STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225752	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Hill Nursing Center	655 Dedham St Wrentham, MA 02093

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview and document review, the facility failed to maintain kitchen equipment in safe operating condition. Specifically, the facility failed to promptly repair or replace a broken dish machine.Findings include:Review of the facility's policy titled Maintaining Food Service Equipment, last reviewed 1/1/25, indicated but was not limited to:-The facility shall maintain all food preparation, storage, and service equipment in good repair and condition to prevent foodborne illness, ensure resident safety, and comply with federal and state regulatory requirements.-Equipment shall be: -Cleaned and sanitized per manufacturer guidelines -Inspected regularly -Preventatively maintained -Removed from service if unsafePreventative Maintenance-Documentation includes: -Malfunctioning equipment immediately removed from service -Food safety impact assessed -Alternate procedures implemented if necessary -Repair order generated and trackedReview of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 4-5 Maintenance and Operation 4-501 Equipment 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. During breakfast and lunch meals of the entire survey period from 2/25/26 through 3/3/26, residents were observed eating their meals out of aluminum and Styrofoam take-out containers.On 2/25/26 at 9:00 A.M., the surveyor observed the following in the main kitchen:-Dish machine door (clean side) missing a handle. In its place was a piece of metal attached to the door. At the base of the handle a carabiner clip held a thin cable that extended upward, through a pulley and ran along a bracket mounted to the ceiling, ran through another pulley and was attached to a long piece of PVC pipe wrapped in white tape that hung down and served as a weight to open the dish machine door.-Dietary Aide #2 using the dish machine on the rinse cycle and manually pulling out a drain plug to prevent water from spilling onto the floor.During the kitchen walk-through on 2/25/26 at 9:00 A.M. and a subsequent visit to the kitchen at 2:23 P.M., Dietary Aide #1 and Dietary Aide #2 said the dish machine has not worked properly for at least a year. They said the handle to the door on the clean side of the dish washer broke last March and the former Maintenance Director improvised a repair late last summer. Dietary Aide #3 said the dish machine is no longer dispensing sanitizer because the drain mechanism is not functioning to activate the sanitizer. He said the functioning of the machine had been declining for a while before it finally broke a few months ago. He said they use the machine to rinse the cups and flatware, but they have had to serve residents all of their meals in disposable to-go containers.During the Resident Group Interview on 2/26/26 at 11:00 A.M., 8 out of 8 residents said they were told a few months ago that the dishwashing machine is broken and they are waiting for a part to repair it. They said they were told that they will be eating their meals from to-go containers until the machine is fixed.During an interview on 2/26/26 at 7:35 A.M. and 9:35 A.M., the Food Service Manager (FSM) said the handle on the dish machine broke last year and the former Maintenance Director improvised a repair to make the door function, but it has never been properly repaired. She said she has a concern with infection control because she cannot ensure the components the Maintenance Director used to repair the door can be kept clean and sanitized. She said sometime in late December or early January, the dish machine stopped functioning properly and failed to sanitize the dishes. She said they immediately (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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	began serving food to residents in take-out containers. The FSM said she notified the Administrator immediately when the dish machine broke and was told a company was contacted for a repair quote. However, no one has come out to inspect the machine, and it still has not been repaired. She said dish machine water temperatures have been an issue for quite a while and she notified the Administrator of this. She said when someone came out to look at the dish machine's broken door assembly last August, the technician also recommended a hot water booster because the water temperature was low. The FSM said she has kept the Administrator informed of her ongoing concerns through email and verbal communication.During an interview on 2/26/26 at 11:24 A.M., the Administrator said he lost his Maintenance Director a few weeks ago and hired a new Maintenance Director last week. He provided the survey team with information related to the dish machine including contacts for dish machine repair, repair documentation, email communication, invoices and recommendations regarding the dish machine in the main kitchen from May 2025 to February 2026.Review of all documentation provided to survey team by the Administrator and FSM from May 2025 through February 2026 failed to indicate any preventative maintenance records, repair work orders or any evidence that concerns with the facility's dish washing machine were addressed timely. A quote for the door assembly repair and dish machine replacement was provided to the facility on 5/20/25 and 8/1/25. There was no evidence that the dish machine vendor was notified, assessed or repairs made to the dish machine once the Administrator or Maintenance Director were made aware it was not functioning in late December/early January2026.During a telephonic interview on 3/1/26 at 2:55 P.M., Vendor #1 said he does not work for the dish machine company the facility uses, rather he works for the lending company the dish machine vendor uses. He said he has never spoken to the Administrator, and the only communication was via email when he sent financing information and a credit application link to him in August 2025.During a telephonic interview on 3/2/26 at 10:38 AM., the dish machine repair Vendor #2 said last August he inspected the facility's dish machine and found there was a lot wrong with the machine. He said he also identified that the water temperature was not adequate. Vendor #1 said he recommended the facility replace the dish machine and get a hot water booster to ensure adequate temperatures. He said he wrote up and provided the Administrator with a proposal for a new dish machine, a hot water booster and provided contact information for a financing company and has not heard from him since that time.During an interview with the Administrator on 3/2/26 at 10:47 A.M., the Administrator could not explain why there was no preventative maintenance records, no repair work orders, a three month delay in repairing the dish machine door assembly and more than a two month delay in addressing the non-functioning sanitizing cycle of dish machine resulting in residents in the facility eating all of their meals in disposable take-out containers.