right leg below the knee amputation (BKA), and Peripheral Vascular Disease (PVD).ˆ Review of the Consultant Podiatrist Note, dated 8/4/25, indicated Resident #19 was examined and included the following: -presence of reddened, warm, discolored, and atrophy in the Resident's left foot. -No nails were on the left first, second and third toes, and there were signs of infection present. -Diabetic ulcers were located on the following:>great left toe which had presence of erythema, redness, edema, drainage and odor >left second toe which had presence of erythema, redness, edema, drainage and odor >third left toe which had presence of erythema, redness, edema -findings were discussed with Resident #19 and Nurse #2. Review of the September 2025 Physician's Orders included the following: >Wound Consult as indicated, initiated 5/27/23 >Consults: Podiatry ., initiated 6/5/23 >Diabetic foot care: wash foot with gentle soap and water, dry well. Monitor for any abnormalities, daily in the evening, initiated 6/8/23>Left first and second toe: cleanse with Normal Saline, blot dry, apply Baza AF to periwound, apply 1/4 Dakins soaked gauze to wound bed. Cover with double layer Xeroform, cover with ABD with rolled gauze and tape. Change BID and as needed (PRN), every day and evening shift for wound care, ordered 9/1/25.ˆ >Calcium Alginate to the toes on the left foot. Place in-between toes and on tope place ABD on wrap with kling. Clean the wound with saline daily and as needed, ordered 8/6/25.ˆ -The September 2025 Physician's orders failed to indicate treatment orders for the open areas on the Resident's left shin. Review of the September 2025 TAR indicated both treatments to the Resident's left toes (dated 8/6/25 and 9/1/25) were documented (indicated with a check mark) as administered to Resident #19 from 9/2/25 through 9/4/25. Further review of the September 2025 TAR indicated: -the treatment started on 9/1/25, was ordered twice daily -9/2/25: checked off as administered twice -9/3/25 and 9/4/25: checked off as administered once. On 9/4/25 at 8:38 A.M., the surveyor observed the following: -Resident #19 was up, dressed in shorts and seated in a wheelchair in the hallway. -An undated wrap was observed on the Resident's left foot, and he/she was wearing a surgical shoe. -The left shin was deep red in color, there were no bandages on the left leg, and a round dime sized open area was observed on the middle front of the left shin. A clear colored fluid was observed from the red colored wound bed.ˆ During an interview at the time, Resident #19 said he/she never had pain in his/her left leg and was not aware of any treatment to the shin area. Resident #19 said that the Nurse was supposed to change his/her dressing to the left foot twice daily, but it was only changed once since he/she had been re-admitted to the facility.ˆThe surveyor observed Resident #19 touching the fluid located in the exposed open area on the left shin with his/her fingers during the interview. Review of the August 2025 and September 2025 TARs indicated Nurses #2, #3, and #4 provided wound care and/or diabetic foot care for Resident #19. Nurse #2 was hired in the facility on 5/5/25.Nurse #3 was hired in the facility on (continued on next page)

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Lee Healthcare	620 Laurel Street Lee, MA 01238

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/1/17.Nurse #4 was hired in the facility on 3/26/25. During interviews on 9/5/25 at 9:00 A.M., 11:30 A.M., and 12:59 P.M., the Director of Nursing (DON) said the following: -all residents should have weekly skin checks completed and if they were not completed, there should be documentation in the clinical record as to why the skin assessment was not done.ˆ -Resident #19 was at increased risk of skin issues because of his/her diagnoses of Diabetes, PVD and history of non-compliance, so it was important to complete the weekly skin evaluations.ˆ -The DON reviewed the Resident's clinical record, saw the two treatment orders which were in place and still active for the Resident's left foot wounds and said that the treatment ordered for 8/6/25 was not an appropriate order and should have been discontinued.ˆ -If a resident was identified with a skin issue/area, the Wound Care Provider would be notified so they would be monitored during weekly wound rounds with the Assistant Director of Nurses (ADON). During those wound rounds, measurement of the wounds would be obtained. -In addition to the weekly wound rounds, the Nurses should be completing the treatments as ordered by the Provider and be notifying the Provider if there were any changes. The Nurses should also be completing a weekly Non-Pressure Ulcer Evaluation for Resident #19 since the wounds were identified on 8/4/25. The DON reviewed the Resident's clinical record, and found this evaluation was not completed until 8/22/25.ˆ During an interview on 9/9/25 at 1:52 P.M., the Coporate Clinical Nurse said the facility was unable to find evidence that a wound care competency was completed for Nurse #2 since hire. During an additional interview on 9/9/25 at 2:54 P.M., the Administrator said the following:-Nurse #3 had a wound care competency completed on 4/29/24.-Nurse #2 did not have a wound care competency completed since hire. During an interview on 9/09/25 at 2:58 P.M., the DON said wound care competencies should be completed on hire and annually thereafter. The DON said relative to Nurse #3, the wound care competency was due on 4/29/25 and had not been completed yet. During a follow-up interview on 9/10/25 at 10:38 A.M., the Corporate Clinical Nurse said he was made aware that there were concerns regarding nursing competencies that were not completed timely for three of the five Nurses reviewed. The Corporate Clinical Nurse said that it was important to have the wound care competencies completed to ensure the Nurses provided safe and effective wound care.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete a performance review of every nurse aide at least once every 12 months, for five Certified Nurse Aide (CNA #1, #2, #4, #5, and #6), out of five total records sampled. Specifically, the facility failed to ensure annual performance reviews were completed every 12 months for CNAs #1, #2, #4, #5, and #6. Findings include: Review of the facility provided CNA Active Employee Listing, undated, indicated the following: -CNA #1 was hired 7/28/15-CNA #2 was hired 7/1/24-CNA #4 was hired 12/4/23. -CNA #5 was hired 7/1/24. -CNA #6 was hired 2/5/24. During an interview on 9/9/25 at 2:51 P.M., the Director of Nursing (DON) said CNA performance reviews should be completed annually with all CNA's who worked in the facility. The DON said she was unable to locate annual performance reviews for CNA #1 and CNA #2.During a follow-up interview on 9/9/25 at 3:41 P.M., the DON said she was unable to provide annual performance reviews for CNAs #4, #5, and #6. During an interview on 9/10/25 at 11:32 A.M., the Administrator said annual performance reviews should be completed annually for all CNAs who worked in the facility. The Administrator further said it was important to complete performance reviews to assess the CNAs performance, ensure they are knowledgeable about the care they perform, provide feedback, and identify any education a CNA may need. The Administrator said this was important to ensure residents at the facility were provided with quality care.