STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225764	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kimball Farms Nursing Care Center	40 Sunset Avenue Lenox, MA 01240

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to adhere to infection control standards of practice to prevent contamination and the spread of infections for six Residents (#43, #25, #5, #8, #3, and #40) out of a total sample of 17 residents, and on two units (Windemere and [NAME]) out of a total of three units. Specifically, the facility failed to ensure that:1) for Resident's #43, #25, #5, #8 and #3, who resided on the Windemere unit, the facility staff used the correct Personal Protective Equipment (PPE: items such as gowns, masks, eye protection or gloves that are used to prevent the spread of infection) for residents who were on Contact/Droplet Isolation for COVID-19 infection placing other residents and staff at risk of cross contamination and infection. 2) for Resident #40, who resided on the Sedgewick Unit, the facility staff followed Enhanced Barrier Precautions (EBP: the use of PPE for residents who are at higher risk of contracting an infection) during high contact care for a Resident with an indwelling urinary catheter device placing him/her at risk for the spread of infection. Findings include: Review of the facility policy COVID-19 Prevention and Outbreak Management, revised 9/17/25, indicated the following: -It is the practice of this facility to follow the guidance of government resources including Centers for Disease Control and Prevention (CDC), Centers for Medicaid and Medicare Services (CMS), Massachusetts Department of Public Health (DPH), and American Health Care Association (AHCA). -Positive COVID-19 Screening: >Immediately place the resident on Isolation/special Droplet precautions. Review of the CDC's Infection Control Guidance: SARS-CoV-2 [COVID-19 infection] dated 6/24/24 indicated the following: -This guidance applies to all U.S. settings where healthcare is delivered, including nursing homes and home health. -Personal Protective Equipment >HCP [health care providers] who enter the room of a patient with suspected or confirmed SARS-CoV-2 should adhere to Standard Precautions [a set of precautions such as washing hands before and after contact with a patient and use of gloves when coming in contact with bodily fluids is likely to prevent the spread of infection] and use a NIOSH [National Institute for Occupational Safety and Health] Approved particulate respirator with N95 or higher [a type of mask that filters out small infectious particles carried in the air], gown, gloves and eye protection (i.e., goggles or a face shield (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that covers the front and sides of the face). Review of the Isolation Droplet/Contact Precautions signs in use in the facility indicated the following: -In addition to standard precautions staff and providers must use: >Gown >N95 Respirator >Eye protection >Gloves 1a. On 12/3/25 at 8:36 A.M., the surveyor observed Unit Manager (UM) #2 delivering a breakfast tray to Resident #43. The surveyor observed the following: -an Isolation Droplet/Contact Precautions sign was observed on the outside of the doorway of Resident #43's room. -UM #2 was observed to enter the Resident's room with a surgical mask already in place, without donning (putting on) a gown, gloves, eye protection or changing her surgical mask to a N95 Respirator mask and deliver the breakfast tray to the Resident. -UM #2 was observed to exit the room, observe the signage outside of the Resident's doorway and then perform hand hygiene. -a PPE cart was observed nearby in the hallway with an ample supply of gowns, gloves, face shields and N95 Respirators. During an interview on 12/3/25 at 9:33 A.M., UM #2 said that she initially thought the sign outside of the Resident's room was for EBP as she was not aware the Resident had COVID-19. UM #2 further said she should have worn the required PPE when delivering the Resident's meal tray but did not. 1b. On 12/3/25 at 8:41 A.M., the surveyor observed the following while Certified Nurse's Aide (CNA) #5 was delivering breakfast trays: -CNA #5 donned the appropriate PPE and served a tray to Resident #25 where an Isolation Droplet/Contact Precautions sign was posted outside the Resident's door. -CNA #5 exited Resident #25's room and doffed (removed) the face shield, gown and gloves and performed hand hygiene. -CNA #5 donned a new gown, gloves and face shield and entered Resident #5's room where an Isolation Droplet/Contact Precautions sign was posted outside the door and delivered a tray to Resident #5 without doffing the N95 Respirator worn in Resident #25's room and donning a new N95 Respirator. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/3/25 at 9:24 A.M., CNA #5 said that she was supposed to change her N95 Respirator after exiting a room where a Resident is COVID-19 positive, but she had not. 1c. On 12/3/25 at 9:23 A.M., the surveyor observed Nurse #3 getting ready to enter Resident #8's room where an Isolation Droplet/Contact Precautions sign was posted outside the door. Nurse #3 was observed to drop the PPE gown she was donning on the floor, pick up the gown from the floor and donned the same gown before entering the Resident's room. During an interview on 12/3/25 at 9:40 A.M., Nurse #3 said that she should not have donned the gown that fell on the floor because the floor is dirty. 1d. On 12/3/25 at 9:40 A.M., the surveyor observed the following relative to CNA #4: -CNA #4 entered Resident #8's room, where an Isolation Droplet/Contact Precautions sign was posted outside the door, without donning eye protection. -CNA #4 exited Resident #8's room after doffing his gown and gloves. -CNA #4 performed hand hygiene and donned a new gown and gloves. -CNA #4 then entered Resident #3's room, where an Isolation Droplet/Contact Precautions sign was posted outside the door, without donning eye protection. During an interview on 12/3/25 at 9:47 A.M., CNA #4 said he was unsure if he should have worn eye protection in Resident #8's and Resident #3's rooms. The surveyor and CNA #4 reviewed the Isolation Droplet/Contact Precautions sign posted outside of Resident #3's room and CNA #4 said he should have worn eye protection but was unsure why this was important. During an interview on 12/3/25 at 10:03 A.M., the surveyor reviewed the (UM #2, CNA #5, Nurse #3 and CNA #4) observations with the Infection Control Preventionist (ICP). The ICP said that UM #2 should have worn PPE when entering a room with an Isolation Droplet/Contact Precautions sign posted outside the door, CNA #5 should have changed her N95 Respirator after exiting a room with an Isolation Droplet/Contact Precautions sign posted outside the door, CNA #4 should have worn eye protection in a room with an Isolation Droplet/Contact Precautions sign posted outside the door, and did not comment on Nurse #3. The ICP further said that not wearing or changing PPE as indicated was a concern due to the risk of transmission of infection. 2. Resident #40 was admitted to the facility in January 2024 with multiple diagnoses including obstructive and reflux uropathy and resided on the Sedgewick Unit.^ Review of the facility policy titled Infection Prevention and Control Manual, dated 1/10/23 indicated the following in part: -Enhanced Barrier Precautions (EBP) expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of Multi-Drug-Resistant Organisms (MDRO's) to staff hands and clothing. MDRO's may be indirectly transferred from resident to staff during these high contact activities. -EBP will be used in these conditions: All residents on the unit with indwelling medical devices e.g., (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.urinary catheter.ˆ -EBP require gowns and gloves for all high contact care. Examples: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care . urinary catheter. Review of Resident #40's December 2025 Physician orders indicated an order dated 8/11/25, to maintain the Foley Catheter (an indwelling urinary catheterˆusedˆtoˆdrainˆurineˆfromˆtheˆbladder) every shift.ˆ On 12/3/25 at 8:31 A.M., the surveyor observed the following outside Resident #40's bedroom: -EBP signage was posted outside of the Resident's bedroom. -A PPE bin was located outside of the Resident's room and was stocked with gowns and gloves. -Resident #40's bedroom door was closed. -CNA #2 said that CNA #1 was in Resident #40's room providing care for the Resident. ˆ -CNA #1 exited Resident #40's room while removing her gloves. CNA #1 was not wearing a PPE gown at this time. During an interview on 12/3/25 at 9:46 A.M., CNA #2 said staff are required to wear PPE when providing care for Resident #40 because the Resident had a urinary catheter.ˆ During an interview on 12/3/25 at 9:48 A.M., CNA #1 said she was not aware Resident #40 had an EBP sign on his/her door and she did not wear the appropriate PPE when providing care this morning for the Resident. CNA #1 said she and another CNA provided care for Resident #40 and she could not recall if anyone in the room had on the correct PPE when providing care for the Resident but should have because Resident #40 had a catheter.ˆˆ