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure that the resident representative had information in advance to exercise their rights for two Residents (#24 and #30), out of a total sample of 12 residents. Specifically, the facility failed to ensure:1. For Resident #24, a [NAME] Treatment Plan (court approved treatment plan for the administration of antipsychotic medications) was active and current for administration of an antipsychotic medication; and2. For Resident #30, the Health Care Proxy (HCP: health care agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions) was informed in advance and provided information necessary to make healthcare decisions, including the risk and benefits and dose change of psychotropic medications.Findings include:Review of the facility's policy titled Informed Consent, last revised 1/1/20, indicated but was not limited to:-It is the policy of this facility that the resident must be given the opportunity to be given informed consent prior to the administration of psychotropic drugs.-Written verification of the informed consent must be on the resident's chart prior to initiation of any procedures.-An informed consent must be obtained before the order may be carried out by the nursing staff.1. Resident #24 was admitted to the facility in November 2016 with diagnoses including dementia and schizophrenia.Review of the Minimum Data Set (MDS) assessment, dated 1/10/26, indicated Resident #24 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 99. Further review of the MDS indicated Resident #24 had received an antipsychotic medication and had a Guardian (a person who has been appointed by a court or otherwise has the legal authority to care for the personal and property interests of another person who is deemed incapacitated).During a telephonic interview on 2/25/26 at 2:04 P.M., Guardian #1 said Resident #24 was restarted on their antipsychotic medication in 2024. She said Resident #24 did not have a current [NAME] treatment plan. Guardian #1 said they had been after the facility for them to go back to court and put a [NAME] treatment plan in place for Resident #24 since their medication was restarted in 2024, but the facility has not done so.Review of Resident #24's current Physician's Orders indicated but was not limited to:-Risperidone (antipsychotic) Oral Solution 1 milligram (mg)/milliliter (ml), give 1.5 ml by mouth two times a day for Schizophrenia, dated 9/18/24Review of Resident #24's medical record failed to indicate a current [NAME] treatment plan was in place.During an interview on 2/26/26 at 10:41 A.M., the Director of Social Service said Resident #24 had been receiving an antipsychotic medication since 2024 and did not have an active [NAME] treatment plan. She said she had been working with an Attorney's office on Resident #24's [NAME] treatment plan since 2024. She said when she would reach out to the Attorney's office by phone or email and they would not return her calls/emails. She said there were gaps in communication between her to the Attorney and from the Attorney to her and sometimes there would be months before they would get in touch. She provided the surveyor with communication between herself and the Attorney's office. She said she had notified the Administrator about the difficulty in getting information from the Attorney's office. She said there were life events she had that delayed the process. She said there have not been any attempts to transition to another Attorney to move the process along.During a telephonic interview on 2/26/26 at 11:24 A.M., the Paralegal said one set of documents had been provided to the court, but the court lost them. She said the court also had changed the process in how to obtain a [NAME] treatment plan. She said the Attorney had some life events which delayed the process. She said there were delays on both the facility's side and the Attorney's side with the process of obtaining a [NAME] treatment plan for Resident #24.During an interview on 3/3/26 at 6:01 P.M., the Administrator and Director of Nursing (DON) said Resident #24 should have had an active [NAME] treatment plan in place prior to being started on Risperidone.2. Resident #30 was admitted to the facility in February 2020 with diagnoses including dementia and major depressive disorder.Review of (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the MDS assessment, dated 2/21/26, indicated Resident #24 had a moderate cognitive impairment as evidenced by a BIMS score of 11 out of 15. Further review of the MDS indicated Resident #30 was prescribed antipsychotic and antidepressant medication and had an invoked HCP.Review of Resident #30's current Physician's Orders indicated but was not limited to:- Abilify (antipsychotic) 5 mg, give 1 tablet by mouth in the morning, dated 9/05/25 - Trazodone (antidepressant) 50 mg, give 3 tablets (150 mg) in the evening, dated 1/16/26- Venlafaxine extended release (antidepressant) 150 mg cap daily, dated 1/11/26Review of Resident #30's psychotropic consent forms:-Abilify, dated 1/2/26, signed by Resident #30-Trazodone, dated 11/23/25, signed by Resident #30-Venlafaxine, date 1/11/26, signed by Resident #30Review of Resident #30's advanced directives indicated his/her HCP was activated on 1/31/24.Further review of Resident #30's medical record failed to indicate Resident # 30's HCP was notified of the medication changes.During an interview on 3/3/26 at 12:05 P.M., Nurse #2 reviewed Resident #30's Abilify, Trazodone, and Venlafaxine consents and medical record. She said Resident #30's HCP was activated and should have been called to obtain consent for the changes in Resident #30's psychotropic medications. She said she did not see any documentation of Resident #30's HCP being notified about the medication changes.On 3/3/26 at 9:31 A.M., the surveyor called and left a message for Resident #30's HCP, without a return call back.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview, the facility failed to ensure staff provided care and services consistent with accepted standards of clinical practice for four Residents (#2, #4, #8 and #32), out of a total sample of 12 residents. Specifically, the facility failed to ensure:1. For Resident #2,a. care and treatment to the Resident's implanted cardiac pacemaker met professional standards of care;b. a physician's order for the use of an air mattress, including settings, was obtained prior to its use; and 2. For Resident #4, a physician's order for the use of an air mattress, including settings, was obtained prior to its use;3. For Resident #8, a physician's order for the use of an air mattress, including settings, was obtained prior to its use;4. For Resident #32, care and treatment to the Resident's implanted cardiac pacemaker met professional standards of care.Findings include:According to the National Institute of Health, Treatment/Management of permanent pacemakers-Postoperatively, monitor rhythm and device function, obtain interrogation of the device, and restore settings as appropriate. (September 12/2022) Review of the American Heart Association guidance titled Living with Your Pacemaker, dated 10/29/24, indicated but was not limited to: -Pacemakers should be checked every six months or one year to assess the battery and find out how the wires are working. -Pacemaker batteries usually last 10-15 years -Carry a pacemaker identification card signifying: -Type of pacemaker -Type of leads -Manufacturer -Date of Implant -Paced rate -Model -Serial number Review of the facility's policy titled Care of Resident with a Pacemaker, dated revised 9/17/20, indicated but was not limited to: -Purpose of the Procedure: The purpose of this procedure is to provide information about and guidance for the care of a resident with pacemaker. -Monitoring: 3. The pacemaker battery will be monitored remotely through the telephone or an internet connection. The resident's cardiologist will provide instructions on how and when to do this. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Documentation: 1. For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: a. The name, address and telephone number of the cardiologist; b. Type of pacemaker c. Type of leads d. Manufacturer and model; e. Serial number; f. Date of implant; and g. Paced rate. Review of the facility's policy titled Air Mattress, last revised 7/20/20, indicated but was not limited to: -Air mattresses are medical support devices that assist in pressure redistribution and skin integrity preservation. -Their use must be based on individualized resident assessments and integrated into the resident's comprehensive care plan. -Staff must ensure the air mattress is not overly inflated or deflated, which can pose a risk of falls or impaired healing. -Implementation: Nursing staff will ensure the air mattress is in place, properly functioning, and adjusted to the resident's weight and needs. 1. Resident #2 was admitted to the facility in February 2025 with coronary artery disease, heart failure, and a stage three pressure ulcer (a full-thickness loss of skin extends to the subcutaneous tissue but does not cross the fascia beneath it. Slough or eschar may be visible, and the lesion may be foul-smelling) and had a pacemaker. Review of the Minimum Data Set (MDS) assessment, dated 11/21/25, indicated Resident #2 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15, had limitation in range of motion in his/her lower extremities and was at risk for developing pressure ulcers. The MDS failed to indicate Resident #2 had a pacemaker. a. Review of hospital discharge summary documentation, dated 2/5/25, indicated but was not limited to: -X-ray (medical imaging that uses radiation to take pictures of the inside of your body) examination: left-sided dual lead pacemaker is noted; 2 leads appear unremarkable. Monitoring wires present. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Physician's Orders indicated but was not limited to: -Pacemaker (2/12/25) Further review of the medical record failed to indicate any additional information about the pacemaker as well as any care and services required, and no care plan was developed for Resident #2's pacemaker device. b. On 2/25/26 at 2:45 P.M., the surveyor observed Resident #2 lying in bed awake. An air mattress was on the bed and set to 150 pounds (lbs.). On 2/26/26 at 2:30 P.M., the surveyor observed Resident #2 lying in bed awake. An air mattress was on the bed and set to 150 lbs. Review of the medical record failed to indicate an order for an air mattress. Review of the medical record failed to indicate a Physician's order, documentation that the air mattress is in place, properly functioning, and adjusted to the resident's weight and needs or a care plan was developed for the use of an air mattress. During an interview on 2/27/26 at 1:37 P.M., Unit Manager (UM) #1 reviewed Resident #2's medical record and said the Resident is at risk for pressure ulcer development has had an air mattress on his/her bed ever since he/she was admitted in February 2025. She said there was no physician's order for its use and there should be. The UM said she was aware the Resident has a pacemaker but was unable to find any information in the medical record about the device or care and services needed to maintain it. During an interview on 2/27/26 at 2:50 P.M., the Director of Nursing (DON) said she was unable to find any information about Resident #2's pacemaker. During a telephonic interview on 3/4/26 at 12:28 P.M., Physician #1 said he does not remember anything about the Resident's pacemaker, who the cardiologist is, or how the device is being monitored. 2. Resident #4 was admitted to the facility in November 2025 with three unstageable deep tissue pressure injuries (depth of wound is unknown because slough or eschar obscures the extent of tissue damage; this injury occurs with prolonged pressure and shear forces at the bone-muscle interface. The result is intact or non-intact skin with persistent, non-blanched, deep red, maroon, or purple discoloration). Review of the MDS assessment, dated 3/4/25, indicated Resident #4 was cognitively intact as evidenced by a BIMS score of 15 out of 15, and had a pressure reducing device in bed. On 2/25/26 at 8:45 A.M., the surveyor observed Resident #4 sitting upright in bed eating breakfast. An air mattress was on the bed and set to 100 lbs. On 2/25/26 at 2:47 P.M., the surveyor observed Resident #4 lying in bed awake. An air mattress was on the bed and set to 100 lbs. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record indicated the following Physician's Orders: -Air mattress at all times while in bed-check placement and function every shift to promote skin integrity (12/16/25) Review of the care plan indicated, but was not limited to: -Air mattress used to promote skin integrity, check placement and functioning every shift (12/16/25) Further review of the medical record failed to indicate a physician's order with weight settings to ensure it was neither over inflated nor under inflated to preserve the Resident's skin integrity. 3. Resident #8 was admitted to the facility in February 2026 and was admitted with a stage 1 pressure area (the skin is intact with non-blanchable superficial reddening of the skin). Review of the MDS assessment, dated 2/9/26, indicated Resident #2 had severe cognitive impairment as evidenced by a BIMS score of 99 (unable to complete interview), was dependent of staff for all activities of daily living and was at risk for developing pressure ulcers. On 2/25/26 at 11:50 A.M., the surveyor observed Resident #8 lying in bed awake. An air mattress was on the bed and set to 240 lbs. On 2/26/26 at 1:10 P.M., the surveyor observed Resident #8 lying in bed awake with bilateral side rails up and in use. An air mattress was on the bed and set to 240 lbs. On 2/27/26 at 9:04 A.M., the surveyor observed Resident #8 in sitting upright in bed being fed by a Certified Nursing Assistant (CNA). An air mattress was on the bed and set to 240 lbs. Review of the medical record failed to indicate a physician's order, documentation that the air mattress is in place, properly functioning, and adjusted to the resident's weight and needs or a care plan was developed for the use of an air mattress. Review of the Hospice provider's documentation (Hospice binder) indicated a note written by Hospice Nurse #1 indicating she ordered a low air loss mattress for the Resident's bed on 2/15/26. During a telephonic interview on 2/27/26 at 12:54 P.M., Hospice Nurse #1 said she has seen Resident #8 twice since he/she had been admitted to the facility: 2/3/26 the day he/she was admitted and 2/25/26. She said while visiting Resident #8 on 2/15/26, she ordered an air mattress for his/her bed because he/she was using a standard mattress and had developed a skin injury. She said the air mattress was delivered right away and placed on the Resident's bed while she was with the Resident on 2/15/26. During an interview on 3/3/26 at 3:00 P.M., the DON said every resident that has an air mattress needs physician's orders with settings according to their weight. She said air mattresses are to be checked by nursing for functioning and accuracy of settings and documented in each resident's medical record. She said she did not know why Residents #2, #4 and #8 do not have physician's orders/physician's orders with settings for their air mattresses, but they should have them. 4. Resident #32 was admitted to the facility in February 2026 with diagnoses including orthostatic (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hypotension (a sudden, significant drop in blood pressure) and hypertension (high blood pressure). Review of the MDS assessment, dated 2/8/26, indicated Resident #32 had intact cognition as evidenced by a score of 14 out of 15 on the BIMS. Further review of MDS, Section I diagnosis, did not indicate presence of a cardiac pacemaker (diagnosis code Z95.0). During an interview on 2/25/26 at 3:55 P.M., Resident #32 said he/she had a pacemaker. Resident #32 said he/she had fallen a lot because his/her blood pressure would go low. Review of Resident #32's hospital discharge paperwork indicated but was not limited to: -He/she had a history of orthostatic hypotension and bifascicular block (a heart conduction disorder where two of the three main electrical pathways below the atrioventricular (AV) node are blocked) status post pacemaker in 1/24. In terms of his/her bifasicular block, cardiology was consulted on last admission due to concerns for repeat falls and syncope. His/her device was reprogrammed/increased by [company name] to 60 beats per minute (BPM). Review of Resident #32's medical record failed to indicate he/she had an implanted pacemaker. During an interview on 2/27/26 at 3:00 P.M., Nurse #1 said she did not know that Resident #32 had a pacemaker. During an interview on 2/27/26 at 3:04 P.M., Unit Manager (UM) #1 said the admitting nurse would identify on admission if a resident had a pacemaker and then notify the physician and obtain orders for care and management of the device. UM #1 said Resident #32's pacemaker was omitted from the admission orders. During an interview on 2/27/26 at 3:09 P.M., the DON said the pacemaker was missed. It should have been identified on admission that Resident #32 had a pacemaker and orders for care should have been obtained along with information about the pacemaker.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations and interviews, the facility failed to maintain an environment free of accident hazards. Specifically, the facility failed to ensure a resident care area was free from a portable radiator (space heater), a burn/fire hazard risk.Findings include:On 2/25/26 at 10:32 A.M., the surveyor observed a black portable radiator, plugged in, on, and hot to touch in Resident #7, #24, and #34's room. During an interview at this time, Resident #34 said he/she did not know where the portable radiator came from, but he/she liked having it in their room because they liked their room hot.On 2/25/26 at 1:08 P.M., the surveyor observed a black portable radiator, plugged in, on, and hot to touch in Resident #7, #24, and #34's room.On 2/25/26 at 4:09 P.M., the surveyor observed Resident #7, #24, and #34 in their room with the portable radiator plugged in, on, and hot to touch.On 2/26/26 at 9:04 A.M., the surveyor observed Resident #7 and #34 in their room, the portable radiator was plugged in, on, and hot to touch. During an interview at this time, Resident #7 said he/she did not know where the portable radiator had come from but an employee from the facility put it in their room the other day because it was cold in their room.During an interview with observation on 2/26/26 at 9:13 A.M., Certified Nursing Assistant (CNA) #1 observed the portable radiator plugged in and said she was not sure when the portable space heater had been placed in Resident #7, #24, and #34's room. She said the Residents would always complain it's cold in their room, though she personally thought it was warm in there. She said she was not sure if the portable radiator should be in their room; she had never seen one anywhere she had worked before.During an interview with observation on 2/26/26 at 9:18 A.M., Nurse #1 observed the portable radiator plugged in and on. She said the previous Maintenance Director had placed it in Resident #7, #24, and #34's room because they would complain it was cold in their room. She placed her hand on top of the portable radiator and pulled it back quickly. She said it was warm and she would not want to keep her hand on it long.During an interview with observation on 2/26/26 at 9:29 A.M., the Maintenance Director said he had just started working at the facility about a week ago and was not sure if portable radiators were allowed in resident care areas. He said prior to bringing in new electrical equipment it should been checked to ensure there were no loose wires, it was grounded (provides a path for excess electricity to escape in case of a fault, preventing potential electric shock), turn off if it was knocked over, and in safe operational order. He said he did not see any evidence on the portable radiator that it was checked to ensure it functioned properly. He placed his hand on the portable radiator and said it was hot to touch.During an interview with observation on 2/26/26 at 9:33 A.M., the Director of Nursing (DON) observed the portable radiator. She said the portable radiator was placed in Resident #7, #24, and #34's room when it was bitterly cold and the temperature outside was 0 degrees Fahrenheit (F) and Resident #7's family member demanded a portable radiator be placed in their room. She said she believed the previous Maintenance Director inspected the portable radiator but was not sure.During an interview on 2/26/26 at 2:58 P.M., the Administrator said it was against the facility's policy to have portable radiators in resident care areas because they were fire hazards. He said he was aware Residents #7, #24, and #34 had a portable radiator in their room, but Resident #7's family member insisted on it. He said the previous Maintenance Director brought up the portable radiator and he was under the impression the portable radiator had been inspected prior to being placed in Resident #7, #24, and #34's room. He said the portable radiator should have been marked with a label indicating it had been inspected and safe to use but it was not.

