STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415075	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Retirement Home Inc	30 Sayles Hill Road Manville, RI 02838

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 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 surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, relative to 4 of 8 residents reviewed with an air mattress, Resident ID #s 86, 91, 111, and 135, 1 of 3 residents reviewed for oxygen administration, Resident ID #70, and for 1 of 1 resident reviewed with an order for daily weights, Resident ID #93. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients. 1a. Record review revealed Resident ID #86 was admitted to the facility in February of 2024 with diagnoses including, but not limited to, Parkinson's disease and adult failure to thrive. Record review revealed a physician's order dated 2/26/2024 which states in part, Air mattress to bed for comfort and pressure reduction. Check Setting according to resident weight. Special Instructions: Check settings every shift . Record review revealed the resident weighed 119.6 pounds (lbs.) on 6/5/2025. During surveyor observations on the following dates and times, the resident was observed in bed with the air mattress set to 300 lbs.: - 6/10/2025 at 8:57 AM - 6/11/2025 at 3:19 PM During a surveyor interview with Licensed Practical Nurse (LPN), Staff A on 6/11/2025 at 3:19 PM, she acknowledged the above observation. Additionally, she revealed that she was unaware of what the mattress should be set to. 1b. Record review revealed Resident ID #91 was admitted to the facility in January of 2024 with diagnoses including, but not limited to, Ankylosing hyperostosis (a condition where ligaments and tendons become hard and calcified, often leading to bone spurs and stiffness) and osteoarthritis. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed a physician's order dated 3/24/2025 which states in part, Air mattress to bed for comfort and pressure reduction. Special Instructions: Check settings every shift . Record review revealed the resident weighed 141 lbs. on 10/1/2024. During surveyor observations on the following dates and times, the resident was observed in bed with the air mattress set to 350 lbs.: - 6/9/2025 at 12:58 PM - 6/10/2025 at 3:27 PM - 6/11/2025 at 9:00 AM During a surveyor interview with Staff A on 6/11/2025 at 3:19 PM, she acknowledged the air mattress was set to 350 lbs. Additionally, she revealed that she was unaware of what the mattress should be set to. 1c. Record review revealed Resident ID #111 was admitted to the facility in September of 2022 with a diagnosis including, but not limited to, cerebral infarction (stroke). Record review revealed a physician's order dated 11/24/2024 which states in part, Air mattress to bed for comfort and pressure reduction set to 250 lb. Special Instructions: Check settings every shift . Record review revealed the resident weighed 212 lbs. on 6/9/2025. During surveyor observations on the following dates and times, the resident was observed in bed with the air mattress set to 325 lbs.: - 6/9/2025 at 10:30 AM - 6/10/2025 at 12:54 PM - 6/11/2025 at 1:35 PM During a surveyor interview with LPN, Staff B on 6/11/2025 at 2:38 PM, she acknowledged that the resident's air mattress was set to 325 lbs. and not to 250 lbs., per the physician's order. 1d. Record review revealed Resident ID #135 was readmitted to the facility in May of 2025 with diagnoses including, but not limited to, sepsis, the need for assistance with personal care, and sciatica. Record review revealed a physician's order dated 5/8/2025 which states in part, Air mattress to bed for comfort and pressure reduction. Special Instructions: Check settings every shift . Record review revealed the resident weighed 175.8 lbs. on 6/9/2025. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During surveyor observations on the following dates and times, the resident was observed in bed with the air mattress set to 100 lbs.: - 6/9/2025 at 9:10 AM - 6/11/2025 at 3:23 PM During a surveyor interview with Staff A on 6/11/2025 at 3:23 PM, she acknowledged the resident's bed was set to 100 lbs. Additionally, she revealed the resident does not weigh 100 lbs. and the air mattress setting should be readjusted to be closer to the resident's weight. During surveyor interviews with the Director of Nursing Services (DNS) on 6/12/2025 at 11:27 AM and 11:35 AM, he revealed that he would expect Resident ID #111's air mattress to be set to 250 lbs. per the physician's order. Additionally, he revealed his expectation would be for Resident ID #s 86, 91, and 135's air mattresses to be set to the residents' weights and for the physician's orders to be clarified to include the residents' weights. 