STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225757	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Valley Health & Rehabilitation	573 Granby Rd South Hadley, MA 01075

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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** 3. Resident #68 was admitted to the facility in April 2025 with diagnoses including Stage 4 Pressure Ulcer of the sacral region, open wound of the front wall of the thorax, open wound of left lower leg, open wound of the left thigh, Unstagable Pressure Ulcer of the left heel, Diabetes and Peripheral Vascular Disease (PVD). Review of the Skin Assessment, dated 4/28/25, indicated Resident #68 had the following skin concern areas: -chest surgical incision -pressure ulcer to the coccyx (tail bone) -cluster of blisters to the right rear thigh -vascular area to the outer left ankle -two vascular areas to the left heel -vascular area to the left lateral (outer side) lower extremity -vascular scabs to the left toes -vascular area to left lateral lower extremity below the knee Review of the May 2025 Physician's orders indicated Resident #68 had treatment orders for the following areas initiated on 4/29/25: -coccyx -left Achilles (tendon that connects calf muscles to the heel bone) and left toes -left medial (towards the middle) foot -left lower extremity -left lateral malleolus (outer side of the ankle) (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-left Achilles -left lateral foot -sternoclavicular area (area between collar bone and breast bone) Review of the MDS Assessment, dated 5/4/25, indicated Resident #68: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15. -has two Stage 3 Pressure Ulcers and one Stage 4 Pressure Ulcer which was present on admission. -had no other wound or skin problems including surgical wounds or arterial and vascular wounds noted under Section M (Skin Conditions). Review of the Skin Care Plan, initiated 4/29/25, indicated Resident #68: -has Stage 4 Pressure Ulcer on his/her sacrum (a triangular bone in the lower back) -has a left heel wound -has left lower extremity wounds -has a front wall chest wound On 5/21/25 at 8:32 A.M., the surveyor observed Resident #68 dressed, seated at the edge of the bed and eating breakfast, with a dressing observed on the Resident's upper chest. During an interview at the time, Resident #68 said he/she had a chest wound. During an interview on 5/23/25 at 8:34 A.M., Unit Manager (UM) #1 said Resident #68 had a Pressure Ulcer, diabetic ulcers, vascular ulcers, and a surgical area which had been present since admission. During an interview on 5/23/25 at 8:35 A.M., MDS Nurse #2 said the MDS assessment dated [DATE], was not accurate and did not include the Resident's surgical wound, diabetic wound, or vascular wounds. 4. Resident #90 was admitted to the facility in October 2022 with diagnoses including chronic pain, abnormal posture, and low back pain. Review of the MDS Assessment, dated 4/10/25, indicted Resident #90: -had clear speech, was understood and understands others. -was cognitively intact as evidenced by a BIMS score of 13 out of 15. -was on scheduled and as needed (PRN) pain medication. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Section J of the MDS Assessment indicated Resident #90 should be assessed for pain. Further review of Section J indicated the pain assessment was not completed (not assessed or dashed) and that the staff assessment was also not completed (not assessed or dashed). During an interview on 5/27/25 at 12:59 P.M., MDS Nurse #1 said the Pain assessment was not completed for the MDS assessment dated [DATE] because the assessment was not completed within the required timeframe. MDS Nurse #1 said the MDS Nurse would complete the pain assessment under Section J of the MDS Assessment and that this information was important to obtain so that the Resident's MDS assessment was accurate. MDS Nurse #1 further said the information in Section J should be obtained five days up until the assessment reference date of 4/10/25, for Resident #90's MDS Assessment 5. Resident #91 was admitted to the facility in April 2025 with diagnoses including malignant neoplasm of the tongue, other lesions of the oral mucosa, and pain related to neoplasm (acute on chronic). Review of the Nursing Assessment, dated 4/23/25, indicated Resident #91: -had an alteration in his/her oral status. -had broken or chipped teeth. -had mouth/facial pain. Review of the MDS Assessment, dated 4/29/25, indicated Resident #91: -was cognitively intact as evidenced by a BIMS score of 15 out of 15. -had no abnormal mouth tissue (ulcers, masses or oral lesions). -had no mouth or facial pain, discomfort or difficulty with chewing. -had no obvious or likely cavity or broken natural teeth. -had difficulty swallowing. Review of the April 2025 Physician's orders indicated the following: -Lidocaine Viscous HCL Mouth/Throat Solution (local anesthetic/numbing medication used for mouth and throat pain), 2%, give 1 application orally every six hours as needed for mouth pain, initiated 4/23/25 -Morphine Sulfate Oral Solution (opioid medication used to treat moderate to severe pain) 20 mg/milliliter (ml), give 5 mg as needed orally every four hours for moderate pain, initiated 4/23/25 -Oxycodone (opioid medication used to treat moderate to severe pain) HCL 5 mg every four hours for severe pain, initiated 4/23/25 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the April 2025 Medication Administration Record indicated the following medications were administered from 4/23/25 to 4/29/25: -Lidocaine Viscous -Morphine Sulfate -Oxycodone HCL Review of the Provider Note, dated 4/26/25, indicated the following: -Resident #91 was evaluated -Continues management with Oxycodone and Morphine for tongue cancer related to pain -Resident has oral pain, cancer of the tongue, dental cavities/cancer related pain On 5/21/25 at 8:22 A.M., the surveyor observed Resident #91 dressed and eating breakfast in his/her room. During an interview at the time, Resident #91 said he/she has oral pain, has medication for his/her oral pain, but was looking to talk to his/her Provider about his/her continued pain. Resident #91 said he/she had numerous infected/broken teeth that needed to be extracted and was working with the facility to make an appointment. During an interview on 5/23/25 at 9:58 A.M., Nurse #1 said Resident #91 had regular complaints of mouth pain and had oral sores due to mouth cancer. During an interview on 5/23/25 at 11:27 A.M., MDS Nurse #2 said she reviewed Resident #91's medical record which indicated he/she did have mouth pain during the assessment period for the MDS assessment dated [DATE]. MDS Nurse #2 further said that the Resident's abnormal mouth tissue, and presence of broken teeth should also have been coded on the 4/29/25 MDS Assessment but were not. 2. Resident #33 was admitted to the facility in September 2021, with diagnoses including Fibromyalgia and chronic pain. Review of Resident #33 most recent Quarterly MDS Assessment, dated 4/16/25, indicated Resident #33: -had clear speech, -was able to make him/herself understood, and was able to understand others. Further review of the Quarterly MDS Assessment failed to indicate documentation that Resident #33 had been interviewed about his/her chronic pain. Review of Resident #33's May 2025 Physician's orders indicated the following: -Pain assessment 0-10 every shift, for pain monitoring, start date of 9/16/21. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Acetaminophen Tablet (analgesic medication) give 500 milligrams (mg) by mouth every six hours as needed for pain .start date of 3/12/24 -Pregabalin (medication used to treat nerve and muscle pain) Oral Capsule 100 mg, give one capsule by mouth two times a day related to Fibromyalgia, start date of 1/16/25. Review of Resident #33's April 2025 Medication Administration Record (MAR) indicated the following: -Resident #33 was administered Pregabalin daily as ordered. Review of Resident #33's Care Plan titled Resident #33 is on pain medication therapy, initiated 9/26/24, indicated the following intervention: -Administer Analgesic medications as ordered by Physician. Monitoring/document side effects and effectiveness every shift (Q-Shift), initiated 10/17/24. During an interview on 5/27/25 at 1:09 P.M., MDS Nurse #1 said a Resident interview was not completed for Resident #33's 4/16/25 Quarterly MDS Assessment. MDS Nurse #1 further said Resident #33 was able to be interviewed and a Resident pain assessment should have been completed with Resident #33 within five days of 4/16/25 and this was not done. MDS Nurse #1 said not completing the Resident pain assessment with Resident #33 did not give an accurate picture of Resident #33's current pain level for the assessment. Based on record reviews, and interviews, the facility failed to accurately complete Minimum Data Set (MDS) Assessments that reflected the residents status as of the Assessment Reference Date for five Resident's (#80, #33, #68, #90 and #91), out of a total sample of 28 residents. Specifically, 1. For Resident #80, the facility staff failed to code the MDS assessment accurately relative to a pressure ulcer under Section M. 2. For Resident #33, the facility failed to complete the Pain Assessment under Section J with the Resident involvement, when the Resident had clear speech, was able to make him/herself understood, and understood others. 3. For Resident #68, the facility failed to accurately code skin conditions under Section M on the comprehensive MDS Assessment relative to surgical, diabetic and vascular wounds that were present. 4. For Resident #90, the facility failed to complete the Pain Assessment under Section J on an MDS Assessment when the Resident had clear speech and was able to make him/herself understood. 5. For Resident #91, the facility failed to accurate code oral/dental status under Section L of the MDS assessment relative to abnormal mouth tissue, broken dentition and presence of mouth pain. Findings include: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #80 was admitted to the facility in May 2024 with diagnoses including pressure ulcer of sacral region. Review of Resident #80's May 2025 Physician orders included but was not limited to: -Coccyx wound: cleanse with Normal Saline, apply zinc to the peri-wound, pack with Puracol (a collagen based wound product), cover with dry clean dressing daily, effective 4/3/25. Review of Resident #80's admission Skin Assessment from May 2024 included but was not limited to: -The Resident had an unstageable (deep pressure injury where the base of the ulcer is covered by nonviable tissue making it impossible to accurately assess the depth to stage) pressure ulcer that measured nine centimeters (cm) by five cm by one-half cm (9 cm x 5 cm x 1/2 cm) on the sacral/coccyx area. Review of Resident #80's Person-Centered Care Plan included but was not limited to: >Focus - Resident has a Stage Three (full thickness skin loss exposing fat but not reaching muscle, tendon or bone) pressure ulcer to the sacral/coccyx area, initiated on 6/5/24. >Goal - Resident's pressure ulcer will show signs of healing and remain free from infection, initiated 6/5/24, revision date 12/29/24, and target date on 8/25/25. Review of Resident #80's most recent Skin Assessment, dated 5/15/25, included but was not limited to: -Resident has a stage three pressure ulcer that measured 3 cm x 1 cm x 3/4 cm to the sacral/coccyx area. Review of Resident #80's most current and completed MDS assessment dated [DATE], included but was not limited to: -Resident has one, Stage Three pressure ulcer. -Resident did not have the pressure ulcer present on admission to the facility. During an interview on 5/27/25 at 1:00 P.M., MDS Nurse #1 said that the facility did not have a policy related to coding of resident MDS's, and that the facility followed the Resident Assessment Instrument (RAI) Manual to code all MDS assessments. The surveyor and MDS Nurse #1 reviewed the electronic medical record (EMR) for Resident #80 and MDS Nurse #1 said Resident #80 had been admitted with the pressure ulcer to the sacral/coccyx area and the pressure ulcer had not yet healed or closed since the Resident had been admitted . MDS Nurse #1 said Resident #80's MDS Assessment (dated 3/4/25) had been coded incorrectly because the pressure ulcer was present on admission, had not yet healed or closed and should have been coded as being present on admission. MDS Nurse #1 said accurate MDS coding was important for care planning to ensure proper care and services were in place for Resident #80.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observations, interviews, and record reviews, the facility failed to provide treatment and care in accordance with professional standards of practice relative to podiatry services and skin assessment for one Resident (#110), out of a total sample of 28 residents. Specifically, for Resident #110, the facility failed to: -implement podiatry recommendations when the Resident received podiatry care and services and was recommended to have continued wound treatment to the right great toe. -perform a weekly skin assessment as ordered, putting the Resident at risk for infection and delayed wound healing. Findings include: Resident #110 was admitted to the facility in November 2024, with diagnoses including chronic viral Hepatitis C, and Adjustment Disorder with Depressed Mood. Review of the Minimum Data Set (MDS) Assessment, dated 2/24/25, indicated Resident #110 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a total possible score of 15. During an interview on 5/20/25 at 11:15 A.M., Resident #110 said that he/she was concerned about his/her right great toe because the Podiatrist came in last week, removed his/her toenail, and placed a band aid on the right great toe. Resident #110 further said that staff had not removed and looked at the toe since the Podiatrist had placed the band aid. Resident #110 then showed the surveyor his/her right foot and a band aid was securely applied to the right great toe. Review of the active Physician orders for Resident #110, dated 5/22/25, indicated the following: -Consults: Podiatry, Dental, Audiology, Optometry or Behavioral Health, initiated 1/26/25. -Weekly skin check: complete weekly skin check documentation .on weekly skin evaluation assessment every day shift, every Saturday, initiated 11/23/24. Further review of the Physician orders failed to indicate any treatment orders in place for Resident #110's right great toe. Review of the Consultant Podiatry documentation, dated 5/15/25, indicated the following: -Resident #110 was examined by the Podiatrist on 5/15/25. -A Podiatry Progress Note indicated the right great toe with mild erythema (redness) and swelling, ½ loosening or separation of the toenail. -Recommend new orders: Right great toe contusion with loss of nail. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>Please cleanse area with sterile saline solution, >Please apply topical antibiotic i.e. bacitracin once daily with sterile dressing for two weeks, >monitor for signs and symptoms of infection, >Please contact PCP (Primary Care Provider) in case this [infection] occurs and consider oral antibiotics. Review of Resident #110's clinical record failed to indicate that a weekly skin assessment had been performed as ordered for the Resident on: -Saturday 5/10/25 -Saturday 5/17/25 During an interview on 5/21/25 at 9:29 A.M., Nurse #6 said she was aware that Resident #110 was seen by the Podiatrist last week but was unaware that Resident #110 had a bandaid on his/her right great toe. Nurse #6 said that the Podiatrist writes recommendations on the Consultant Podiatry Documentation Sheet and gives the sheet to the Unit Manager (UM). Nurse #6 further said that there were no treatment orders in place for the care of Resident #110's right great toe. During an interview on 5/21/25 at 10:09 A.M., UM #2 said Resident #110 had a Physician's order in place for weekly skin assessments to be performed every Saturday but no weekly skin assessment had been performed for Resident #110 on 5/17/25 as ordered. UM #2 further said that if the weekly skin assessment had been completed 5/17/25, staff would have seen the band aid on the Resident's toe and followed up with the Provider. UM #2 said the Consultant Podiatry Group sends an email to the facility that includes a summary report of podiatry recommendations for residents that were provided services. UM #2 said that she was unsure if she received the summary report from the Podiatrist visit on 5/15/25. UM #2 said that the podiatry recommendations for Resident #110 should have been printed out and placed into the Physician Assistant's (PA)'s book for the PA to review and prescribe a treatment. UM #2 said she was unsure if the recommendations for Resident #110 had been communicated to the PA. During an interview on 5/21/25 at 10:22 A.M., the PA said that she was never notified of the podiatry recommendations for Resident #110's right great toe, but she should have been notified of the recommendations made by the Podiatrist.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards of practice to prevent and treat a pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) for one Resident (#40), of six applicable residents reviewed for pressure, out of a total sample of 28 residents. Specifically, the facility staff failed to evaluate and monitor a pressure ulcer located on Resident #40's left ischium (left lower back of the hip bone) to help identify any wound changes, promote healing and prevent deterioration of the wound, infection, and new ulcers from developing. Findings include: Review of the facility policy titled Pressure Ulcer Prevention effective May 2023, indicated the following documentation to be recorded in the resident's medical record: -Any change in the resident's condition -All assessment data (i.e. wound bed color, size, drainage etc.) obtained when inspecting the wound -The type of wound care provided -The date and time the wound care was given Resident #40 was admitted to the facility in March 2024, with diagnoses including Paraplegia, Diabetes Mellitus II (DM II), and pressure ulcer of the sacral region and left ischium. Review of the Minimum Data Set (MDS) Assessment, dated 3/23/25, indicated Resident #40 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15. Review of Resident 40's Physician orders dated 5/27/25, indicated the following: -Santyl external ointment 250 mg/GM (gram) topically every day shift for wound care to left ischium. On 5/20/25 at 12:18 P.M., the surveyor observed Resident #40 lying in bed, with the head of the bed elevated and a Negative Pressure Wound Therapy device (NPWT: a medical treatment device connected by tubing to a wound dressing that uses suction to assist in wound healing) set to 125 mm (millimeters) of Hg (mercury). During an interview at the time, Resident #40 said he/she had a large sacral wound and a smaller ischial wound on his/her back side and that the NPWT device was applied to the sacral wound and not on the ischial wound. Resident #40 also said he/she is followed by a wound doctor and goes out to the wound clinic every week. Review of the Treatment Administration Record (TAR), dated 5/1/25 through 5/31/25, indicated the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cleanse left ischium with normal saline, pat dry. - .apply a nickel size layer of Santyl to wound bed. - .cover with dry clean dressing. Further review of the TAR indicated a wound documentation ledger and corresponding spaces for the documentation of wound characteristics observed during the provision of wound care: >Progress- I = Improved, N=No >Change- W= Worsened >Wound Base- C=Clean, Slough=S, Eschar=E >Drainage Amount- None=0, Small=S, Moderate=M, Large=L >Drainage Type- Serous=S, Serosanguinous=SS, Purulent=P Review of the TAR for 5/22/25 through 5/28/25, failed to indicate: -any wound characteristic documentation on the TAR in the spaces corresponding to Resident #40's left ischial wound on these dates. -any indication that the left ischium wound status was evaluated and monitored on these dates. Review of the facility Skin Assessments, dated 5/12/25 and 5/26/25, failed to indicate any evaluation and monitoring were completed relative to the characteristics of Resident #40's left ischial wound. During an interview on 5/27/25 at 3:36 P.M., the Director of Nursing (DON) said that facility staff were expected to document wound descriptions on the TAR in the spaces provided so that any wound changes could be identified. The DON said that it was important to document descriptions of the wound bed, drainage characteristics, and signs of infection with every dressing change performed. During a follow-up interview on 5/27/25 at 4:59 P.M., the DON said that there was no wound documentation entered on the TAR from 5/22/25 through 5/27/25, relative to the description of Resident #40's left ischial wound but there should have been documentation on the TAR.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, interviews, and record reviews, the facility failed to ensure one Resident (#2), of four applicable residents reviewed with feeding tubes, in a total sample of 28 residents, had care and services in place for enteral feedings and gastrostomy site care. Specifically, for Resident #2, the facility failed to ensure Physician's orders were implemented and/or that orders were in place relative to enteral feeding (refers to any method of feeding that uses the gastrointestinal (GI) tract to deliver nutrition and calories) care including: -Gastrostomy (G-tube: surgical procedure for inserting a tube through the abdomen wall and into the stomach to administer medications, fluids and nutrition) site care. -Monitoring and recording residuals (amount of fluid or other contents remaining in the stomach after a feeding and a crucial indicator of gastric emptying and assist with assessing tolerance to the feeding). -Administration of the prescribed feedings when tube feeds and water boluses were not administered by staff due to the Resident being asleep. -Physician orders relative to the accurate route medication should be administered when the Resident was ordered nothing by mouth (NPO) and the medications were prescribed to be administered by mouth. Findings include: Review of the facility policy titled Enteral Nutrition, dated March 2023, indicated adequate nutritional support through enteral nutrition is provided to residents as ordered, and included the following: -The nurse confirms that orders for enteral nutrition are complete. Complete orders include: >the enteral nutrition product >delivery site (tip placement) >the specific enteral access device (nasogastric [nose and to the stomach], gastric [stomach], jejunostomy [tube inserted into the small intestine] tube, etc.) >administration method (continuous, bolus [large doses of formula several times a day poured slowly into a syringe attached to a feeding tube], intermittent) >volume and rate of administration >the