STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225058	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Braintree Nursing and Rehabilitation Center	95 Commercial Street Braintree, MA 02184

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for two of three sampled residents (Resident #2 and #3), the Facility failed to ensure that upon admission, they developed and implemented baseline care plans with interventions, treatments, goals, and outcomes that addressed the residents' overall immediate care needs.Findings include:Review of the Facility Policy titled Baseline Care Plans, dated as last revised 05/2025, indicated that a baseline plan of care for each resident is to include the instructions needed to provide effective and person-centered care of the residents that meet professional standards of quality care. The Policy further indicated that the baseline care plan be developed within 48 hours of admission and supervising staff should verify within 48 hours that a baseline care plan has been developed.1) Resident #2 was admitted to the Facility in 9/2025, diagnoses include a history of a Traumatic Brain Injury (TBI) with seizure disorder, multiple falls, acute urinary retention with an indwelling catheter (flexible tube inserted into the bladder to drain urine) in place, and cirrhosis (severe scarring of the liver from long term damage) secondary to alcohol use.Review of Resident #1 Hospital Discharge summary, dated [DATE], indicated his/her immediate care needs were identified as followed;-Acute urinary retention with an indwelling catheter in place;-Need for Enhanced Barrier Precautions (infection control measure during high-contact resident care, especially for those with devices);-High risk for falls related to seizure disorder; and-Titration of antipsychotic medication.Review of Resident #2's Medical Record indicated that there was no documentation to support that Baseline Care Plans were developed and implemented to address these areas of concern within 48 hours of his/her admission.2) Resident #3 was admitted to the Facility in 11/2025, diagnoses chronic obstructive pulmonary disease, pneumonia, Normal Pressure Hydrocephalus (NPH, an excess of cerebrospinal fluid builds up in the ventricles) dysphagia (difficulty swallowing) with the need for a gastrostomy tube (tube inserted into stomach to provide nutrition), and pressure injury. Review of Resident #3 Hospital Discharge summary, dated [DATE], indicated his/her immediate care needs were identified as followed;- Pneumonia with antibiotic and oxygen use;-Gastrostomy Tube in place for Nutrition.-Need for Enhanced Barrier Precautions;-Anticoagulation therapy; and-Actual Pressure Injury and continued risk for skin breakdown. Review of Resident #3's Medical Record indicated that there was no documentation to support that Baseline Care Plans were developed and implemented, or that the Comprehensive Care Plans addressed these areas of concern were in place within 48 hours of admission.During an interview on 12/02/25 at 2:16 P.M., the Unit Manager said that she was not aware that Residents # 2 and #3 did not baseline care plans completed and said that it was a team effort to complete the baseline care plans starting with the admitting nurse.The Unit Manager said that as a team, the management staff are to review a new admission chart the next day at morning meeting to ensure that the baseline care plans are completed.During an interview on 12/02/25 at 4:07 P.M., the Assistant Director of Nurses (ADON) said that she was unaware that Resident #2 and Resident #3's baseline care plans had not been completed.The ADON said that the admitting nurses are responsible for initiating the baseline care plan for the residents and each section should be filled out. The ADON said that the team is to review the baseline care plans the day after admission (or as close to) for completion. During an interview on 12/02/25 at 4:54 P.M., the Director of Nurses (DON) said that she was not aware of Residents #2, and #3 baseline care plans were incomplete and had not addressed their immediate care needs.The DON said that it is the Facility's expectation that the admitting nurse is to initiate the resident's baseline care plan and said, along with the other disciplines complete the Baseline care plan within 48 hours of admission.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #2), whose Hospital Discharge Summary included instructions related to voiding trials and the removal of his/her indwelling catheter (flexible tube inserted into the bladder to drain urine), the Facility failed to ensure he/she underwent a voiding trial and was assessed timely for potential removal of the catheter, which resulted in the extended use of an indwelling device.Findings include:Resident #2 was admitted to the Facility in 9/2025, diagnoses include a history of a Traumatic Brain Injury (TBI) with seizure disorder, multiple falls, acute urinary retention with an indwelling catheter in place, and cirrhosis (severe scarring of the liver from long term damage) secondary to alcohol use.Review of Resident #2's Hospital Discharge summary, dated [DATE], indicated that an indwelling catheter had been placed secondary to acute urinary retention. The Discharge Summary indicated to attempt a voiding trial once discharged from the acute hospital and remove the indwelling catheter as able. Review of Resident #2's admission Minimum Data Set (MDS) assessment, dated 10/02/25, indicated he/she had an indwelling catheter. Review of Resident #2's Care Plan titled Indwelling Catheter, dated 10/16/25, indicated he/she had a urinary catheter, however the care plan failed to include interventions related to conducting voiding trials and attempting to remove the indwelling device.Review of Resident #2's Physician Assistant Progress Note, dated 10/20/25, indicated to follow-up with urology for any voiding trials.Review of Resident #2's medical record indicated that there was no documentation to support nursing staff communicated with urology, attempted a voiding trial or removed the indwelling catheter as indicated in his/her Hospital Discharge Summary.During an interview on 12/02/25 at 12:29 P.M., Resident #2 said he/she had no idea why he/she still has an indwelling catheter in place and wondered when they would be taking the tube out!During an interview on 12/02/25 at 12:42 P.M., Nurse #9 said that she does not know why Resident #2 had an indwelling catheter in place and said that she does not know why they have not attempted to remove Resident #2's indwelling catheter.During an interview on 12/02/25 at 4:54 P.M., the Director of Nurses (DON) said that she was not aware that Resident #2 had instructions on his/her discharge summary to attempt a voiding trial and to remove his/her indwelling catheter as able.The DON said that it is the Facility's expectation that nursing read each resident's discharge summary and verify all orders upon admission. The DON said that all indwelling catheters should be removed in a timely manner unless otherwise indicated by a physician.