2. Record review revealed Resident ID #70 was admitted to the facility in March of 2025 with diagnoses including, but not limited to, heart failure, edema (the accumulation of fluid in extremities), and an acute cough. Record review revealed a physician's order dated 3/15/2025 for oxygen at 2 Liters (L) per minute via nasal cannula (a medical device used to provide supplemental oxygen therapy) continuously. During surveyor observations the resident was observed receiving oxygen at 4 L per minute via nasal cannula on the following dates and times: - 6/9/2025 at 12:52 PM - 6/10/2025 at 9:01 AM, 12:35 PM, and at approximately 3:30 PM - 6/11/2025 at 8:45 AM During a surveyor interview on 6/11/2025 at 3:19 PM with Staff A, she acknowledged that the resident was not receiving oxygen at 2 L continuously, per the physician's order. During a surveyor interview with the DNS on 6/12/2025 at 11:35 AM, he indicated that he would expect the physician's order would be followed relative to the oxygen liter flow. 3. Record review revealed Resident ID #93 was admitted to the facility in October of 2023 with diagnoses including, but not limited to, Alzheimer's disease, edema (swelling caused by too much fluid trapped in the body), and congestive heart failure. Record review revealed a physician's order dated 1/29/2025 to obtain daily weights three times per week on Monday, Wednesday, and Friday prior to the morning meal. Special Instructions indicate to notify the physician if there is a weight gain greater than 3 lbs. in a day or greater than 5 lbs. in a week. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the June 2025 Treatment Administration Record revealed the resident weighed 145.8 lbs. on 6/2/2025 and 151.2 lbs. on 6/9/2025, indicating a weight gain of 5.4 lbs. Further record review failed to reveal evidence that the physician was notified of the above-mentioned weight gain. During a surveyor interview with Registered Nurse, Staff C, on 6/11/2025 at 2:57 PM, she revealed that the 3rd shift (11:00 PM - 7:00 AM) nurse obtained the resident's weight on the morning of 6/9/2025 and did not notify her of the weight discrepancy. Additionally, she revealed that she did not notify the physician of the resident's 5.4 lbs. weight gain. During a surveyor interview with the Nurse Practitioner on 6/11/2025 at 3:03 PM, she indicated that she would have expected to have been notified of the resident's weight gain, per the physician's order. During a surveyor interview with the DNS on 6/11/2025 at 3:06 PM, he acknowledged that the resident experienced a weight gain of over 5 lbs. in a week and would have expected the physician to be notified as ordered. Cross Reference F-842

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observations, record review, and staff interview, it has been determined that the facility failed to ensure that a resident receives treatment and care in accordance with professional standards of practice for 1 of 1 resident reviewed with edema (swelling due to excess fluid trapped in the body's tissues), Resident ID #51. Findings are as follows: Review of an undated facility policy titled, WHEN THERE IS A CHANGE OF CONDITION states in part, .The resident's attending physician or on-call physician must be notified when a change of condition has occurred . resident responsible party must be notified. Changes in condition include but are not limited to .A need to alter resident's medical treatment . Record review revealed the resident was readmitted to the facility in June of 2024 with diagnoses including, but not limited to, Alzheimer's disease, acute kidney failure, hypertensive heart (a condition caused by chronic high blood pressure) and chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood). Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 4 out of 15, indicating the resident has severe cognitive impairment. Record review revealed the resident was seen by the physician on 6/1/2025 with no acute issues present. Record review revealed the following progress notes: -6/5/2025 at 4:31 PM, Resident had a non-productive cough this shift, lung sounds assessed, s/he has bilateral wheezing on exertion. -6/5/2025 at 2:50 PM, Resident continues on the respiratory protocol. -6/6/2025 at 5:02 AM, Resident was noted with a coughing episode from 1:30 AM until 1:45 AM and lung sounds diminished (a condition when the lungs do not fully inflate). -6/8/2025 at 5:33 PM, Resident has diminished lung sounds with a faint expiratory wheeze (a noise heard on exhaling) and an occasional cough was noted. During a surveyor observations of the resident on 6/9/2025 at approximately 10:30 AM and again at 3:36 PM, the resident was observed to have swelling to his/her lower legs and had a congested, non-productive cough. Record review revealed the following physician's orders: 3/28/2025 - Diuretic (a medication used to treat fluid retention and high blood pressure) use, monitor for edema, congestion and weight changes every shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/3/2025 - Furosemide (Lasix-a diuretic medication) 40 milligrams (mg) twice a day. 6/5/2025 - Monitor respiratory status, include lung sounds and document in nursing notes every shift for three days. Further record review failed to reveal evidence that the resident's respiratory status was assessed per the above-mentioned orders on the following dates and shifts: -6/5/2025 3:00 PM - 11:00 PM -6/6/2025 7:00 AM - 3:00 PM -6/6/2025 3:00 PM - 11:00 PM -6/6/2025 11:00 PM - 7:00 AM -6/7/2025 7:00 AM - 3:00 PM -6/7/2025 3:00 PM - 11:00 PM -6/7/2025 11:00 PM - 7:00 AM During an additional surveyor observation on 6/11/2025 at approximately 9:00 AM through 9:45 AM, the resident was observed seated in his/her wheelchair with an occasional non-productive cough and swelling to both of his/her lower extremities. During a surveyor interview on 6/11/2025 at 10:03 AM with Certified Medication Technician, Staff D, he revealed that he observed the resident coughing on 6/10/2025 and 6/11/2025. He indicated that he wanted to give the resident a medication for his/her cough on 6/10/2025 but the resident did not have a physician's order. Additionally, he was unable to recall if he notified the nurse. During a surveyor interview on 6/11/2025 at 9:53 AM with Licensed Practical Nurse, Staff A, she acknowledged that she observed the resident coughing on 6/11/2025. She revealed that she had not assessed the resident's respiratory status. Record review of the June 2025 Treatment Administration Record (TAR) revealed Staff A signed off the physician's order to monitor the resident for edema and congestion on 6/9/2025 during the 7:00 AM to 3:00 PM shift as completed. During a surveyor interview with Staff A on 6/11/2025 at 12:49 PM, she revealed she did not assess the resident for the presence of edema on 6/9/2025 even though she had documented that the assessment was completed. Additionally, she indicated that the resident was experiencing crackles at the bases of both of his/her lungs on 6/9/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor observation immediately following the above interview with Staff A, she began to assess the resident for the presence of edema in his/her bilateral extremities. Staff A indicated that the resident presented with 4+ pitting edema (when the edema is pressed it leaves a dimple this is called pitting edema. A 4+ pitting edema indicates severe edema that can take up to 2-5 minutes to rebound) in his/her right lower extremity and 3+ pitting edema(this indicates severe edema and can take up to 30 seconds or more to rebound) in his/her left lower extremity, after this concern was brought to her attention by the surveyor. Further review failed to reveal evidence that the physician was notified of the resident's change in condition until 6/11/2025, after it was brought to the facility's attention by the surveyor, 6 days after initially being assessed by a nurse on 6/5/2025. Record review revealed the following physician's orders were obtained after the surveyor brought the resident's change in condition to the facility's attention: -The order for Lasix was increased from 40 mg twice a day to 60 mg twice daily for 4 days - A chest x-ray was to be obtained - A basic metabolic panel (a blood test that measures eight different substances in your blood, providing information about your body's metabolism, fluid balance, and kidney function) was to be obtained - A Pro BNP (a blood test used to measure heart failure) was to be obtained Additional record review revealed the Pro BNP was obtained on 6/12/2025 with a result of 827.0 picograms/milLiliter (pg/mL), which indicates an elevated value (a normal reference range is 0-300.0 pg/mL). During a surveyor interview on 6/11/2025 at approximately 3:10 PM with the Nurse Practitioner, she revealed that she was not made aware of the resident's change in condition on 6/5/2025. She further indicated that she would have expected to have been notified. During a surveyor interview on 6/11/2025 at 1:12 PM, with the Director of Nursing Services, he indicated that he would expect the provider to be notified of the resident's change in condition when it was identified on 6/5/2025, that the resident would have been assessed every shift for three days as ordered, and the findings to be reported to the provider. Additionally, he indicated that he would expect that the nurses would monitor the resident for the presence of edema and congestion every shift per the physician's order.