volume/rate goals and recommendations for advancement towards these >instructions for flushing (solution, volume, frequency, timing, and 24-hour volume) (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The provider will consider the need for supplemental orders, including: >confirmation of tube placement >oral care >checks for gastric residual volume Resident #2 was admitted to the facility in November 2024 with diagnoses including gastrostomy status, underweight, severe protein-calorie malnutrition, adult failure to thrive and dysphagia (difficulty swallowing). Review of the Nutrition Care Plan, initiated 11/25/24, indicated Resident #2 had malnutrition and evidence of muscle wasting and included a goal for the Resident to accept the tube feeding as ordered by the Physician in order to promote gradual weight gain. The plan of care included the following interventions: -enteral protocols in place, initiated 11/25/24 -TwoCal HN (type of enteral feeding solution) via G-tube . revised 3/16/25 Review of the Tube Feed Care Plan, initiated 11/19/24, indicated the following interventions: -Resident was dependent with tube feedings and water flushes. See Physician's orders for current feeding orders, initiated 11/19/24 -Check tube placement and gastric contents/residual volume per facility protocol and record, revised 11/20/24 Review of the Potential for Skin Impairment Care Plan, initiated 11/20/24, indicated Resident #2: -was at risk due to weakness, impaired mobility and G-tube use -G-tube care as ordered -Monitor insertion site for skin breakdown, initiated 11/20/24 Review of the Minimum Data Set (MDS) Assessment, dated 2/26/25, indicated Resident #2: -had no speech. -was rarely or never understood or understands other. -has severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 0 out of 15. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was on a feeding tube and received greater than 51 percent (%) of calorie needs and more than 501 cubic centimeters (cc: unit of measure equivalent to milliliters) daily. Review of Resident #2's May 2025 Physician's orders included the following: -weekly skin checks, initiated 11/19/24 -NPO (nil per os, or nothing by mouth) diet ., initiated 11/22/24 -Monitor for abdominal distention and pain every shift, initiated 12/30/24 -Enteral Feed Order, six times a day, give via gravity (method of delivering formula using the force of gravity which would be positioned above the patient and without the need for a pump) 150 milliliters (ml) of TwoCal HN, initiated 3/20/25 -Water bolus prior to G-tube feed, administer a total of 200 ml, 100 ml pre and 100 ml post feed, six times a day, free flush of 100 ml prior to TwoCal HN admin and post TwoCal HN administration, initiated 3/20/25 -the following medications were ordered to be administered by mouth: >Benztropine (medication to treat movement disorders) 0.5 milligrams (mg), give 3 tablets by mouth daily >Celexa (antidepressant medication) 10 mg, give 0.5 tablet by mouth daily >Miralax (laxative medication) 17 grams (gm) per scoop, give 1 scoop by mouth daily >Acetaminophen (analgesic medication used for pain and/or fever) 325 mg, give 2 tablets by mouth as needed every 6 hours Further review of Resident #2's Physician's orders failed to indicate evidence of: -orders/frequency of mouth care to be provided -instructions relative to G-tube site care, including cleaning of the area, monitoring of the site, as referenced on the Resident's Skin Impairment Care Plan. -instructions relative to residual checks referenced on the Resident's Tube Feed Care Plan and parameters (specific instructions) in which to hold the tube feeding. Review of the April 2025 and May 2025 Medication Administration Records (MARs) indicated the Resident's scheduled G-tube feedings and water boluses were held due to the Resident sleeping on the following dates/times: -4/13/25 at 1:00 A.M. and 5:00 A.M. -5/20/25 at 5:00 A.M. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/21/25 at 5:00 A.M. Further review of the April 2025 and May 2025 MARs failed to indicate documented evidence of: -G-tube site care -documentation of residual amounts -mouth care provided On 5/21/25 at 12:40 P.M., the surveyor observed Resident #2 seated in a specialized wheelchair near the nurses station. Resident #2 had his/her eyes closed and was observed to be very thin. On 5/27/25 at 2:41 P.M., the surveyor and Unit Manager (UM) #2, who was the Nurse assigned to Resident #2's care for that shift reviewed Resident #2's clinical record. UM #2 said the Resident received scheduled G-tube feedings six times daily and did not take food/fluids/medications by mouth. UM #2 said the Resident's G-tube site should be monitored every shift and that there should be Physician's orders for monitoring the site for signs of infection and treatment orders for scheduled dressing changes to clean and provide care to the Resident's G-tube site, but there were currently no orders to do this. UM #2 further said the Resident should also have an order to assess for the placement of the G-tube prior to the scheduled feedings and currently there were no Physician's orders do to this for Resident #2. UM #2 said Resident #2 received scheduled bolus feedings via the G-tube using a piston syringe (medical device used to inject or withdraw fluids), and the Physician's orders should include instructions to change the piston syringe daily and to check and document residuals prior to the G-tube feedings with parameters (specific amounts) on when to hold the G-tube feedings, but there were currently no Physician's orders for this. At this time, the surveyor and UM #2 observed Resident #2's room and observed a piston syringe dated 5/23 on the Resident's bedside table, and UM #2 said the piston syringe should have been changed daily. The surveyor and UM #2 reviewed the April 2025 and May 2025 MARs which indicated the scheduled G-tube feedings and water boluses were not administered due to the Resident sleeping, and UM #2 said the Resident's enteral feeding and water should be administered even if he/she were sleeping. UM #2 said that because the Resident was NPO, the Resident's medications should be received through the G-tube and that the medications ordered and documented as administered by mouth were not accurate. Please refer to F842.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview, and record review, the facility failed to assess for continued use of a prophylactic antibiotic, for one Resident (#63), of two applicable residents reviewed for antibiotic use, out of a total sample of 28 residents. Specifically, for Resident #63, the facility failed to: -ensure the Physician orders for the Infectious Disease (ID) and Endocrinology Consults were implemented as required. -coordinate ID and Endocrinology appointments to assess for the need/rationale for continued use of a prophylactic antibiotic (Ciprofloxacin) prescribed for chronic osteomyelitis, when the Resident requested to discontinue the medication. Findings include: Resident #63 was admitted to the facility in April 2021, with diagnoses including chronic osteomyelitis (infection of the bone), Diabetes and constipation. Review of the Minimum Data Set (MDS) Assessment, dated 3/11/24, indicated Resident #63: -was cognitively intact as evidenced by Brief Interview of Mental Status (BIMS) score of 13 out of possible 15 points. -received an antibiotic during the assessment period. Review of the Provider Note, dated 4/7/25, indicated the following: -Resident #63 reported he/she did not want to take Ciprofloxacin (antibiotic) any longer and that the Resident has been on the antibiotic for a couple years. -The Provider indicated to continue the