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that Advance Directives were honored for one Resident (#11), out of a total sample of 26 residents. Specifically, for Resident #11, the facility failed to ensure that the Physician's orders accurately reflected the Resident/Resident Representative's wishes as indicated on the Medical Orders for Life-Sustaining Treatment (MOLST: legal document that allows individuals to communicate their preferences for life-sustaining treatment to healthcare providers) form, putting the Resident at risk for being resuscitated (perform full measures including cardiopulmonary resuscitation and intubation) when the advanced directive wishes were for no resuscitation (do not resuscitate [DNR]). Findings include: Review of the facility policy Advance Directives, revised January 2024, indicated the following: -Advance directives will be respected in accordance with state law and facility policy -The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive Resident #11 was admitted to the facility in July 2025 with diagnoses including Chronic Lymphocytic Leukemia and Heart Failure. Review of Resident #11's Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a total possible score of 15. Review of Resident #11's MOLST form, completed and signed by the Resident on 7/16/25, indicated the Resident desired to be a DNR. Review of Resident #11's September 2025 Physician's Orders indicated an active order, initiated on 7/23/25, for Advance Directive: Full Code (indicates the desire for resuscitation). During an interview on 9/3/25 at 3:53 P.M., the surveyor and Nurse #4 reviewed Resident #11's MOLST form and Physician Orders together. Nurse #4 said that the Physician's Orders indicated the Resident was a full code, but the MOLST form indicated the Resident desired to be a DNR. Nurse #4 further said that this was a concern because the Resident could be resuscitated when he/she did not desire to be resuscitated. During an interview on 9/3/25 at 4:09 P.M., the Director of Nursing (DON) said that the expectation relative to Advance Directives was that the Physician's Order should match the MOLST form because that is where staff would get the information on whether or not they should resuscitate the Resident should the Resident's heart stop.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review and interviews, the facility failed to respond to or resolve grievances for one Resident (#54) out of a total sample of 26 residents. Specially the facility failed to respond to three grievances filed by Resident #54's family on 4/25/25. Findings include:Review of the facility policy titled Grievances, last updated on 2/2024, indicated the following in part:-The administrator is identified as the grievance official responsible for oversight of the grievance process in the facility. This includes responsibility for reviewing and tracking grievances, necessary investigating, ensuring that grievances are addressed and a response provided.-Any resident, and or health care representative, family member, employee or appointed advocate may file a grievance without fear or discrimination or reprisal in any form-Grievances may be submitted orally or in writing.The administrator will review the findings with the person investigating the grievance to determine what corrective actions need to be made-The resident, and/or health care representative, or person filing the grievance on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. This report will be completed by the administrator within seven (7) working days of receipt of the grievance.Resident #54 was admitted to the facility in March 2025 with diagnoses that included Dementia.Review of the grievance binder indicated three grievances had been filed by Family Member #1 on behalf of Resident #54 on 4/25/25.Review of the three grievances dated 4/25/25 indicated the following areas were blank:-Department notified and date-Action taken-Followed up-Signature of the department head-Signature of Executive Director and date During an interview on 9/8/25 at 3:58 P.M., Family Member #1 said she had completed multiple grievances and had sent multiple emails to the Administrator. Family Member #1 said by the time the Administrator would follow up on the grievance, too much time had gone by, and staff could not remember what had happened. During an interview on 9/9/25 at 3:26 P.M., the Administrator said when a grievance comes in, it went to the Social Worker, which was then given to the appropriate department relating to the topic of concern. The department responsible for following up on a particular grievance was expected to resolve the issue, complete the bottom of the form and then provide a copy to the Social Worker. The Social Worker would then provide the Administrator with the resolved grievance for him to review and sign off that it had been resolved. The Administrator and the surveyor reviewed the three grievances completed on 4/25/25 by Family Member #1. The Administrator said that the three grievance forms were not completed and did not have a follow up/resolution as required. During a follow-up interview on 9/9/25 at 3:54 P.M., the Administrator said he could not locate any evidence that the three grievances completed by Family Member #1 had been followed up on and/or responded to.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview the facility failed to ensure a Notice of Transfer or Discharge and a Bed Hold were provided to residents or their resident representatives at the time of transfer or shortly there after and that the Office of the State Long-term Care Ombudsman was notified at the time of transfer or shortly there after for one Resident (#74) out of a total sample of three residents reviewed for closed records and for one Resident (#70) out of a total of 26 active records reviewed.Specifically, 1. For Resident #74 and #70 the facility failed to ensure the Office of the State Long-term Care Ombudsman was notified when Resident #74 and #70 were transferred from the facility to the hospital, and 2. Additionally, for Resident #70 the facility failed to ensure the -Resident/Representative had been provided with a copy of the bed hold policy, a notice of intent to transfer and that the appropriate information had been provided to the receiving facility, that included a discharge summary with vital information relative to the Resident and his/her level of care. Findings include:Review of the facility policy titled Transfer or Discharge Notice, revised 11/2024, indicated the following: -Our facility shall provide a resident and/or the resident's representative with a thirty (30)-day written notice of an impending transfer or discharge. -Under the following circumstances, the notice will be given as soon as it is practicable… -The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility;… -The resident and/or representative will be notified in writing of the following information: -The reason for the transfer or discharge; -The effective date of the transfer or discharge; -A statement of the resident's right to appeal the transfer or discharge: … -The facility bed hold policy: -The name, address, and telephone number of the Office of the State Long-term Care Ombudsman;… -A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman. 1. Resident #74 was admitted to the facility in July 2025 with diagnoses including but not limited to Peripheral Vascular Disease, Type 2 Diabetes with multiple Diabetic leg and foot Ulcers, and Atherosclerotic Heart Disease. Review of the Wound Nurse Practitioner's Note dated 7/31/25 indicated the following: -Resident #74 had suspected deterioration of blood flow in his/her legs, was having increased pain, and he/she was “not feeling well”, and to send Resident #74 to the emergency department. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Progress Note dated 7/31/25 indicated Resident #74 was sent to the hospital and was admitted . During an interview on 9/8/25 at 10:08 A.M., the Social Worker (SW) said she had recently started as the SW at the facility and Resident #74 was sent out to the hospital prior to her beginning work in the facility. The SW said she was unable to locate any documentation that the Office of the State Long-term Care Ombudsman had been notified when Resident #74 was discharged to the hospital on 7/31/25. During a follow up interview on 9/8/25 at 10:28 A.M., the SW said a list of all residents in the facility who were discharged should be compiled each month, at the end of the month the list was faxed or emailed to the Office of the State Long-term Care Ombudsman, and she was unable to find any documentation a list was compiled for July 2025 when Resident #74 was discharged to hospital, to show the Office of the State Long-term Care Ombudsman had been notified as required 2. Resident #70 was admitted to the facility July 2025 with diagnoses that included Type 2 Diabetes, below the left knee leg amputation, above the right knee leg amputation, Chronic Kidney Disease, wound on the lower back and pelvis. Review of a Nurses Note, dated 7/11/25, indicated Resident #70 was sent to the emergency department due to abnormal labs per the morning shift nurse. Further review of the medical record indicated no documented evidence of the following required information: -Resident/Representative had been provided with a copy of the bed hold policy or a notice of intent to transfer. -That the appropriate information had been provided to the receiving facility, that included a discharge summary with vital information relative to the Resident and his/her level of care. -Notification to the Ombudsman. During an interview on 9/8/25 at 3:49 P.M., Nurse #1 said when a resident was sent out to the hospital the nurse completed a form on the computer that included the bed hold, the summary/reason for discharge, vitals, and other important information. During an interview on 9/8/25 at 4:18 P.M., with the Director of Nursing (DON) and the Administrator, the DON said they were unable to find any evidence of the required documentation for Resident #70's transfer to the hospital on 7/11/25, nor evidence that the Ombudsman had been notified, as required.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) Assessments were completed accurately to reflect the resident's status for eight Residents (#1, #3, #4, #6, #23, #31, #48, and #67), out of a total of 26 residents sampled.Specifically, for Residents #1, #3, #4, #23, #31, #48, and #67, the facility failed to ensure the Section F-Preferences for Customary Routine and Activities Assessment was completed with the Resident or a Staff Interview was completed if the Resident was unable to participate in a Resident Interview for the most recent comprehensive MDS Assessment. Findings include:1. Resident #1 was admitted to the facility in August 2025 with diagnoses including but not limited to Paraplegia, Osteomyelitis, Adult Failure to Thrive, and Type 2 Diabetes. Review of Resident #1's most recent comprehensive MDS assessment dated [DATE] indicated he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact, he/she had clear speech, and was able to make him/herself understood. Further review of the 8/5/25 MDS Assessment indicated no evidence of a Resident Interview or Staff Interview had been completed relative to Resident #1's Preferences for Customary Routine and Activities as evidence by both the Resident Interview and Staff Interview in Section F being dashed. 2. Resident #3 was admitted to the facility in July 2017 with a diagnosis of Huntington's Disease. Review of Resident #3's most recent comprehensive MDS assessment dated [DATE] indicated he/she was unable to speak, was rarely able to make him/herself understood, had long term and short- term memory problems, and his/her ability to make daily decisions was severely impaired. Further review of the 8/11/25 MDS Assessment indicated no evidence Staff Interview had been completed relative to Resident #3's Preferences for Customary Routine and Activities as evidence by the Staff Interview in Section F being dashed. 3. Resident #4 was admitted to the facility in June 2016 with diagnoses including but not limited to Huntington's Disease, Post Traumatic Stress Disorder, and Bipolar Disorder. Review of Resident #4's most recent comprehensive MDS assessment dated [DATE] indicated he/she scored a 10 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was moderately cognitively impaired and was usually able to make him/herself understood. Further review of the 8/12/25 MDS Assessment indicated no evidence a Resident Interview or Staff Interview had been completed relative to Resident #4's Preferences for Customary Routine and Activities as evidence by both the Resident Interview and Staff Interview in Section F being dashed. 4. Resident #6 was admitted to the facility in December 2024 with diagnoses including but not limited to Bipolar Disorder, Peripheral Vascular Disease, and Congestive Heart Failure. Review of Resident #6's most recent comprehensive MDS assessment dated [DATE] indicated he/she scored a 13 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact, he/she had clear speech, and was able to make him/herself understood. Further review of the 8/19/25 MDS Assessment indicated no evidence a Resident Interview or Staff Interview had been completed relative to Resident #6's Preferences for Customary Routine and Activities as evidence by both the Resident Interview and Staff Interview in Section F being dashed. 5. Resident #23 was admitted to the facility in September 2024 with diagnoses including but not limited to Type 2 Diabetes, Repeated Falls, and Depressive Disorder. Review of Resident #23's most recent comprehensive MDS assessment dated [DATE] indicated he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact, he/she had clear speech, and was able to make him/herself understood. Further review of the 8/19/25 MDS Assessment indicated no evidence a Resident Interview or Staff Interview had been completed relative to Resident #23's Preferences for Customary Routine and Activities as evidence by both the Resident Interview and Staff Interview in Section F being dashed. 