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, it has been determined that the facility failed to accurately maintain the resident's medical record in accordance with accepted professional standards and practices relative to 3 of 8 residents reviewed with an mattress, Resident ID #s 86, 91, and 135, 1 of 3 residents reviewed for oxygen administration, Resident ID #70, and for 1 of 1 resident reviewed for the use of an incentive spirometer (a handheld medical device used to help patients improve the functioning of their lungs, by training patients to take slow and deep breaths), Resident ID #66. Findings are as follows: 1a. Record review revealed Resident ID #86 was admitted to the facility in February of 2024 with diagnoses including, but not limited to, Parkinson's disease and adult failure to thrive. Record review revealed a physician's order dated 2/26/2024 which states in part, Air mattress to bed for comfort and pressure reduction. Check Setting according to resident weight. Special Instructions: Check settings every shift . Record review revealed the resident weighed 119.6 pounds (lbs.) on 6/5/2025. During surveyor observations on the following dates and times, the resident was observed in bed with the air mattress set to 300 lbs.: - 6/10/2025 at 8:57 AM - 6/11/2025 at 3:19 PM Record review of the June 2025 Treatment Administration Record (TAR) revealed that the order was signed off as completed during first shift on 6/10 and 6/11/2025. During a surveyor interview with Licensed Practical Nurse (LPN), Staff A, on 6/11/2025 at 3:19 PM, she acknowledged that the air mattress was set to 300 lbs and that the air mattress was not set to the resident's weight. During a surveyor interview with Staff A on 6/11/2025 at 3:19 PM, she acknowledged the air mattress was set to 350 lbs. and that it was not set to the resident's weight. Additionally, she revealed that she had documented the order as completed 6/11/2025 without checking what weight the air mattress was set to. 1b. Record review revealed Resident ID #91 was admitted to the facility in January of 2024 with diagnoses including, but not limited to, Ankylosing hyperostosis (a condition where ligaments and tendons become hard and calcified, often leading to bone spurs and stiffness) and osteoarthritis. Record review revealed a physician's order dated 3/24/2025 which states in part, Air mattress to bed for comfort and pressure reduction. Special Instructions: Check settings every shift . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During surveyor observations on the following dates and times, the resident was observed in bed with the air mattress set to 350 lbs.: - 6/9/2025 at 12:58 PM - 6/10/2025 at 3:27 PM - 6/11/2025 at 9:00 AM Record review of the June 2025 TAR revealed that the order was signed off as completed during first shift on 6/9, 6/10, and 6/11/2025. During a surveyor interview with Staff A on 6/11/2025 at 3:19 PM, she acknowledged the air mattress was set to 350 lbs. and that it was not set to the resident's weight. Additionally, she revealed that she had documented the order as completed on 6/9 and 6/11/2025 without checking what the air mattress was set to. 1c. Record review revealed Resident ID #135 was readmitted to the facility in May of 2025 with diagnoses including, but not limited to, sepsis, the need for assistance with personal care, and sciatica. Record review revealed a physician's order dated 5/8/2025 which states in part, Air mattress to bed for comfort and pressure reduction. Special Instructions: Check settings every shift . Record review revealed the resident weighed 175.8 lbs. on 6/9/2025. During surveyor observations on the following dates and times, the resident was observed in bed with the air mattress set to 100 lbs.: - 6/9/2025 at 9:10 AM - 6/11/2025 at 3:23 PM Record review of the June 2025 TAR revealed that the order was signed off as completed during first shift on 6/9 and 6/11/2025. During a surveyor interview with Staff A on 6/11/2025 at 3:23 PM, she acknowledged the resident's bed was set to 100 lbs. and that it was not set to the resident's weight. Additionally, she revealed that she had documented the order as completed on 6/9 and 6/11/2025 without checking what the air mattress was set to. During a surveyor interview with the Director of Nursing Services (DNS) on 6/12/2025 at 11:35 AM, he revealed that he would expect Resident ID #s 86, 91, and 135's air mattresses to be set to their weights. Additionally, he would expect nurses to sign off the orders as completed in the TAR after the air mattress settings are checked. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review revealed Resident ID #70 was admitted to the facility in March of 2025 with diagnoses including, but not limited to, heart failure, edema (fluid accumulation in extremities), and an acute cough. Record review revealed a physician's order dated 3/15/2025 for oxygen at 2 Liters (L) per minute via nasal cannula (a medical device used to provide supplemental oxygen therapy) continuously. During surveyor observations, the resident was observed receiving oxygen at 4L per minute via nasal cannula on the following dates and times: - 6/9/2025 at 12:52 PM - 6/10/2025 at 9:01 AM, 12:35 PM, and at approximately 3:30 PM - 6/11/2025 at 8:45 AM Record review of the June 2025 Medication Administration Record (MAR) revealed that the resident was documented as receiving oxygen at 2L per minute on the above-mentioned dates and times, although the resident was observed by the surveyor receiving approximately 4L of oxygen. During a surveyor interview on 6/11/2025 at 3:19 PM with Staff A, she acknowledged that she signed off the resident's MAR on 6/9 and 6/11/2025 without checking the liter flow of oxygen. During a surveyor interview with the DNS on 6/12/2025 at 11:35 AM, he indicated that he would expect the physician's order would be followed relative to oxygen liter flow and that nurses would ensure the resident is receiving the correct liter flow of oxygen before documenting the order as completed. 