Ciprofloxacin 250 mg twice daily with no stop date, for [suppression] and an order was placed for the Resident to follow up with ID. Review of the May 2025 Physician's orders indicated the following: -Ciprofloxacin HCl Oral Tablet 250 milligrams (mg), Give 250 mg by mouth two times a day for chronic osteomyelitis, initiated 6/4/24 with no stop date . Review of the May 2025 Medication Administration Record (MAR) indicated Resident #63: -was administered the Ciprofloxacin 250 mg on seven out of 53 occurrences. -On the remaining dates/times, for 46 occurrences, Resident #63 refused the medication. Review of the completed Physician's orders indicated the following: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Please schedule ID follow-up for a chronic suppressive therapy - Resident wishes to stop (the medication), initiated on 4/17/25 and end date 4/18/25. -Refer to Endocrinology for evaluation on necessity to continue long term antibiotics, initiated on 4/29/25 and end date 4/30/25. Review of Resident #63's clinical record failed to indicate documented evidence that an ID consult or Endocrinology evaluation was scheduled to assess the need for continued use of antibiotic therapy. During an interview on 5/27/25 at 9:40 A.M., during a review of the facility Antibiotic Stewardship Program, the Director of Nursing (DON), who also was the Infection Preventionist (IP), said she did not track residents who were on prophylactic antibiotics. The DON said she was not aware that Resident #63 requested to discontinue the antibiotic treatment. The DON/IP said she would follow up to see if the ID consult was initiated to assess for the continued need for Resident #63's antibiotic. During an interview on 5/27/25 at 2:32 P.M., Unit Manager (UM) #2 said the Provider gave a verbal order for the ID consult (on 4/7/25) which did not get put into the Resident's electronic health record (EHR) as a Physician's order. UM #2 said the Provider asked about the ID consult again on 4/29/25, but the appointment had not yet been made. UM #2 said the facility used to have medical records book resident appointments, but this task was now delegated to the Unit Managers. UM #2 said because she was frequently working as the floor Nurse, scheduling the Resident's appointment was missed. During a follow-up interview on 5/27/25 at 3:33 P.M., the DON/IP said there was no evidence that the requested appointments (ID and Endocrinology) were set up for Resident #63.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interview, and record review, the facility failed to ensure two Residents (#90 and #181), out of a total of 28 sampled Residents, received laboratory services as ordered by the Physician. Specifically, the facility failed to: 1. For Resident #90, obtain weekly Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) labwork as ordered by the Physician. 2. For Resident #181, obtained Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) labwork as ordered by the Physician. Findings include: 1. Resident #90 was admitted to the facility in October 2022 with diagnoses including Severe Protein-Calorie Malnutrition and Cerebral Infarction (stroke). Review of the May 2025 Physician orders indicated the following: -Complete Blood Count (CBC: measures the number and characteristics of different types of blood cells) and Comprehensive Metabolic Panel (CMP: blood test that provides broad overview of the body's metabolic health including kidney function, liver function, electrolyte balance, blood sugar and protein levels) every Monday, initiated 1/6/25 Review of the Resident #90's clinical record failed to indicate documented evidence that CBC and CMP labwork was obtained as ordered during the month of May 2025. During an interview on 5/27/25 at 4:37 P.M., Unit Manager (UM) #1 said Resident #90's weekly labs were not obtained in May 2025 as ordered by the Physician. 2. Resident #181 was admitted to the facility in May 2025 with diagnoses including Neuromuscular Dysfunction of the Bladder and Hypertension. Review of the May 2025 Physician orders indicated the following: -CBC, CMP on 5/17/25 (Saturday), then on every Monday, initiated on 5/16/25 Review of Resident #181's clinical record failed to indicate documented evidence that the CBC and CMP ordered on 5/17/25 and on 5/19/25 (Monday) were obtained as ordered by the Physician. During an interview on 5/21/25 at 10:50 A.M., UM #1 said because Resident #181's labwork was scheduled for a weekend (Saturday 5/17/25), the facility staff would need to notify the contracted laboratory service to notify them that labwork needed to be drawn on a non-scheduled day. UM #1 further said the ordered labwork for 5/19/25 was not completed. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 5/22/25 at 10:58 A.M., UM #1 said Resident #181's labwork was not obtained as ordered by the Physician on 5/17/25 and on 5/19/25. UM #1 said this was a systems issue and that education on the process for how to request resident labwork needed to be completed with the nursing staff. UM #1 said if resident labwork was ordered for a weekend or holiday, the facility staff would need to contact the contract laboratory service company to notify them that the labwork needed to be drawn, but this was not done for Resident #181. UM #1 further said that routine labwork needed to be put on a separate requisition lab slip from the non-routine labwork, and this also did not occur for Resident #181.

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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. 2. Resident #91 was admitted to the facility in April 2025 with diagnoses including Severe Protein-Calorie Malnutrition, Adult Failure to Thrive and Acidosis. Review of the May 2025 Physician's orders included the following: -Sodium Chloride (medication used to replenish water and salt in the body), give one tablet daily, initiated 5/8/25 Review of the May 2025 MAR indicated the Sodium Chloride was administered to Resident #91 in the month of May 2025. On 5/27/25 at 3:13 P.M., the surveyor and Nurse #1 observed the Sodium Chloride medication prescribed to Resident #91. Nurse #1 said Resident #91 was receiving 1 gram (gm) of Sodium Chloride daily and that the Physician's order should include the medication dosage but it currently did not. During an interview on 5/27/25 at 3:15 P.M., Unit Manager (UM) #1 said Resident #91's order for Sodium Chloride should indicate the dosage of the medication to be administered. UM #1 said the Resident's current order for Sodium Chloride was an incomplete order and would need to be clarified with the Physician. 3. Resident #2 was admitted to the facility in November 2024 with diagnoses including gastrostomy status, underweight, severe protein-calorie malnutrition, adult failure to thrive and dysphagia (difficulty swallowing). Review of the Tube Feed Care Plan, initiated 11/19/24, indicated the following interventions: -Resident was dependent with tube feedings and water flushes. See Physician's orders for current feeding orders, initiated 11/19/24 Review of the May 2025 Physician's orders included the following: -NPO (nil per os, or nothing by mouth) diet ., initiated 11/22/24 -the following medications were ordered to be administered by mouth: >Benztropine (medication to treat movement disorders) 0.5 milligrams (mg) give 3 tablets by mouth daily >Celexa (antidepressant medication) 10 mg, give 0.5 tablet by mouth daily >Miralax (laxative medication) 17 grams (gm) per scoop, give 1 scoop by mouth daily >Acetaminophen (analgesic medication used for pain and/or fever) 325 mg, give 2 tablets by mouth as needed every 6 hours (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/27/25 at 2:41 P.M., the surveyor and Unit Manager (UM) #2, who was the Nurse assigned to Resident #2's care for that shift reviewed Resident #2's clinical record. UM #2 said the Resident received scheduled G-tube feedings six times daily and did not take food/fluids/medications by mouth. UM #2 said because the Resident was not to receive anything by mouth, the Resident's medications should be received through the G-tube and that the medications ordered and documented as administered by mouth was not accurate. Based on interview, and record review, the facility failed to ensure completed and accurate medical records were maintained for three Residents (#15, #91 and #2), out of a total sample of 28 residents. Specifically, 1. For Resident #15, the facility failed to ensure that staff documented daily fluid intakes when Resident #15 was on a fluid restriction. 