6. Resident #31 was admitted to the facility in August 20025 with diagnoses including but not limited to Alzheimer's Disease with Early Onset, Depressive Disorder, and Epilepsy. Review of Resident #31's most recent comprehensive MDS assessment dated [DATE] indicated (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he/she was unable to speak, was rarely able to make him/herself understood, had long term and short- term memory problems, and his/her ability to make daily decisions was severely impaired. Further review of the 7/8/25 MDS Assessment indicated no evidence Staff Interview had been completed relative to Resident #3's Preferences for Customary Routine and Activities as evidence by the Staff Interview in Section F being dashed. 7. Resident #48 was admitted to the facility in May 2024 with diagnoses including but not limited to Type 2 Diabetes, Spinal Stenosis, and Primary Generalized Osteoarthritis. Review of Resident #48's most recent comprehensive MDS assessment dated [DATE] indicated he/she had clear speech, and was sometimes able to make him/herself understood. Further review of the 8/5/25 MDS Assessment indicated no evidence a Resident Interview or Staff Interview had been completed relative to Resident #48's Preferences for Customary Routine and Activities as evidence by both the Resident Interview and Staff Interview in Section F being dashed. 8. Resident #67 was admitted to the facility in December 2021 with diagnoses including but not limited to Congestive Heart Failure, Peripheral Vascular Disease, and Torsades de pointes (rare heart rhythm disturbance). Review of Resident #67's most recent comprehensive MDS assessment dated [DATE] indicated he/she had a BIMS score of 9 out of 15 indicating he/she was moderately cognitively impaired, had clear speech, and was usually understood. Further review of the 8/26/25 MDS Assessment indicated no evidence a Resident Interview or Staff Interview had been completed relative to Resident #48's Preferences for Customary Routine and Activities as evidence by both the Resident Interview and Staff Interview in Section F being dashed. During an interview on 9/8/25 at 2:38 P.M., the MDS Nurse said the facility had been without an Activities Director for some time and the Resident and Staff Interview for Section F were not being completed as it was part of the Activities Director job. She further said for Residents #1, #4, #6, #23, #48, and #67 a Resident Interview should have been attempted for Section F and if it was unable to be completed a Staff Interview should have been completed for their most recent comprehensive MDS Assessment and this was not done. She said for Residents #3 and #31 a Staff Interview for Section F should have been completed for the Residents most recent comprehensive MDS Assessment and this was not done.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure its staff followed professional standards for care and services relative to a suprapubic catheter (an indwelling urinary catheter placed directly into the bladder through the abdomen) and a colostomy (a surgical procedure where a portion of the large intestine is brought through the abdominal wall to carry stool out of the body) for one Resident (#70), out of a total sample of 26 residents. Specifically, the facility failed to obtain Physician orders on how to provide care and services for both the suprapubic catheter and the colostomy. Additionally, the facility failed to develop policies and procedures on how to provide care and services for both the suprapubic catheter and the colostomy, putting the Resident at an increased risk of infection, complications and/or improper care techniques.Findings include:Resident #70 was admitted to the facility July 2025 with diagnoses that included Type 2 Diabetes, below the left knee leg amputation, above the right knee leg amputation, Chronic Kidney Disease, wound on the lower back and pelvis and paraplegia. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the following:-Resident #70 was moderately cognitively impaired as evidence by a Brief Interview for Mental Status score of 12 out of 15-Resident #70 had an indwelling catheter and an ostomy. Review of Physician orders from July-September 2025 indicated no orders in place for care and services relative to a suprapubic catheter or colostomy. Review of Resident #70's care plans indicated the following in part:-Resident had a suprapubic catheter due to, initiated on 7/3/25>At risk of infection due to suprapubic catheter with history of urinary tract infection (UTI)>Position below the bladder>Check tubing for kinks every two hours>Monitor/document for pain/discomfort>Monitor/record/report to medical director signs and symptoms of a UTI-Alteration in bowel elimination related to colostomy, initiated on 7/3/25. >Assist resident with ostomy care as needed>Obtain appropriate supplies for ostomy care During an interview on 9/4/25 at 9:39 A.M., Resident #70 said he/she takes care of the urinary drainage bag and the colostomy him/herself. The Resident said he/she brought in supplies from home and had not yet needed the facility to replace them. Resident #70 said he/she goes to urology once a month for the suprapubic catheter and that the nursing staff checked the site to ensure there were no infections. Resident #70 said he/she had no issues with either the ostomy or the suprapubic catheter. During an interview on 9/4/25 at 11:17 A.M., the Assistant Director of Nursing (ADON) said the following:-Someone with a colostomy should have orders in place that indicated how to provide care for the colostomy including cleansing and changing of the wafer 9 (a plastic ring that is used to connect the pouch system and the skin barrier, used to help hold the pouch in place and come in different sizes) as needed. -If she were the nurse providing care for Resident #70, she would observe the area, assess and chart on the ostomy site three times a shift or as needed. -She was not sure what the facility policy was relative to colostomies or suprapubic catheters-There should be an order that indicated the size of the wafer so the facility staff can order the appropriate supplies.-There should be an order on how to provide care for the colostomy. -There should be an order on how to provide care for the Resident's suprapubic catheter that include how to clean the area, as well as changing the dressing every night shift. The ADON reviewed the Resident's Physician orders from July-September 2025 and said she did not see any orders in place for the colostomy or the suprapubic as she would have expected for all three months. The ADON reviewed the Resident's care plans for the colostomy and the suprapubic catheter and said some of the information was there they were not comprehensive. During an interview on 9/4/25 at 4:34 P.M., the Director of Nursing (DON) said they do not have a policy or protocols on suprapubic catheters or ostomies.