3. Record review revealed Resident ID #66 was re-admitted to the facility in June of 2025 with diagnoses including, but not limited to, myocardial infarction (heart attack), chronic obstructive pulmonary disease, and acute/chronic respiratory failure with hypoxia (low oxygen levels). Record review revealed a physician's order dated 6/4/2025 to encourage the use of an incentive spirometer every shift. During surveyor observations on the following dates and times, there was no incentive spirometer located in the resident's room: - 6/9/2025 at approximately 10:30 AM - 6/12/2025 at approximately 10:00 AM Record review of the June 2025 TAR revealed the resident was documented as having been encouraged to use the incentive spirometer during first shift on 6/9 and 6/11 by Staff A and on 6/12 by LPN, Staff E. During a surveyor interview and observation with Staff E on 6/11/2025 at 10:00 AM, he indicated that he could not find the incentive spirometer in the resident's room and would need to order one. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview with Staff A on 6/12/2025 at 11:00 AM, she acknowledged that she documented the order as completed on 6/9 and 6/11 without encouraging the use of or checking to see if the resident used the incentive spirometer. During a surveyor interview with the DNS on 6/12/2025 at 11:35 AM, he indicated he would expect the nurses to complete the order before documenting it as completed in the resident's record. Cross Reference F-658

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections, relative to staff wearing the appropriate personal protective equipment (PPE) for 1 of 1 resident observed for wound care and transfers, Resident ID #21. Findings are as follows: Review of a facility policy titled, .Policy for Enhanced Barrier Precautions [EBP] (infection control measures which require donning gown and gloves during high-contact residents' care activities) states in part, .the [facility name redacted] home is committed to ensuring the highest quality of care for our residents. It is to that end that this policy will follow CMS [Centers for Medicare and Medicaid Services] for guidance and or regulations of the RIDOH [Rhode Island Department of Health] and the Centers for Disease Control and Prevention associated with infection control practices related to Enhanced Barrier Precautions .Enhanced Barrier Precautions are indicated for nursing home residents with any of the follow[ing] .EBP is primarily intended to where high-contact care activities occurs, in the residents room, including transfers that are bundled together with other high contact activity such as morning or evening care . Signage must be present outside residents' rooms to signal individuals entering a room the specific actions they should take to protect themselves and the residents . Record review revealed the resident was readmitted to the facility in October of 2023 with diagnoses including, but not limited to, muscle weakness and difficulty in walking. During a surveyor observation on 6/9/2025 at approximately 10:00 AM, there was an EBP sign observed outside of the resident's door which stated in part, .wear gloves and gown for this following High-Contact Resident Care Activities .Transferring . Record review of a physician's order revealed the following: - 3/5/2020 - the resident is to be assisted with a Hoyer lift by 2 staff for all transfers. - 5/5/2025 - Maintain Enhanced Barrier Precautions related to a wound. - 5/5/2025 - Cleanse the wound to the left ischium (a paired bone located within the pelvis which forms the lower and the back portion of the hip) with normal saline, pat dry with gauze, apply Medihoney (a medical-grade honey that aids in wound healing) follow by plain calcium alginate then cover with a dressing. Review of a document titled, Weekly Wound Assessment dated 6/2/2025 revealed a stage two pressure ulcer (a partial-thickness skin loss involving the the second layer of the skin) on the left ischium measuring 0. 8 centimeters (cm) x 0.5 cm x 0.1 cm. (continued on next page)

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	415075	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Retirement Home Inc	30 Sayles Hill Road Manville, RI 02838