2. For Resident #91, the facility failed to ensure a dosage for Sodium Bicarbonate was included in the Physician's orders to ensure accurate administration of the medication when the Resident was being administered the medication without an ordered dosage. 3. For Resident #2, the facility failed to ensure accurate routes for medication administration were documented when the Resident was unsafe to receive medication/food/fluid by mouth. Findings include: 1. Review of the facility policy titled Encouraging and Restricting Fluids, revised 10/2010, indicated the following: -Follow specific instruction concerning fluid intake or restrictions. -Be accurate when recording fluid intake. -Record fluid intake on the intake side of the intake and output record. Record fluid intake in milliliters (mls). Resident #15 was admitted to the facility in October 2024 with diagnoses including Lymphedema and Generalized Edema. Review of Resident #15's most recent Minimum Data Set (MDS) Assessment, dated 2/11/25, indicated Resident #15 scored a 15 out of 15 on the Brief Interview of Mental Status (BIMS) Assessment indicating he/she was cognitively intact. During an interview on 5/20/25 at 8:27 A.M., Resident #15 said he/she was on a fluid restriction relative to his/her diagnosis of Lymphedema. Resident #15 said nursing staff managed his/her fluid restriction. Review of Resident #15's May 2025 Physician's orders indicated the following order with a start date of 4/4/25: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Fluid restriction as directed 1500 cubic centimeter (cc) per day: *Nursing: 720 cc: 7:00 A.M.-3:00 P.M.: 360 cc (in own container 16 ounces (oz) ice and 4 oz water) 3:00 P.M.-11:00 P.M.: 360 cc (in own container 16 ounces (oz) ice and 4 oz water) 11:00 P.M.-7:00 A.M.: 0 cc (medications are in apple sauce) *Dietary: 780 cc: *Breakfast: 300 cc *Lunch: 240 cc *Supper: 240 cc . Review of Resident #15's Care Plan titled Resident #15 has fluid overload or potential fluid volume overload due to disease process: Lymphedema, initiated 11/2/24, indicated the following intervention: -Monitor and document intake and output as per facility policy, initiated 11/2/24. Review of Resident #15's May 2025 Medication Administration Record (MAR), indicated the following: -On 16 out of 20 days, Resident #33 received 360 cc during the 7:00 A.M.-3:00 P.M. shift. -On one out of 20 days, Resident #33 received 700 cc during the 7:00 A.M.-3:00 P.M. shift. -On one out of 20 days, Resident #33 received 540 cc during the 7:00 A.M.-3:00 P.M. shift. -On one out of 20 days, Resident #33 received 380 cc during the 7:00 A.M.-3:00 P.M. shift. -One day out of 20 days, was marked yes with no total cc during the 7:00 A.M.-3:00 P.M. shift. -On 17 out of 20 days, Resident #33 received 360 cc during the 3:00 P.M-11:00 P.M. shift. -On one day out of 20 days, Resident #33 received 340 cc during the 3:00 P.M-11:00 P.M shift. -On one day out of 20 days, Resident #33 received 240 cc during the 3:00 P.M.-11:00 P.M. shift. -On one day out of 20 days, was marked yes with no total cc on the 3:00 P.M.-11:00 P.M. shift. -On 16 days out of 20 days, Resident #33 received 60 cc during the 11:00 P.M.-7:00 A.M. shift. -On four days out of 20 days, Resident #33 received 0 cc during the 11:00 PM.-7:00 A.M. shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #15's May 2025 MAR failed to indicate: -documentation of the total daily fluid intake. -documentation of how much fluid the Resident consumed during his/her meals. During an interview on 5/21/25 at 11:23 A.M., Nurse #3 said Resident #15 was on a fluid restriction because he/she had a diagnosis of Lymphedema. Nurse #3 said it was important to monitor the Resident's daily fluid intake to make sure he/she was not at risk for fluid overload. During a follow-up interview on 5/21/25 at 12:37 P.M., Nurse #3 said fluid intake should be documented on a Resident's MAR by the Nurses each shift. Nurse #3 said the Nurses only document what they provide to the Resident during the medication pass and when they gave him/her 16 ounces (oz) of ice. Nurse #3 said that nursing did not document what was provided on the Resident's meal trays for fluid. The surveyor and Nurse #3 reviewed Resident #15's May 2025 MAR, and Nurse #3 said with the documentation that was available she was unable to tell how much fluid Resident #15 consumed each day as there was no 24-hour totals. Nurse #3 also said there was no documentation indicating how much fluid Resident #15 consumed during his/her meals as the documentation recorded on the MAR appeared to only be what was provided at medication pass and the allotted ice Resident #15 received. During an interview on 5/21/25 at 12:44 P.M., Certified Nurses Aide (CNA) #1 said Resident #15 got one cup of coffee in the morning and one cup of juice or ginger ale in the afternoon. The surveyor and CNA #1 observed Resident #15's meal tray which had vanilla ice cream and peach in fruit juice. CNA #1 said she was unsure if the ice cream or the juice in the peaches counted as additional fluid for Resident #15. CNA #1 said the CNAs were not responsible for keeping track of how much fluid Resident #15 took in at each meal. During an interview on 5/22/25 at 8:43 A.M., the Food Service Director (FSD) said the dietary department only ensures that the total amount of fluid Resident #15 could have was written on the Resident's meal ticket. The FSD said the dietary department did not measure out any fluids for the Resident at meals and that nursing should be checking Resident #15's tray at each meal and adjusting what was on the tray to accommodate Resident #15's fluid restriction. The FSD said items such as ice cream cups, soups, Jello cups, and fruit in juice cups should all be counted as fluid and staff on the units should know which items on a Resident's tray count towards total fluid intake. During an interview on 5/22/5 at 9:37 A.M., the Dietician said nursing should be adding all fluid intake Resident #15 consumes daily so the total fluid intake can be monitored and adjusted if needed. The Dietician said nursing staff should be counting not only the water and ice they give Resident #15, but they should also be recording how much fluid Resident #15 consumes at each meal from his/her meal tray. The surveyor and the Dietician reviewed Resident #15's May 2025 MAR and the Dietician said it did not appear nursing was recording all of Resident #15's daily fluid intake and they were not calculating a total daily fluid intake. The Dietician said while it was not the only tool she utilized to monitor a Resident for changes, it would be beneficial for her to be able to review how much fluid Resident #15 was taking in daily so the fluid restriction could be adjusted if needed especially if Resident #15 was to experience an episode of fluid overload and changes in his/her edema.