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	225752	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Hill Nursing Center	655 Dedham St Wrentham, MA 02093

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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 employee record review and interview, the facility failed to complete performance reviews of Certified Nursing Assistants (CNAs) at least once every 12 months and provide regular in-service education based on the outcome of these reviews for five out of five CNAs' (#1, #2, #3, #4, #5) employee records reviewed. Findings include:Review of the facility's policy titled Nurse Aide In-Service Training, revised 9/17/20, indicated but was not limited to:-The facility will complete a performance review of nurse aides at least every 12 months.-In-service training will be based on the outcome of the annual performance reviews, addressing weaknesses identified in the reviews. Review of the Facility Assessment, last reviewed 10/22/25, indicated but was not limited to:-Each clinical staff member is provided with an annual performance review and if education is needed to enhance performance in a certain area, then targeted educational in-services are provided. Review of the following five CNAs' personnel files, who had been employed by the facility for over 12 months, failed to indicate a performance evaluation was completed in 2025:-CNA #1, date of hire 11/23/22-CNA #2, date of hire 9/15/14-CNA #3, date of hire 7/22/21-CNA #4, date of hire 6/8/22-CNA #5, date of hire 9/4/19 During an interview on 3/2/26 at 1:10 P.M., the Director of Nursing (DON) said she was behind on her annual reviews and had not completed them for the last year. She said in-services were not based off annual performance reviews but off if she saw something. She said in-servicing should be based on annual performance reviews.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, records reviewed, and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment. Specifically, the facility failed to:1. Maintain an accurate surveillance system that reflected potential illnesses and infections in the facility; and2. Ensure resident hand hygiene was implemented during meal service.Findings include:1a. Review of the revised 2024 McGeer criteria indicated but was not limited to the following: Syndrome: Cellulitis, soft tissue, or wound infection Must fulfill at least 1 criterion: Pus at wound, skin, or soft tissue At least four of the following new or increasing signs or symptoms -Heat -Redness (erythema) at affected site -Swelling at affected site -Tenderness or pain at affected site -Serous drainage at the affected site At least one of the following: -Fever -Leukocytosis -Acute changed mental status -Acute functional decline Review of the facility's monthly surveillance line listings for January 2026 indicated but was not limited to the following: Resident #30: Category: Right Lower Extremity Cellulitis; Date of Onset: 1/5/26; Symptoms Red/Warm; Site: Right Lower Foot; Final Status: Healthcare Acquired Infection (HAI); Counted: Yes Review of Resident #30's Medical Record indicated but was not limited to the following: -1/3/26 7:52 P.M., Nurse's Note Right leg red, swollen, and hot when ace wrap removed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/5/26 6:13 P.M., Nurse's Note Right leg red, swollen, and warm to touch. The January surveillance line listing did not have enough symptoms documented to indicate any McGeer infection for skin had been met in accordance with the facility pre-defined criteria and, therefore, should not have been counted as an HAI infection within the facility. b. Review of the revised 2024 McGeer criteria indicated but was not limited to the following: Respiratory Tract Infection Syndrome: Bronchitis or Tracheobronchitis Must fill 1, 2, and 3 1. Chest X-ray not performed, or negative for pneumonia or a new infiltrate 2. At least two of the following criteria: -New or increased cough -New or increased sputum production -Oxygen saturation level less than 94% on room air, or greater than a 3% decrease from baseline Oxygen saturation level -New or changed lung exam abnormalities -Pleuritic (inflammation of the lung lining (pleura), causing sharp chest pain, particularly when breathing or coughing) chest pain -Respiratory rate greater than 25 breaths a minute Review of the facility's monthly surveillance line listings for February 2026 indicated but was not limited to the following: Resident #1: Category: Congested Cough; Date of Onset: left blank; Symptoms: Congested cough/Wheeze; Result: negative chest x-ray; Final Status: left blank; Counted: left blank Review of Resident #1's Medical Record indicated but was not limited to the following: -12/19/25 1:17 P.M., Nurse's Note Resident #1 has been experiencing cold symptoms for 4 days, repeat 4-plex swab (a nasal swab test to simultaneously detects and differentiates for different types of respiratory viruses COVID-19, influenza A and D and Respiratory Syncytial Virus) and chest x-ray ordered this shift. No complaints of pain or discomfort. Vital signs stable. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12/20/25 6:50 P.M., Nurse's Note Increased coughing, complaining of chest hurting from cough, Oxygen Saturation level 87% to 89% room air. This evening Oxygen Saturation level 85% on room air after nebulizer treatment, oxygen applied Oxygen Saturation 92% on 2 Liters of Oxygen via nasal cannula. The December surveillance line listing did not have enough symptoms documented to indicate any McGeer infection for a respiratory tract infection had been met in accordance with the facility pre-defined criteria. During an interview on 3/3/26 at 2:14 P.M., the Director of Nursing (DON)/Infection Preventionist (IP) said the Infection Surveillance Logs were used to track potential infections in the facility. She said the facility used McGeer criteria to define infections. The infection DON and the surveyor reviewed the December 2025 and January 2026 surveillance line listings. She said her expectation was for them to be complete, fully, accurately, and to meet McGeer criteria, but they did not. 2. Review of the facility's policy titled Dining Services, last revised 1/1/20, indicated but was not limited to the following: -[Facility name] shall provide dining and nutrition services that promote resident health, safety, dignity, independence, and quality of life in accordance with Centers for Medicare and Medicaid Services (CMS) Requirements of Participation. -Purpose: To ensure safe food handling practices -Food Safety and Sanitation: The facility shall ensure hand hygiene compliance On 2/26/26 from 12:00 P.M. to 12:20 P.M, the surveyor observed staff serving meals to 24 residents in the main dining room with no hand hygiene offered to residents prior to meal delivery or between residents. On 2/27/26 from 8:30 A.M. to 8:46 A.M., the surveyor observed staff serving meals to 21 residents in the main dining room with no hand hygiene offered to residents prior to meal service and no staff performed hand hygiene between passing trays to residents. On 2/27/26 from 12:04 P.M. to 12:25 P.M., the surveyor observed staff serving meals to 22 residents in the main dining room with no hand hygiene offered to residents prior to meal service and no staff performed hand hygiene between passing trays to residents. On 3/2/26 at 8:31 A.M., the surveyor observed staff serving meals to 24 residents in the main dining room with no hand hygiene offered to residents prior to meal service and no staff performed hand hygiene between passing trays to residents. On 3/2/26 at 12:08 P.M. to 12:36 P.M., the surveyor observed staff serving meals to 22 residents in the main dining room with no hand hygiene offered to residents prior to meal service and no staff performed hand hygiene between passing trays to residents. On 3/3/26 from 12:10 P.M. to 12:15 P.M., the surveyor observed staff serving meals to 27 residents in the main dining room with no hand hygiene offered to residents prior to meal service and no staff (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	performed hand hygiene between passing trays to residents. During an interview on 3/3/26 at 3:00 P.M., the DON said staff must sanitize their hands and the residents' hands prior to meals. During an interview with Unit Manager #1, Nurse #3 and Nurse #4 on 3/3/26 at 2:30 P.M., they said they did not know that residents should be offered/provided hand hygiene prior to meals. During an interview on 3/3/26 at 3:00 P.M., the DON said she was not aware that staff were not assisting residents with hand hygiene prior to eating meals and it should be done for infection control.