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Lee Healthcare	620 Laurel Street Lee, MA 01238

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review and interviews, the facility failed to provide an environment that was free of potential accidents and hazards and implement the facility policy to ensure smoking safety for two residents (#70 and #1) of three applicable residents reviewed for smoking, out of a total sample of 26 residents. 1. For Resident #70 the facility failed to ensure adequate supervision was provided and an individualized care plan was developed.2. For Resident #1, the facility failed to ensure that the Resident was assessed for safety prior to the Resident resuming smoking at the facility placing the Resident at risk for injury. Findings include: Review of the facility policy titled Smoking Policy- Residents, last revised on 3/2024, indicated the following: -The resident will be evaluated upon admission or when a resident chooses to smoke to determine of the resident's ability to smoke safely -Any smoking related concerns will be noted in the resident care plan -Residents who are supervised for smoking will be monitored by a staff member or designee during the allowed smoking times -Residents are not allowed to keep lighters with them 1. Resident #70 was admitted to the facility in July 2025 with diagnoses that included Type 2 Diabetes, below the left knee leg amputation, above the right knee leg amputation, Chronic Kidney Disease, wound on the lower back and pelvis. During an interview on 9/4/25 at 9:45 A.M., Resident #70 said he/she smoked and that he/she went out to smoke during the designated smoking times. Resident #70 further said the staff hold his/her smoking paraphernalia. Review of the Smoking Evaluation, dated 7/22/25, indicated the following: -Resident is safe to smoke with supervision without protective smoking equipment -Resident is safe to light own cigarette with staff supervision Review of the Social Service Evaluation dated 7/2/25, indicated the Resident was a current smoker. Review of the Chronic Obstructive Pulmonary Disease (COPD) Care Plan, initiated on 7/2/25, indicated the Resident had a history of smoking. Further review of the Resident #70's care plans indicated no documented evidence that a smoking care plan had been initiated to reflect his/her current smoking status. On 9/8/25 at 11:00 A.M., the surveyor observed six residents waiting in the hallway to go out for the11:00 A.M. smoke time. At the time of this observation, there were no staff with the residents. On 9/8/25 at 11:18 A.M., the surveyor observed the six residents going through the locked door (utilized a number code on a keypad to exit) that exited to the smoking area. One resident held the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	door open for the other five residents and said, “oh geez, how did you guys get out there”, while laughing. There was no staff supervision in the smoking area at this time. Resident #70 had a lit cigarette in his/her hand. Another resident went to Resident #70 to ask for a lighter and Resident #70 said “you have to wait the state is watching.” At this time another resident was observed to open a pack of cigarettes, and the surveyor noted a lighter inside of the cigarette pack. On 9/8/25 at 11:22 A.M. the surveyor observed a Certified Nurse's Aide (CNA) enter the smoking area to supervise the residents. During an interview on 9/8/25 at 1:03 P.M., the Administrator said the following: -All Residents who smoke are deemed independent, but we do have supervised smoking. -Nurses hold cigarettes and lighters on the nurses' carts and the residents have to ask for these items when they want to smoke. -Residents are allowed to light their own cigarettes with supervision. -He had heard about the residents in the smoking area unsupervised and had the code to enter the smoking area changed as it was clear one of the residents had the code and let all the residents out at the11:00 A.M., smoking time that morning. -The residents should have been supervised when they were lighting their cigarettes and smoking and they were not supervised, as required. During an interview on 9/8/25 at 1:46 P.M., the Minimum Data Set (MDS) Nurse said when Resident #70 was first admitted to the facility he/she was very compromised and may not have been going outside to smoke. She said she was unaware that the Resident was currently smoking. The MDS Nurse said that typically these topics were reviewed during the daily clinical rounds that occurred every morning, and she did not recall this information coming up. The MDS Nurse said if she had known about the Resident's smoking, she would have updated the Resident's care plan to reflect his/her current smoking status. During this interview the surveyor and MDS Nurse reviewed Resident #70's Smoking Assessment completed on 7/22/25 and the current care plans. The MDS Nurse said a smoking care plan was not in place for Resident #70 and there should have been. She further said the care plan should have been updated timely after the 7/22/25 Smoking Assessment had been completed. 2. Resident #1 was admitted to the facility in September 2024 with diagnoses including Paraplegia and Injury of the Spinal Cord at C5 (the fifth cervical vertebra in the neck) level. Review of Resident #1's Smoking Evaluations indicated the following: -Evaluation completed on 3/14/25 at 7:43 P.M. indicating the Resident did not desire to smoke -Evaluation completed on 9/3/25 at 11:16 P.M. indicating the Resident was independent with smoking -No additional smoking evaluations between 3/14/25 and 9/3/25 evaluation dates (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Smoking List provided to surveyors on entrance by the facility failed to indicate that Resident #1 was a smoker. During an interview on 9/3/25 at 9:00 A.M., Resident #1 said that he/she had been smoking when he/she first came to the facility but had stopped for a while. Resident #1 further said that he/she had started smoking again a few weeks ago. On 9/3/25 at 11:10 A.M., the surveyor observed Resident #1 outside in the courtyard smoking. During an interview on 9/5/25 at8:57 A.M. , Activities Aide (AA) #1 said that she helped to supervise smoking times at the facility. AA #1 further said that Resident #1 had stopped coming out to smoke but that about a month ago he/she had decided to start smoking again and had resumed coming outside to smoke. During an interview on 9/9/25 at 1:58 P.M., the Director of Nursing (DON) said that a smoking assessment should be done as soon as a resident indicates they wish to smoke. The surveyor reviewed the observation of Resident #1 smoking and his/her Smoking Evaluations with the DON. The DON said the smoking assessment should have been completed before the Resident resumed smoking to ensure that he/she was safe while smoking.