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During a surveyor observation on 6/12/2025 at 7:50 AM, Registered Nurse (RN), Staff C, was observed entering the resident's room for a dressing change without wearing a gown as ordered. After removing the resident's soiled dressing with gloves, she entered the resident's bathroom to perform hand hygiene. However, when she exited the bathroom she indicated that she had forgotten to put on a gown before starting the wound dressing change. She exited the room, put on a gown and gloves then resumed the resident's wound dressing change. During the wound dressing change, Staff C was observed cleansing the wound with a gauze previously soaked with normal saline, she then placed the soiled gauze directly on the bedside table. Further, Staff C was observed placing the dirty cotton swabs used to spread the Medihoney and the calcium alginate to the wound bed, on the bedside table. Staff C failed to disinfect the bedside table after the wound dressing was completed. Furthermore, Staff C was observed exiting the resident's room to the hallway without taking off her gown. When she realized she still had the gown on, she went back to the room to take it off. During a surveyor interview immediately following the wound dressing observation, Staff C acknowledged she did not wear a gown as required prior to starting the resident's wound dressing change and failed to remove the gown prior to exiting the resident's room. Additionally, she acknowledged that she placed the soiled dressing items directly on the bedside table and did not disinfect it afterwards. 2. During a surveyor observation on 6/12/2025 at 8:16 AM two Nursing Assistants (NAs), Staff F and G, were observed entering the resident's room without wearing a gown or gloves. Additionally, Staff F and G were observed rolling the resident onto his/her side in attempts to place a Hoyer pad underneath him/her. Further, Staff F and G were observed transferring the resident from the bed to a wheelchair without wearing a gown or gloves. During a surveyor interview immediately following the above observation, both Staff F and G acknowledged that they failed to follow the EBP protocol as ordered and acknowledged that they should have when they transferred the resident. During a surveyor interview on 6/12/2025 at 10:54 AM with the Staff Educator, he indicated that he would expect the staff to follow the infection control protocol when required. Additionally, he indicated that he would expect the staff to wear the appropriate PPE before providing care to the residents who are on EBP, as ordered, and/or per the signage on the doors.

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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. Based on record review and staff interview, it has been determined that the facility failed to establish an Infection Prevention and Control Program (IPCP) that must include, at a minimum, an antibiotic stewardship program which includes antibiotic use protocols and a system to monitor antibiotic use to ensure that residents who require an antibiotic, are prescribed the appropriate antibiotic for 3 of 5 residents reviewed for antibiotic use, Resident ID #s 69, 85, and 135. Findings are as follows: According to a Centers for Disease Control and Prevention (CDC) document titled, The Core Elements of Antibiotic Stewardship for Nursing Homes states in part, Perform antibiotic 'time outs.' .Nursing homes should have a process in place for a review of antibiotics by the clinical team two to three days after antibiotics are initiated to answer these key questions: - Does this resident have a bacterial infection that will respond to antibiotics - If so, is the resident on the most appropriate antibiotic(s), dose, and route of administration? - Can the spectrum of the antibiotic be narrowed or the duration of therapy shortened (i.e., de-escalation)? - Would the resident benefit from additional infectious disease/antibiotic expertise to ensure optimal treatment of the suspected or confirmed infection . 1. Record review revealed that Resident ID #69 was admitted to the facility in January of 2020 with a diagnosis including, but not limited to, Parkinson's disease. Record review revealed the resident received doxycycline (an antibiotic) 100 milligrams (mg) twice daily from 6/3/2025 through 6/10/2025, for an infection of the great toe. Record review failed to reveal evidence that an antibiotic time out or a review was conducted. 2. Record review revealed that Resident ID #85 was readmitted to the facility in March of 2024 with a diagnosis including, but not limited to, type II diabetes. Record review revealed the resident received cephalexin (an antibiotic) 500 mg twice daily from 6/5/2025 through 6/12/2025 as a preventative measure related to a surgical incision. Record review failed to reveal evidence that an antibiotic time out or a review was conducted. 