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement an antibiotic stewardship program which included antibiotic use protocols and monitoring of antibiotic use in accordance with the facility's antibiotic stewardship program. Findings include:Review of the Centers for Disease Control and Prevention (CDC) guidance titled The Core Elements of Antibiotic Stewardship for Nursing Homes, undated, indicated but was not limited to the following:- The purpose of an antibiotic stewardship program is to improve the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance.- Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.- The CDC recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use.- Any action taken to improve antibiotic use is expected to reduce adverse events, prevent emergence of resistance, and lead to better outcomes for residents in this setting. Review of the facility's policy for Antibiotic Stewardship, revised 9/17/2020, indicated but was not limited to:-Antibiotics will be prescribed and administered to residents under the guidance of the Facility's Antibiotic Stewardship Program.-Orientation, training, and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and overall community.-If an antibiotic is prescribed, prescribers will provide complete antibiotic orders, including the following elements: -Drug name; -Dose; -Frequency of administration; -Duration of treatment; -Root of administration; and -Indication for use.-When antibiotics are prescribed over the phone, the primary care practitioner will assess the resident within 72 hours of the telephone order. Review of the facility's policy for Antibiotic Stewardship-Orders for Antibiotics, revised 9/17/2020, indicated but was not limited to:-Appropriate indications for use of antibiotics include: -Criteria met for clinical definition of active infection or suspected sepsis; and -Pathogen susceptibility, based on culture and sensitivity, to antimicrobial or therapy begun. Wall culture is pending. Review of the facility's policy for Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes, revised 9/17/2020, indicated but was not limited to:-Antibiotic usage and outcome data will be collected and documented using a facility approved antibiotic surveillance tracking log. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility wide antibiotic stewardship.-As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist, or designee.-At the conclusion of their review, the provider will be notified of the review findings.All resident antibiotic regimens will be documented on the facility-approved Antibiotic Surveillance Tracking Log. The information gathered will include: -Resident name; -Date symptoms appeared; -Name of Antibiotic; -Site of infection -Date of culture; -Stop date; and -Outcomes 1. Review of Resident #25's October 2025 Physician's Orders indicated but was not limited to:-Ciprofloxacin (antibiotic) 500 milligrams (mg), give one tablet once daily seven days, dated 10/7/25 Further review of Resident #25's medical record failed to indicate:-signs and symptoms for antibiotic use;-laboratory results;-primary care physician's documentation; or-nursing documentation from 10/4/25 to 10/9/25. Review of Resident #25's Nurse's Note, dated 10/9/25, indicated but was not limited to:-Continues on antibiotics for Urinary Tract Infection, no dysuria (pain, burning, or discomfort during urination), no hematuria (blood in the urine), no ill effects from antibiotic treatment. Review of Resident #25's October 2025 Medication Administration Record (MAR) indicated he/she received seven doses of Ciprofloxacin as ordered. Review of the facility's October 2025 Infection Tracking Log sheet failed to indicate Resident #25 had received an antibiotic. During an interview on 3/3/26 at 2:14 P.M., the Infection Preventionist (IP)/Director of Nursing (DON) said orders for antibiotic therapy are discussed daily during morning meeting. She said when a resident had a new order for an antibiotic their medical record should (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contain documentation including a diagnosis, signs and symptoms, a progress note associated with the physician's order and indication and should be tracked on the monthly Infection Tracking Log. She reviewed the October 2025 Infection Tracking Log and reviewed Resident #25's medical record. She said there was no documentation in Resident #25's medical record indicating why he/she was started on an antibiotic or any documented symptoms of infection. The IP/DON said Resident #25's antibiotic was not tracked or monitored by the facility on the facility-approved Antibiotic Surveillance Tracking Log. 2. Review of the revised 2024 McGeer criteria indicated but was not limited to the following:-Syndrome: Cellulitis, soft tissue, or wound infection-Must fulfill at least 1 criterion: -Pus at wound, skin, or soft tissue-At least four of the following new or increasing signs or symptoms -Heat -Redness (erythema) at affected site -Swelling at affected site -Tenderness or pain at affected site -Serous drainage at the affected site-At least one of the following: -Fever -Leukocytosis -Acute changed mental status -Acute functional decline Review of the facility's January 2026 surveillance sheet indicated but was not limited to:January 2026:-Resident- Resident #30-Date of onset: 1/5/26-Symptoms: Red and warm-Site: Right Lower Foot-Treatment: Keflex (antibiotic) 1/5/26 to 1/12/26-Category: Healthcare Associated Infection-Counted: Yes Review of Resident #30's January Physician's Orders indicated but was not limited to:-Keflex 500 mg tab twice daily for seven days, dated 1/5/26. Further review of Resident #30's medical record indicated but was not limited to:-1/3/26 Nurse's Note- Right leg red, swollen, and hot when ace wrap (elastic [NAME] used for compression and support) removed.-1/5/26 Nurse's Note- Right leg red, swollen, and warm. Review of concerns failed to indicate Resident #30's symptoms, with an onset date of 1/5/26, met McGeer criteria for infection however an antibiotic was prescribed and administered twice daily for seven days (for total of 14 doses). During an interview on 3/3/26 at 2:14 P.M., the IP/DON reviewed Resident #30's symptoms and the McGeer criteria for a skin infection and said Resident #30's signs and symptoms did not meet McGeer criteria for a skin infection. She said the expectation was for prescribed antibiotics to meet McGeer criteria.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on record review and interview, the facility failed to provide education and/or offer the COVID-19 vaccination as required or appropriate per the Centers for Disease Control and Prevention (CDC) recommendations for five of five employee records reviewed for immunizations.Findings include:Review of the Centers for Disease Control (CDC) COVID-19 Vaccination for Long-term Care Residents, dated 6/11/25, indicated but was not limited to:-Vaccine recommendations: -CDC recommends an updated COVID-19 vaccine for most adults ages 18 years and older, including people who live and work in long-term care (LTC) settings, get 1 dose of an updated COVID-19 vaccine. -CDC recommends everyone ages 65 years and older, including people who live and work in LTC settings, get 2 doses of an updated COVID-19 vaccine 6 months apart.Review of the facility's policy titled COVID-19 Personnel vaccination requirement, dated as revised 10/1/25, indicated but was not limited to the following: -To reduce the risk of COVID-19 transmission within the facility and protect residents, staff, and visitors through vaccination promotion, documentation, infection control practices, and compliance with federal regulatory requirements.