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review, and interview, the facility failed to ensure that the Consulting Pharmacist Medication Regimen Reviews (MRRs) were reviewed by the attending Physician timely and implemented as recommended for three Residents (#9, #31, and #8) out of a total sample of 26 residents. Specifically, for Resident's #9, #31, and #8, the facility failed to ensure that the Resident's Attending Physician reviewed and implemented or declined the Pharmacist MRRs timely. Findings include: 1. Resident #9 was admitted to the facility in February 2025 with diagnoses including but not limited to Congestive Heart Failure, Chronic Kidney Disease, and Unspecified Mood Disorder. Review of Resident #9's Pharmacy MRRs dated 2/26/25, 3/19/25, and 5/15/25, indicated the following Pharmacist Recommendations: -Acetaminophen 650 milligrams (mg) by mouth every six hours as needed (PRN) for pain or temperature. Give (2) 325 mg tabs to equal 650 mg. Not to exceed 3000 mg in 24 hours. -Oxycodone 5 mg by mouth every six hours as needed (PRN) for pain. -Please clarify what type of pain (using pain assessment tool) each medication is to be used for. This will help improve pain management and avoid confusion or excessive dosing. Review of the 2/26/25 and 3/19/25 Pharmacy MRRs indicated the Physician had not reviewed and agreed to the recommendation or declined the recommendation, as evidenced by no response and Physician's signature. Review of the 5/15/25 Pharmacy MRR indicated the recommendation was addressed but remained unsigned by the Physician. During an interview on 9/4/25 at 10:02 A.M. the Director of Nursing (DON) said MRRs should be reviewed by the Physician or if applicable by the nursing staff shortly after they were received from the Pharmacist, usually within two to three days. The DON said the Physician should review the MRR and accept or decline with documentation as to why they were declining the recommendation and then sign the MRR. The DON said the 2/26/25 and 3/19/25 MRRs for Resident #9 were not completed timely and were not addressed until the same MRR recommendations were made in May 2025. 2. Resident #31 was admitted to the facility in August 2023 with diagnoses including recurrent Depressive Disorder, early onset Alzheimer's Disease, delusion disorder, and anxiety disorder. Review of Resident #31's Pharmacy MRR dated 5/15/25 indicated the following Pharmacist Recommendation: -Resident was seen by psych [sic] on 5/9/25 and a gradual dose reduction (GDR) was recommended for Risperdal (antipsychotic medication). I do not see the prescriber rejected this, dose has not been changed. Please follow up with primary Medical Doctor (MD) regarding potential GDR of Risperdal per psych [sic] eval. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Behavioral Health Nurse Practitioner's Note dated 5/8/25, indicated: -Recommend GDR Risperdal to 0.25 mg twice daily (BID), monitor and document behavior changes. Further review of the 5/15/25 Pharmacy MRR indicated a note that the Behavioral Health Group recommendation and MRR were addressed on 7/29/25 by the DON. No documentation was provided that the Physician reviewed and/or declined the MRR in May 2025 when the recommendation was made on 5/15/25. During an interview on 9/4/25 at 2:19 P.M., the DON said the Behavioral Health Group recommendation to do a GDR on Resident #31's Risperdal should have been provided to the Physician to review when the recommendation was made on 5/9/25. The DON said she was unable to find documentation that the 5/15/25 MRR was provided to the Physician shortly after the Pharmacist's Recommendation were made and neither the Behavioral Health Group recommendation or the Pharmacist's Recommendation were implemented until 7/29/25 and this should have been implemented shortly after the recommendations were made and it was not. 3. Resident #8 was admitted to the facility in September 2022 with diagnoses including Parkinson's Disease and Bipolar Disorder. Review of Resident #8's Consultant Pharmacist Recommendations indicated: -A Consultant Pharmacist Recommendation Form dated 3/19/24 recommending review and decrease dosing for Eliquis from 5 mg twice a day to 2.5 mg twice a day. The Physician/Prescriber Response section was blank. -A Consultant Pharmacist Recommendation form dated 4/24/25 recommending review and decrease dosing for Eliquis from 5 mg twice a day to 2.5 mg twice a day. The Physician/Prescriber Response section was blank. Review of Resident #8's April 2025 Physician's orders indicated: -an order for Eliquis 5 mg twice a day initiated on 10/20/22 and discontinued on 4/30/25 -an active order for Eliquis 2.5 mg twice a day initiated on 4/30/25 During an interview on 9/5/25 at 1:55 P.M., the surveyor and the Director of Nursing (DON) reviewed the Resident's Consultant Pharmacist Recommendations and the DON said that the order was updated on 4/30/25 and now aligned with the recommendation but she did not have evidence that the Consultant Pharmacist Recommendation Forms were reviewed with the Provider. The DON further said she would review Resident #8's medical record to look for evidence to provide to the surveyor. The facility failed to provide any additional information relative to the Pharmacist MRR to the survey team at the time of survey exit.