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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 interviews, and record reviews, the facility failed to maintain an Infection Prevention and Control Program (IPCP) designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility staff failed to: 1. Review the facility's IPCP standards, policies and procedures annually, placing residents and staff at risk for outdated standards of practice for preventing and controlling infections. 2. Develop, monitor, and implement the resident vaccination process within the facility relative to Influenza, Pneumococcal and Covid, placing residents at risk for infection. Findings include: Review of the Facility Assessment, dated November 2024 and reviewed by QAA/QAPI committee in November 2024, indicated but was not limited to: -Services provided: a. Infection prevention and control: >Identification and containment of infections > .use of standard infection prevention and control practices >prevention of infections Review of the facility's policy titled Immunizations and Vaccines-Residents, dated December 2022 included but was not limited to: -It is the policy of this facility that all residents receive immunizations and vaccinations that assist in preventing infectious disease unless .refused by the resident or resident's activated Health Care Proxy (HCP- a person who can make decisions for another person when they are unable to do so themselves). 1. Vaccine information statements and consent for Pneumococcal, Influenza and Covid will be part of the resident's admission packet. Consent for these vaccinations will be obtained .at the time of admission. 2. Orders for administration of vaccines will be obtained from the resident's Physician or Nurse Practitioner (NP). 3. Influenza Vaccination: >Each resident is offered the Influenza vaccination as soon as the vaccine is available through March 31st annually. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Pneumococcal Vaccination: >Recommendations are based on a person's previous Pneumococcal vaccine history. -No evidence specific to Covid Vaccination procedure or process was included in this policy. Review of the facility policy titled Infection Prevention and Control Program (IPCP), dated December 2022, without revision date, included but was not limited to: -Healthcare Associated Infections (HAI). Can cause significant pain and discomfort for residents in nursing homes and can have significant adverse consequences .IPCP must follow national standards and guidelines. -Program development and oversight focus on the prevention and management of infections. >identify staff roles and responsibilities for the routine implementation of the program. >define and manage appropriate resident health initiatives such as immunization programs for influenza, pneumococcal, etc . -The Infection Preventionist (IP) has been appointed to be responsible for the IPCP, and responsibilities shall include . >Implementing evidenced-based infection control practices, including those mandated by regulatory and licensing agencies, and guidelines from the CDC. >Program oversight including planning .monitoring and maintaining all the elements of the program and ensuring that the facility's interdisciplinary team is involved in infection prevention and control. >Implementing measure to prevent the transmission of infectious agents .and procedure-related infections. -Influenza and Pneumococcal immunizations: >Each resident is offered the influenza vaccination between October 1st and March 31st annually. >Each resident is offered a Pneumococcal vaccination unless contraindicated or refused. -No evidence specific to Covid vaccination procedure was included in this policy. -Annual Review: >The facility's IPCP and its standards, policies and procedures will be reviewed at least annually to ensure effectiveness and that they are in accordance with current standards of practice for preventing and controlling infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During an interview on 5/27/25 at 9:10 A.M., the IP said she has been employed at the facility since March 2024. The IP said that the facility IPCP Manual policies and procedures should be reviewed and updated annually then signed by the Medical Director, Director of Nursing (DON) and IP. The surveyor and the IP reviewed the facility's current IPCP manual and the IP said that the IPCP Manual provided and reviewed was the Master IPCP Manual and was the most current one that she was following. The IP said that the most recent annual review and update to the facility's IPCP Manual, policies and procedures had occurred back on 2/2/24 as evidenced by the signature sheet at the front of the manual signed by the Medical Director, DON, and IP. The IP said that the IPCP should have been reviewed and updated by 2/2/25 to ensure IPCP practices were within current guidelines for the facility's residents and staff, but the IPCP had not been reviewed and updated. 2. During a follow-up interview on 5/27/25 at 3:26 P.M., the IP said that the facility followed current guidance from CDC for immunization of the residents. The IP said that all residents should be offered the Influenza, Pneumococcal and Covid vaccines on admission. The IP said that the admitting Nurses were responsible to obtain consent or refusal at the time of admission for all residents. The IP said that once a resident had provided consent for vaccine the admitting Nurse should obtain an order from the resident's Provider. The IP said that the admitting Nurse should then inform the IP that the resident had requested vaccination though an email, phone call, or nursing report. The IP also said that once the vaccine was available it should be administered by the IP or the Nurse that was on duty. The IP said that the process from consent to administration should take about five to seven days. The IP said that she did not have a monitoring system in place prior to today, for resident vaccinations but should have. The IP further said that according to her audit, which had been initiated after the survey team entered the facility, she had identified the following: >Four residents out of 115 residents audited, consented to an Influenza Vaccine for the 2024-2025 season but did not receive the Influenza Vaccine as requested. Five residents had not yet been audited. The IP said that the window for Flu vaccination had ended on March 31st. >Nine residents out of 115 residents audited, had consented to the Pneumococcal Vaccine but did not receive Pneumococcal vaccination timely or as requested. Nine residents had not yet been audited. >11 residents out of 115 residents audited, had consented to the Covid Vaccine but did not receive Covid vaccination timely or as requested. Nine residents had not yet been audited. The IP said several of the residents that had provided vaccine consent had been in the facility for over a year and were not up to date on vaccinations. The IP said that all resident's should have been administered vaccinations timely and as requested. The IP that there was no current Covid immunization policy in place for residents in the facility but there should be. The IP said that failure to develop policy, monitor and administer vaccinations could place the residents at risk for infections.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 3. Resident #2 was admitted to the facility in November 2024 with diagnoses including Severe Protein-Malnutrition, Adult Failure to Thrive and Cerebral Infarction (Stroke). Review of the Immunization Consent form, undated, indicated the following: -Resident #2 had not received the Pneumococcal vaccine. -the Resident's Representative provided consent for Resident #2 to be administered the Pneumococcal Vaccine. Review of the Massachusetts Immunization Information System (MIIS) indicated no history of Pneumococcal vaccination for Resident #2. Review of the MDS Assessment, dated 2/26/25, indicated the following relative to Resident #2: -he/she had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 0 out of a possible 15 points. -the Pneumococcal Vaccine was not up-to-date and the vaccine was not offered. During an interview on 5/27/25 at 8:49 A.M., the DON/IP said Resident #2 had not received the Pneumococcal Vaccine and should have received it because there was a consent for it to be administered. The DON/IP said residents vaccination statuses were reviewed during admission to the facility and if Resident #2's Responsible Party had consented to the Pneumococcal Vaccine, it should have been administered. Based on interview, and record review, the facility failed to ensure Pneumococcal vaccination history was maintained and/or that the Pneumococcal Vaccine was administered after consent was obtained to administer the vaccinations for three Residents (#15, #114, and #2), out of six applicable residents for immunizations. Specifically, the facility failed to ensure: 1. For Resident #15, the Pneumococcal Vaccine was administered after the Resident consented to receive the updated Pneumococcal vaccinations as needed. 2. For Resident #114, the Pneumococcal Vaccine was administered after the Resident's Representative consented for the Resident to receive the updated Pneumococcal vaccinations as needed. 3. For Resident #2, the Pneumococcal Vaccine was administered when the Resident's Representative consented for the administration of the vaccine and the Resident had no history of previously receiving the Pneumococcal Vaccine. Findings include: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Immunizations and Vaccines-Residents, effective 12/2022, indicated the following: -The resident's medical record includes documentation that indicates, at a minimum the following: >The resident or resident's legal representative was provided education regarding the benefits and potential side effects of the pneumococcal immunization; and >That the resident either received the Pneumococcal immunization or did not receive the immunization due to medical contraindications or refusal. -All residents without documentation of adequate immunization, including those with uncertain histories, should be considered not immunized and should be vaccinated accordingly. Review of the Centers for Disease Control and Prevention's (CDC) website, titled Pneumococcal Vaccine Timing for Adults, www.cdc.gov/pneumococcal/index.html, dated 10/2024 indicated the following: -Adults over the age of 50 who have not received any prior Pneumococcal vaccination should receive a Pneumococcal Conjugate Vaccine 20 (PCV20) or PCV21. 1. Resident #15 was admitted to the facility in October 2024 and was over the age of 50. Review of Resident #15's Immunization Consent Form, signed by the Resident on 10/31/24, indicated Resident #15 had not received any Pneumococcal vaccination in the past. Further review of the Immunization Consent Form indicated Resident #15 had consented to receiving an updated Pneumococcal vaccination including Pneumococcal Polysaccharide Vaccine 23 (PPSV23), PCV13, or PCV20 as needed. 2. Resident #114 was admitted to the facility in March 2025 and was over the age of 50. Review of Resident #114's Immunization Consent Form, signed by the Resident's Representative, undated, indicated no documentation was obtained by the facility of previous Pneumococcal vaccinations Resident #114 had received. Further review of the Immunization Consent Form indicated Resident #114's Resident Representative had consented for the Resident to receive an updated Pneumococcal vaccination including PPSV23, PCV13, or PCV20 as needed. During an interview on 5/21/25 at 9:59 A.M., the Staff Development Coordinator (SDC) said when a resident was admitted to the facility, staff were expected to obtain a vaccination history from the resident or the resident's representative, indicating which vaccines the resident had received prior to admission or a Massachusetts Immunization Information Systems (MIIS-system that maintains vaccination history) report should be obtained. The SDC said this information should then be documented in the resident's medical record. The SDC further said if a resident was not up-to-date on his/her vaccinations, the facility should then acquire a vaccination consent from the resident or the resident's representative, a doctor's order to provide the vaccine, and then provide the vaccination shortly after the consent was obtained. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/27/25 at 12:46 P.M., the Director of Nursing (DON) who was also the facility Infection Preventionist (IP), said Resident #15 and the Resident Representative for Resident #114 had consented to both Residents being administered Pneumococcal vaccinations to ensure that the Residents were up-to-date with their Pneumococcal vaccinations, but the vaccinations had been administered to Resident #15 or Resident #114. The DON/IP further said the Pneumococcal vaccines should have been administered to Resident #15 and Resident #114 shortly after they were admitted to the facility. During a follow-up interview on 5/27/25 at 3:26 P.M., the DON/IP said that the facility followed current guidance from CDC for immunization of the residents in the facility.