-Education: -The facility will provide staff with education consistent with CDC guidance. -Documentation of education will be maintained.-Documentation Requirements: -The facility will maintain confidential documentation of vaccination status, dates of doses, booster status, and declination if applicable. -Records will be maintained in employee health files in accordance with confidential standards.Review of Certified Nursing Assistants (CNA) #6, #7, #8, Nurse #5, and Maintenance Director's employee files and employee health records failed to indicate the facility assessed and offered the COVID-19 vaccine, provided them with education, and had proof the vaccination was offered and either accepted or declined.During an interview on 2/26/26 at 2:29 P.M., the Director of Nursing said she was responsible for maintaining employee records and providing education to staff members about vaccinations and offering vaccinations. She reviewed CNAs #6, #7, #8, Nurse #5, and Maintenance Director's employee files and employee health records. She said all five of the employees' health records or personnel records did not have any documentation of being provided education or offered the COVID-19 vaccine, and whether they had declined or accepted it. She said she did offer and provide education to all employees about the COVID-19 vaccine annually and on orientation, but the facility did not have a form for consent or declination for staff to sign.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, record review, and interview, the facility failed to complete a new assessment of the bed, side rails and mattresses in active use for potential entrapment when the bed mattress was changed from the previously assessed mattress, placing two Residents (#2 and #8), out of a sample of 12 residents, who had limited mobility and utilized bilateral side rails, at risk for possible entrapment. Findings include:Review of the facility's policy titled Proper Use of Siderails, revised 2/1/2018, indicated but was not limited to the following:- Manufacturer instructions for the operation of side rails will be adhered to.- When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of space may vary, depending on the type of bed and mattress being used).Review of the Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 03/10/2006, indicated the following: The term entrapment describes an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Resident entrapments may result in deaths and serious injuries. There are seven zones of bed entrapment: Zone One (within the rail), Zone Two (under the rail), Zone Three (between rail and mattress), Zone Four (Under the rail, at the ends of the rail), Zone Five (between split bed rails), Zone Six (between the End of the Rail and the Side Edge of the Head or Foot Board) and Zone Seven (Between the Head or Foot Board and the Mattress End). The hospital bed dimensional limit recommendations are as follows:-Zone One: 4.75 inches-Zone Two: 4.75 inches-Zone Three: 4.75 inches-Zone Four: 2.375 inches and 60-degree angle Review of the facility's policy titled Air Mattress, last revised 7/20/20, indicated but was not limited to:-Air mattresses are medical support devices that assist in pressure redistribution and skin integrity preservation.-Implementation: Ensure that the resident's bed frame and mattress are compatible and meet fire safety and electrical requirements. 1. Resident #2 was admitted to the facility in February 2025 with a stage three pressure ulcer (a full-thickness loss of skin extends to the subcutaneous tissue but does not cross the fascia beneath it. Slough or eschar may be visible, and the lesion may be foul-smelling).Review of the Minimum Data Set (MDS) assessment, dated 11/21/25, indicated Resident #2 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15, had limitation in range of motion in his/her lower extremities and was at risk for developing pressure ulcers.On 2/25/26 at 2:45 P.M., the surveyor observed Resident #2 lying in bed awake with bilateral side rails up and in use. An air mattress was on the bed and set to 150 pounds (lbs.). On 2/26/26 at 2:30 P.M., the surveyor observed Resident #2 lying in bed awake with bilateral side rails up and in use. An air mattress was on the bed and set to 150 lbs.Review of the medical record failed to indicate an order for bilateral side rails or an air mattress.During an interview on 2/27/26 at 1:37 P.M., Unit Manager #1 said Resident #2 is at risk for pressure ulcer development and the Resident has had an air mattress on his/her bed ever since he/she was admitted in February 2025.Review of the facility's Bed Safety Check documentation indicated the Administrator checked Resident #2's bed for safety on 2/12/25. The document indicated Resident #2 had 2 half side rails to his/her bed and had a standard mattress and not an air mattress.2. Resident #8 was admitted to the facility in February 2026 and was admitted with a stage 1 pressure area (the skin is intact with non-blanchable superficial reddening of the skin). Review of the MDS assessment, dated 2/9/26, indicated Resident #2 had severe cognitive impairment as evidenced by a BIMS score of 99 (unable to complete interview), was dependent of staff for all activities of daily living and was at risk for developing pressure ulcers.On 2/25/26 at 11:50 A.M., the surveyor observed Resident #8 lying in bed awake with bilateral side rails up and in use. An air mattress was on the bed and set to 240 lbs.On 2/26/26 at 1:10 P.M., the surveyor observed Resident #8 lying in bed awake with bilateral side rails up and in use. An air mattress was on the bed and set to 240 lbs.On 2/27/26 at 9:04 A.M., the surveyor observed Resident #8 sitting upright in bed being fed by a Certified Nursing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225752	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Hill Nursing Center	655 Dedham St Wrentham, MA 02093

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

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistant (CNA). Bilateral side rails up and in use and an air mattress was on the bed and set to 240 lbs.Review of the medical record indicated the following Physician's order:-May use bilateral side rails for turning and repositioning (2/3/26)Review of the medical record indicated a Hospice Nurse ordered a low air loss mattress for the Resident's bed on 2/15/26.During a telephonic interview on 2/27/26 12:54 P.M., Hospice Nurse #1 said she has seen Resident #8 twice since he/she had been admitted to the facility: 2/3/26 the day he/she was admitted and 2/25/26. She said while visiting Resident #8 on 2/15/26, she ordered an air mattress for his/her bed because he/she was using a standard mattress and had developed a skin injury. She said the air mattress was delivered right away and placed on the Resident's bed while she was with the Resident on 2/15/26. Review of the facility's Bed Safety Check documentation indicated the Administrator checked Resident #2's bed for safety on 2/2/26 (one day prior to the Resident's admission). The document indicated that Resident #8's mattress was an air mattress and not a standard mattress as indicated by Hospice Nurse #1.During an interview on 3/3/26 at 3:36 P.M., the Administrator said he conducted side rail bed safety checks for Residents #2 and #8. He said he's not sure what happened and that the bed safety checks were inaccurate. He said mattresses and bedframes should have been assessed when the air mattresses were applied to the beds.