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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, interview, and record reviews, the facility failed to ensure that complete and accurate medical records were maintained for two Residents (#8, and #11), out of a total sample of 26 residents. Specifically, for Residents #8 and #11, the facility failed to ensure that the Physician Order for nutritional supplements included the amount to be administered, placing the Residents at risk of not receiving adequate nutritional supplementation. Findings include: Review of the facility policy Nutrition, dated June 2018, indicated the following: -Residents maintain acceptable parameters of nutritional status, such as usual or desirable body weight range, and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. -Nutritional Supplements refers to products that are used to complement a resident's dietary needs (e.g., calorie or nutrient dense drinks, total parenteral products [given through intravenous methods], enteral products [given through a feeding tube inserted into the stomach or intestines], and meal replacement products) -Nutrition interventions are evaluated for effectiveness (i.e., meal intake, snack intake, medical food supplement acceptance.) through ongoing monitoring by the IDT [interdisciplinary team] 1. Resident #8 was admitted to the facility in September 2022 with diagnoses including Parkinson's Disease and Bipolar Disorder. Review of Resident #8's Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident had experienced significant weight loss and was not on a prescribed weight loss regimen. Review of Resident #8's September 2025 Physician orders indicated: -an active order initiated on 5/15/25 for House supplement, one time a day with no amount indicated. Review of Resident #8's September 2025 Medication Administration Record (MAR) indicated a place where the Nurse documented the percentage of supplement accepted by the Resident but no indication of the amount to be given. 2. Resident #11 was admitted to the facility in July 2025 with diagnoses including Chronic Lymphocytic Leukemia and Heart Failure (HF). Review of Resident #11's September 2025 Physician orders indicated: -an active order initiated on 8/21/25 for House supplement two times a day, with no indication of the amount to be given. Review or Resident #11's September 2025 MAR indicated House supplement was being administered twice a day with no indication of the amount to be given or record of the amount accepted. During an interview on 9/4/25 at 11:40 P.M., the surveyor and Nurse #4 reviewed Resident #11's House Supplement order. Nurse #4 said the House Supplement order did not include the amount of the supplement the Nurse should give, but that it should. During an interview on 9/9/25 at 1:55 P.M., the Director of Nursing (DON) said that supplement orders should include the amount of supplement to be given as well as a place to document how much supplement was consumed. The surveyor and the DON reviewed Resident #8 and Resident #11's House supplement orders and the DON said that if the order does not include how much supplement should be given then there is no way to know how much supplement was consumed based off of the documentation of percent accepted.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview, and record review, the facility failed to maintain a communication process that included maintaining documentation relative to Hospice services for one Resident (#3) out of a total sample of 26 residents. Specifically, for Resident #3, the facility failed to ensure Hospice Services documentation was readily accessible to all staff and providers for communicating necessary information regarding the resident's care between the nursing home and the Hospice.Findings include:Review of the Inpatient Hospice Services Agreement between the facility and Hospice, dated 10/15/18, indicated the following:>Records:-Creation and Maintenance of Records: Facility shall prepare and maintain complete and detailed records concerning each Hospice Patient receiving Inpatient Services under this Agreement.Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each Hospice Patient, including evaluations, treatments, progress notes. Resident #3 was admitted to the facility in July 2017 with diagnoses including End Stage Huntington's Disease, vascular Dementia, and Dysphagia. Review of the Hospice admission Agreement and Informed Consent Form dated 8/5/25, indicated Resident #3 signed on with Hospice Services on 8/5/25. Review of Resident #3's medical record (both electronic and written) indicated only the following documents were readily available to staff and Providers:-Hospice admission Agreement and Informed Consent, dated 8/5/25.-Hospice Certification of Terminal Illness, dated 8/8/25.-Hospice Plan of Care Effective 8/5/25.-One note from the Hospice Spiritual Counselor, dated 8/12/25. During an interview on 9/8/25 at 10:48 A.M., the Assistant Director of Nurses (ADON) said she thought each resident who received Hospice Services had a Hospice Binder to store Hospice documentation, but she was unsure where these Binders were stored. During an interview on 9/8/25 at 11:49 A.M., Nurse #1 said each Hospice resident should have a separate Hospice Binder to maintain all of the Hospice's documentation, so it was accessible to anyone who needed to review the information. Nurse #1 further said she was unsure if Resident #3 had a Hospice Binder with all of his/her documentation. During a phone interview on 9/8/25 at 12:53 P.M., the Hospice Clinical Supervisor said the staff from Hospice provide handwritten or printed notes to the Nurses at the facility at the time of each visit. The Hospice Clinical Supervisor further said the expectation is the facility staff would ensure all Hospice notes are maintained in a resident's medical record. During an interview on 9/8/25 at 1:32 P.M., the ADON provided the surveyor with a large packet of Hospice documentation that included multiple Hospice Nurses Progress Notes from 8/5/25 through 9/2/25. The ADON said these documents had not been maintained in the facility and she had to call Hospice to have them faxed to the facility after the surveyor asked. The ADON said she was unsure who in the building was the liaison between the facility and Hospice to ensure documentation was maintained and readily available. During an interview on 9/8/25 at 2:19 P.M., with the Director of Nursing (DON) and the Administrator, the Administrator said it was the responsibility of the DON to be the liaison between the facility and Hospice. The DON said each resident receiving Hospice Services should have a Hospice Binder where all their Hospice documentation was maintained. The DON said for Resident #3 she was unaware there was no Hospice Binder and that Resident #3's Hospice documentation was not readily available in the facility.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview, and record review, the facility failed to ensure at minimum quarterly Quality Assurance Performance Improvement (QAPI) meetings were held during one quarter, out of four quarters reviewed.Specifically, the facility failed to ensure that a QAPI meeting for October 2024, was completed as scheduled quarterly to identify issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. Findings include:Review of the facility's last four quarter QAPI meeting attendance sheets indicated a quarterly meeting was scheduled for October 2024, however, the QAPI meeting for October 2024 was not held. During an interview on 9/10/25 at 10:46 A.M., the Administrator said QAPI meetings are required to be held at least quarterly, and the facility did not hold a quarterly QAPI meeting in October 2024 as required.