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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. 3. Resident #2 was admitted to the facility in November 2024 with diagnoses including Severe Protein-Malnutrition, Adult Failure to Thrive and Cerebral Infarction (Stroke). Review of the Immunization Consent form, undated, indicated the following: -Resident #2 has not received the COVID-19 vaccine. -the Resident's Representative provided consent for Resident #2 to receive the COVID-19 vaccine. Review of the Massachusetts Immunization Information System (MIIS) failed to indicate any history that Resident #2 received the COVID-19 vaccination. Review of the MDS Assessment, dated 2/26/25, indicated the following relative to Resident #2: -he/she had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 0 out of a possible 15 points. -COVID-19 vaccine was not up-to-date. During an interview on 5/27/25 at 8:49 A.M., the DON/IP said Resident #2 had not received the COVID-19 Vaccine and should have received it because there was a consent for it to be administered. The DON/IP said residents vaccination statuses were reviewed during admission to the facility and if Resident #2's Responsible Party had consented to the COVID-19 Vaccine, it should have been administered. Based on interview and record review, the facility failed to develop and implement a COVID-19 vaccination policy for three Residents (#15, #114, and #2), out of a total of six applicable residents for immunization review. Specifically the facility failed to ensure: 1. For Resident #15, that documentation was maintained relative to COVID-19 vaccination history, and that the most up-to-date COVID-19 Vaccine was administered when the Resident consented to receive it. 2. For Resident #114, that documentation was maintained relative COVID-19 vaccination history, and that the most up-to-date COVID-19 vaccine was provided when the Resident's Representative consented for the Resident to receive the most up-to-date COVID-19 Vaccines as recommended by the Centers for Disease Control and Prevention (CDC). 3. For Resident #2, that the COVID-19 Vaccine was administered when the Resident Representative consented for Resident #2 to receive the vaccine. Findings include: (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #15 was admitted to the facility in October 2025. Review of Resident #15's Immunization Consent Form, signed by the Resident on 10/31/24, failed to indicate documentation was obtained by the facility relative to Resident #15's COVID-19 vaccination history. Further review of the Immunization Consent Form indicated that Resident #15 had consented to receiving an updated COVID-19 vaccination as needed. 2. Resident #114 was admitted to the facility in March 2025. Review of Resident #114's Immunization Consent Form, signed by the Resident's Representative, undated, failed to indicate that documentation was obtained by the facility relative to Resident #15's COVID-19 vaccination history. Further review of the Immunization Consent Form indicated Resident #114's Resident Representative consented for the Resident to receive an updated COVID-19 vaccination as needed. During an interview on 5/21/25 at 9:59 A.M., the Staff Development Coordinator (SDC) said when a resident was admitted to the facility, staff were expected to obtain a vaccination history from the resident or the resident's representative, indicating which vaccines the resident had received prior to admission or a Massachusetts Immunization Information Systems (MIIS-system that maintains vaccination history) report should be obtained. The SDC said this information should then be documented in the resident's medical record. The SDC further said if a resident was not up-to-date on his/her vaccinations, the facility should then acquire a vaccination consent from the resident or the resident's representative, a doctor's order to provide the vaccine, and then provide the vaccination shortly after consent was obtained. During a follow-up interview on 5/21/25 at 10:46 A.M., the SDC said there were no available COVID-19 vaccinations in the facility and the facility was awaiting a new batch of vaccines. When the surveyor requested the pharmacy request for the newly ordered COVID-19 vaccinations, the SDC said she would speak with the Administrator. During an interview on 5/27/25 at 12:46 P.M., the Director of Nursing (DON), who was also the Infection Preventionist (IP), said the facility had not developed a written COVID-19 vaccination policy. During a follow-up interview on 5/27/25 at 12:46 P.M., the DON/IP said the facility has not maintained documentation of Resident #15's or Resident #114's COVID-19 vaccination history. The DON/IP said Resident #15 and the Resident Representative for Resident #114 had consented to the Residents being given vaccination to ensure they were up-to-date with their COVID-19 vaccinations. The DON/IP said no COVID-19 vaccinations had been administered to Resident #15 and Resident #114 and this should have been done shortly after they were admitted to the facility. The facility failed to provide any documentation to the survey team relative to the facility being in the process of ordering COVID-19 vaccinations from the pharmacy by the end of the survey on 5/27/25.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 interview, and record review, the facility failed to ensure resident beds were routinely inspected to identify areas of possible entrapment on three of three units. Specifically, the facility failed to ensure that resident bed frames, mattresses, and bed rails, were inspected annually as part of a routine maintenance program. Findings include: During the initial entrance conference on 5/20/25 at 8:01 A.M., with the Administrator and the acting Director of Nursing (DON), the Administrator said the facility's capacity was 132 resident beds and the current census was 117 residents. During an interview on 5/23/25 at 2:58 P.M., the Director of Maintenance (DOM) said resident beds were to be inspected for entrapment risk yearly. The DOM said he had a kit that was utilized to measure the zones applicable for entrapment risk and included the mattress, side rails, head and foot boards. The DOM said the facility did not have a current policy relative to routine bed assessments, but that all resident beds should be inspected annually. The DOM provided the surveyor with the Bed Assessment book for review at the time. Review of the Bed Assessment book indicated the following: -25 resident beds were inspected for entrapment from 12/13/23 through 12/14/23 -59 resident beds were inspected for entrapment from 4/1/24 through 11/15/24 -4 resident beds were inspected for entrapment from 11/16/24 through 11/23/24 Further review of the Bed Assessment book failed to indicate documented evidence that resident beds were inspected annually for entrapment. During an interview on 5/23/25 at 3:48 P.M., the Administrator said the facility did not currently have a policy relative to bed assessments. The Administrator said all resident beds should be inspected yearly for entrapment risk by the maintenance department who utilize an entrapment risk tool. During a follow-up interview on 5/23/25 at 4:21 P.M., the DOM said resident bed inspections for entrapment needed to be completed yearly. The DOM said there was currently no process/system in place to ensure the bed inspections were completed routinely and timely.