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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 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on document review and interview, the facility failed to develop and implement their facility assessment (a document assessing the capability of the facility and its resources to provide both emergency and day-to-day care of the population the facility currently serves). Specifically, the facility failed to ensure active involvement of all required members when conducting the facility assessment.Findings include:Review of the Centers for Medicare and Medicaid Services (CMS) guidance, dated 6/18/24, indicated but was not limited to the following:-In conducting the facility assessment, the facility must ensure active involvement of the following participants in the process:a. Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; andb. Direct care staff, including but not limited to, Registered Nurses, Licensed Practical Nurses/Licensed Vocational Nurses, Nursing Assistants, and representatives of the direct care staff, if applicablec. The facility must also solicit and consider input received from residents, resident representatives, and family members. Review of the Facility Assessment, last reviewed 10/22/25, indicated but was not limited to:-Names/Titles of individuals involved in completing the assessment: Administrator, Director of Nursing, Medical Director, Social Service Director, Maintenance Director, and Business Office Manager. The Facility Assessment failed to solicit input from direct care staff or residents, resident representatives, or family members. During an interview on 3/3/26 at 5:08 P.M., the Administrator said only himself, the Director of Nursing, Medical Director, Social Service Director, Maintenance Director, and Business Office Manager were involved in completing the facility assessment which was last updated 8/12/25 and last reviewed 10/22/25. He said no one else was involved in updating the facility assessment including the Governing Body.

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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 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on records reviewed and interviews, the facility failed to ensure Comprehensive Care Plans were reviewed and revised by the interdisciplinary team (IDT) after each assessment, including both the comprehensive and quarterly review assessments, for three Residents (#2, #4, and #16), out of a sample of 12 residents.Findings include:Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, dated as last revised 9/16/2020, indicated but was not limited to:-The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.-The IDT includes: -The Attending Physician; -A registered nurse (RN) who has responsibility for the resident; -A nurse aide who has responsibility for the resident; -A member of the food and nutrition services staff; -The resident and the resident's legal representative (to the extent practicable); and -Other appropriate staff or professionals as determined by the resident's needs or as requested by the resident.-The IDT must review and update the care plan: -When there has been a significant change in the resident's condition; -When a desired outcome is not met; -When a resident has been readmitted to the facility; and -At least quarterly, in conjunction with the required quarterly MDS. 1. Resident #2 was admitted to the facility in February 2025 with coronary artery disease, heart failure, and a stage three pressure ulcer (a full-thickness loss of skin extends to the subcutaneous tissue but does not cross the fascia beneath it. Slough or eschar may be visible, and the lesion may be foul-smelling) and had a pacemaker.Review of the Minimum Data Set (MDS) assessment, dated 11/21/25, indicated Resident #2 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15, had limitation in range of motion in his/her lower extremities and was at risk for developing pressure ulcers.Review of Resident #2's MDS Schedule indicated that MDS assessments had been completed with an Assessment Reference Dates (ARD) of 5/21/25 (quarterly), 8/21/25 (re-admission), 11/21/25 (quarterly).Review of Care Plan Conference documentation indicated the following:-5/29/25 Attendees: Registered Dietitian (RD), Licensed Practical Nurse (LPN). No other IDT members attended or otherwise participated in the comprehensive care plan review as required.-9/18/25 Attendees: RD, Activity Director. No other IDT members attended or otherwise participated in the comprehensive care plan review as required.-12/1/25 Attendees: RD, Activity Director. No other IDT members attended or otherwise participated in the comprehensive care plan review as required.2. Resident #4 was admitted to the facility in November 2025 with three unstageable deep tissue pressure injuries (depth of wound is unknown because slough or eschar obscures the extent of tissue damage; this injury occurs with prolonged pressure and shear forces at the bone-muscle interface. The result is intact or non-intact skin with persistent, non-blanched, deep red, maroon, or purple discoloration). Review of the MDS assessment, dated 3/4/25, indicated Resident #4 was cognitively intact as evidenced by a BIMS score of 15 out of 15, and had a pressure reducing device in bed.Review of Care Plan Conference documentation indicated the following:-3/2/26 Attendees: RD, Social Worker. No other IDT members attended or otherwise participated in the comprehensive care plan review as required.3. Resident #16 was admitted to the facility in October 2024 and had diagnoses including Alzheimer's disease, anxiety, and depression.Review of Resident #16's MDS Schedule indicated that MDS assessments had been completed with an ARD of 7/17/25 (quarterly), 10/15/25, and 1/15/26.Review of Care Plan Conference documentation indicated the following:-No evidence that a Care Plan Conference was held in conjunction with the 7/17/25 quarterly MDS assessment.-10/20/25 Attendees: RD, Activity Director, Social Worker and Resident #16's Health Care Proxy (health care agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions). No other IDT members attended or otherwise participated in the comprehensive care plan review as (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	required.-1/20/26 Attendees: RD, Activity Director. No other IDT members attended or otherwise participated in the comprehensive care plan review as required.During an interview on 3/3/26 at 11:20 A.M., the Director of Social Services (DSS) said she is responsible for coordinating care plan meetings. She said she is usually the only one in attendance and sometimes the RD or Activity Director will participate. She said she is not good about doing the meetings and making sure the required staff participate and she needs to get better at that.During an interview on 3/3/26 at 3:00 P.M., the Director of Nursing (DON) said the DSS sets up care plan meetings, and the IDT should be reviewing and revising each resident's care plan after each MDS assessment. She said she was not aware the care plan conferences were not being conducted with the required attendees.