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that antibiotic use was monitored for one Resident (#5), of five applicable residents reviewed for unnecessary medication review, out of a total sample of 26 residents. Specifically, for Resident #5, the facility failed to ensure a prophylactic antibiotic was monitored and re-evaluated for continued use of the antibiotic. Findings include: Review of the facility policy titled Antibiotic Stewardship Program, revised 1/24, indicated the following: -The Antibiotic Stewardship Program purpose is to monitor the use of antibiotics in residents. -As part of the facility Antibiotic Stewardship Program, clinical infections treated with antibiotics will undergo review by the Infection Preventionist (IP), or designee. -The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. -Residents antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. Resident #5 was admitted to the facility in January 2025 with diagnoses including Peripheral Vascular Disease (PVD), Adjustment Disorder, and Parkinson's Disease. Review of Resident #5's September 2025 Physician's Orders, indicated: -Nitrofurantoin Macrocrystal Oral Capsule (antibiotic) 50 milligrams (mg), Give one capsule by mouth at bedtime for prophylactic treatment of recurrent Urinary Tract Infection (UTI), start date of 7/13/25 Review of Resident #5's Discontinued Physician's Orders since January 2025 indicated the following: -Nitrofurantoin Macrocrystal Oral Capsule, 50 mg, Give one capsule by mouth at bedtime for prophylactic treatment of recurrent UTI, start date of 1/17/25 and discontinued date of 6/3/25. Review of Resident #5's Medication Administration Record (MAR) for 1/17/25 through 6/3/25, and 7/7/25 through 9/9/25, indicated Resident #5 was administered the Nitrofurantoin Macrocrystal daily as ordered. Review of Resident #5's Hospital Discharge summary dated [DATE] indicated Resident #5: -was discharged from the hospital to the facility, -had no diagnosis of a UTI, -no documented history of UTI, -no recommendations to start a prophylactic antibiotic for recurrent UTI. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225749	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee Healthcare	620 Laurel Street Lee, MA 01238

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's Physician Progress Notes dated 1/17/25 and 1/19/25 indicated a diagnosis of urge incontinence of urine and failed to indicate documentation on why Nitrofurantoin Macrocrystals was started for prophylactic treatment of recurrent UTI. Review the IP Infection Surveillance Line Listings from February 2025 through August 2025 (the only line listings provided to the survey team during survey) failed to indicate documentation that Resident #5's use of Nitrofurantoin Macrocrystals was being monitored or reviewed. During an interview on 9/9/25 at 1:34 P.M., the IP said she was unsure what the facilities policy was relative to tracking residents who use antibiotics prophylactically and would have to look into it but would expect that any residents on an antibiotic should be on the line listing whether prophylactically or short term. The IP said it's important to monitor antibiotic use for residents so that resistance to those antibiotics does not occur. During an interview on 9/10/25 at 8:53 A.M., the IP said if a resident had recurrent UTIs and was on a prophylactic medication there should be documentation that the facility staff consulted with the Physician and reviewed that the treatment was appropriate. The IP said if prophylactic treatment was appropriate and the resident remained on the antibiotic, that resident should be added to the monthly antibiotic line listing so the resident could be reviewed monthly or quarterly per the Physician's request. The IP said she was unable to find documentation to support that Resident #5 had a history of recurrent UTIs or documentation as to why the prophylactic use of Nitrofurantoin Macrocrystals was started as Resident #5 was not being tracked on the monthly line listing. The IP said she currently was not tracking prophylactic antibiotic use in the facility, should be tracking this information, but she believed Resident #5 was the only Resident on prophylactic treatment.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure one Resident (#5), of five applicable residents reviewed for immunizations, out of a total sample of 26 residents, was offered to receive or decline the COVID-19 vaccine. Specifically, for Resident #5, the facility failed to offer and provide the COVID-19 vaccine when he/she was not up to date with the COVID-19 vaccination. Findings include: Review of the CDC website (Adult Immunization Schedule Notes | Vaccines & Immunizations | CDC), titled Adult Immunization Schedule, dated 7/2/25, indicated the following relative to COVID-19 vaccination for persons greater than [AGE] years of age: -2 or more doses of 2024-2025 vaccine. -those previously vaccinated before the 2024-2025 vaccine:ˆfollow recommendations above for previously vaccinated persons ages 19-64 yearsˆand administer dose 2 of 2024-2025 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months) ˆ Resident #5 was admitted to the facility in January 2025 and was over the age of 65.ˆ ˆ Review of Resident #5's clinical record indicated the following: -Minimum Data Set (MDS) Assessment, dated 1/21/25, which indicated Covid-19 vaccination status was not up to date.ˆ -Immunization Record which indicated the last Covid-19 vaccine received was in 2021. -Immunization Consent Form was blank with no indication if the Covid-19 vaccine was offered or declined.ˆ -September 2025 Physician's orders that included: May have the Covid-19 vaccine, initiated 1/15/25 ˆ During an interview on 9/9/25 at 11:50 A.M., Nurse #3 said vaccine consents/declinations would be obtained by the Nurse when a resident was admitted to the facility. The surveyor and Nurse #5 reviewed Resident #5's clinical record and Nurse #5 said because the Immunization Consent Form was not completed and consent was not obtained, the Resident would be unable to receive the updated Covid-19 vaccine.ˆˆ ˆ During interviews on 9/9/25 at 12:00 P.M., and 12:18 P.M., the Assistant Director of Nurses (ADON) said consents/declinations for vaccines would be completed by the Nurse at the time of a resident's admission. The ADON said after the Immunization Consent Form was completed, it would be reviewed and if a resident/representative consented to any of the vaccines, the Physician would be notified, and an order would be obtained to administer the vaccine. The ADON said she reviewed the Immunization book for the residents in the facility, and there was no immunization form obtained for Resident #5. The ADON said she would contact the Resident's Representative to inquire about the Covid-19 vaccine and if he/she wanted to have Resident #5 vaccinated.ˆˆ ˆ During a follow-up interview on 9/9/25 at 12:34 P.M., the ADON said she contacted Resident #5's Representative who gave consent for the updated Covid-19 vaccine. The ADON said in reviewing the Resident's clinical record, there was no indication that the Covid-19 vaccine was offered and/or declined previously by the Resident/Resident Representative because the Immunization Consent Form was blank.ˆ