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain a medication pass error rate of less than five percent (%) for one Resident (#58), of three applicable residents, out of 26 medication pass opportunities. The medication error rate was observed to be 15.38%. Specifically, for Resident #58, the facility staff administered: Potassium Citrate (essential mineral) and Metoprolol Succinate (blood pressure medication) medications that were crushed when the orders specified do not crush.A chewable Aspirin (blood thinner that prevents clots forming in the blood) instead of the ordered Enteric Coated (coating on the medication that allows the medication effect to be longer lasting) Aspirin.Polyethylene Glycol eye drops (type of lubricating eye drops) instead of the ordered Dextran 70/Hypromellose 0.1% - 0.3% eye drops (another type of lubricating eye drops). Findings include: Review of the Lippincott Nursing Procedures Ninth Edition (2023) manual indicated the following: -Verify the order on the patient's medication record by checking it against the practitioner's order. -Compare the medication label against the order in the patient's medical record. -If the patient can't swallow a whole tablet or capsule, ask the pharmacist whether the drug is available in liquid form or can be administered by another route. If not, request a crushed tablet (if appropriate) or discuss whether you can crush the tablet yourself or open the capsule and mix it with food. Keep in mind that many enteric-coated timed-released medications and gelatin capsules shouldn't be crushed to prevent possible adverse effects. Contact the practitioner for an order to change the route of administration when necessary. -To help prevent polypharmacy (taking many medications which places a person at greater risk of side effects and drug interactions), you can help older adult patients manage and adhere to their medication regimens by instructing them to take the following actions: >Take medications exactly as directed. Review of the facility policy titled Administration Procedure for all Medications, dated 9/20/23, indicated the following: -Purpose: to administer medications in a safe and effective manner. -Procedure: >Check MAR [Medication Administration Record] for order >Read medication label three times: 1) prior to removing medication package/container from the cart/drawer; 2) prior to removing medication from the package/container; 3) as the package/container is returned to the cart/drawer. Compare label to MAR. Due to the complexity and length/ amount of instructions, some medications may be labeled as use as directed. Refer to MAR for instruction details. Resident #58 was admitted to the facility in July 2024 with the diagnoses including Dementia and Heart Failure. Review of Resident #58's December 2025 MAR indicated: -an active order for Aspirin 81 milligrams (mg) tablet, enteric coated. Give one tab orally at 9:00 A.M., initiated 7/15/24. -an active order for Metoprolol Succinate 50 mg tablet, extended release. Give one tab orally at 9:00 A.M.swallow whole, do not crush or chew. initiated 7/15/24 -Potassium Citrate 10 milliequivalents (mEq) tablet, extended release. Give Two tabs orally twice a day.swallow whole, do not crush or chew.initiated 7/15/24. -Natural Tears (Dextran 70/Hypromellose 0.1% - 0.3% solution). Give two drops to bilateral eyes, initiated 7/22/25 On 12/5/25 at 7:53 A.M., the surveyor observed the following while Nurse #2 prepared and administered medications for Resident #58: -Nurse #2 poured two Potassium Citrate 10 mEq Extended-Release tablets into the medication cup -Nurse #2 poured one Metoprolol Succinate 50 mg Extended-Release tablets into the medication cup -Nurse #2 poured one chewable Aspirin 81 mg tablet into the medication cup -after pouring all other ordered medications into the cup, Nurse #2 crushed all tablets together and mixed them with pudding -After Nurse #2 prepared the medications, she administered the medication and pudding mixture to Resident #58. -Nurse #2 then administered two drops of Polyethylene Glycol eye drops in each of Resident #58's eyes. During an interview on 12/5/25 at 8:13 A.M., the surveyor and Nurse #2 reviewed Resident #58's MAR and Nurse #2 said the orders on the MAR for Potassium Citrate and Metoprolol Succinate indicated that these medications should be taken whole, do not crush and that she had crushed them when she administered the medications but should not have. Nurse #2 said the order for the eye drops specified Natural Tears (Dextran 70/Hypromellose 0.1%-0.3%) and that she had administered (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Polyethylene Glycol but should not have. Nurse #2 further said the order for Aspirin indicated to give the enteric coated form, but she had given the chewable form and should not have. Nurse #2 said she should have contacted the Provider to obtain orders for different forms of the medications instead of administering medications that did not follow the Physician orders. During an interview on 12/5/25 at 10:01 A.M., the Director of Nursing (DON) said the concern with Nurse #2 not following the Physician orders was that there could be an adverse reaction to the medication administration to Resident #58.