3. Record review revealed that Resident ID #135 was readmitted to the facility in May of 2025 with a diagnosis including, but not limited to, heart failure. Record review revealed the resident received doxycycline 100 mg twice daily from 6/6/2025 through 6/12/2025 for pneumonia. Record review failed to reveal evidence that an antibiotic time out or a review was conducted. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor telephone interview on 6/11/2025 at 9:15 AM with the Infection Preventionist, she acknowledged that there were no antibiotic timeouts completed for Resident ID #s 69, 85, and 135. Additionally, she revealed that she would expect antibiotic timeouts to be completed within 48 to 72 hours following the initiation of an antibiotic. Further, she revealed that she is on a leave of absence and indicated that there is not a designated staff member to complete the antibiotic timeouts.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to ensure the resident's medical record includes documentation that the resident was offered or received the indicated pneumococcal vaccination or did not receive the vaccination due to medical contraindications or a refusal for 2 of 5 residents reviewed, Resident ID #s 88 and 111. Additionally, the facility failed to have updated policies regarding pneumococcal immunizations. Findings are follows: According to the Centers for Disease Control and Prevention (CDC), pneumococcal vaccination for adults 65 years or older who have received PCV13 (a type of pneumococcal conjugate vaccination) at any age and the PPSV23 at [AGE] years of age or older, are recommended to receive a single dose of the PCV20 or PCV21 vaccine after 5 or more years from the date of the last pneumococcal vaccine. 1a. Record review revealed Resident ID #88 was readmitted to the facility in March of 2025. Review of the resident's immunization records revealed that the resident received his/her PCV13 vaccine in November of 2015 (at age [AGE]) and his/her PPSV23 vaccine in September of 2019 (at age [AGE]). Record review failed to reveal evidence that the resident was offered, received, or declined the PCV20 or PCV21 vaccine. 1b. Record review revealed Resident ID #111 was readmitted to the facility in November of 2024. Review of the resident's immunization records revealed that the resident received his/her PPSV23 vaccine in December of 2013 (at age [AGE]) and his/her PCV13 vaccine in June of 2018 (at age [AGE]). Record review failed to reveal evidence that the resident was offered, received, or declined the PCV20 or PCV21 vaccine. During a surveyor interview on 6/12/2025 at 11:29 AM with the Infection Preventionist, she revealed that she follows the CDC guidance relative to pneumococcal vaccinations. Additionally, she was unable to provide evidence that Resident ID #s 88 and 111's medical records included documentation that indicates, at a minimum, if the residents were either offered, received, or refused the PCV20 or PCV21 pneumococcal vaccine. 2. Review of a facility policy titled, Resident Vaccination (Flu and pneumonia) dated 3/2020 states in part, . Vaccinations are to be provided in accordance with the most recent ACIP (Advisory Council on Immunization Practices) guidelines for these vaccinations. As of 2019, ACIP has recommended the following pneumonia vaccination schedule (Also follow CDC Vaccination for Elders guidelines): ACIP recommends a routine single dose of PPSV23 for adults aged greater than or equal to 65 years .and who have not previously received PCV13. If a decision to administer PCV13 is made, PCV13 should be administered first followed by PPSV23 at least 1 year later . (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 6/12/2025 at 12:20 PM with the Director of Nursing Services, he acknowledged that the policy that the facility is currently using is not up to date and does not include the current guidelines for pneumococcal vaccinations.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on surveyor observation and staff interview, it has been determined that the facility failed to maintain a safe, functional, and comfortable environment relative to 1 of 3 kitchenettes and the main kitchen. Findings are as follows: 1. During the initial tour of the kitchen on 6/9/2025 at 9:54 AM, in the presence of the Food Service Director (FSD), the walk-in freezer was noted to have an accumulation of ice buildup on the sprinkler head and on the left fan, located near the ceiling of the freezer. During a surveyor interview, immediately following the above observation, the FSD acknowledged the ice buildup and indicated it should be cleaned. 2. During a surveyor observation on 6/9/2025 at approximately 10:30 AM, of the Jamestown Unit Kitchenette, in the presence of the FSD, revealed one microwave, mounted above the counter, which was noted to be severely cracked with peeling paint on the exterior of the microwave. During a surveyor interview, immediately following the above observation, the FSD acknowledged the cracks and peeling paint on the exterior of the microwave and indicated that the microwave would be removed.