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	11/15/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 46562 Based on observations, interviews, and records reviewed, the facility failed to ensure a reasonable accommodation was made for seven Residents (#150, #101, #49, #148, #65, #102, and #93), on the Sunshine Unit with a census of 35. Specifically, the facility failed to ensure the call system was accessible to the Residents to call for staff assistance. Findings include: Review of the facility's policy titled Resident Call System, undated, indicated but was not limited to: -When in their rooms and toilet and bathing areas, residents will have a means of directly contacting caregivers. 1. On the following dates and times, the surveyor observed Resident #150 without a means of directly contacting caregivers. The surveyor observed Resident #150 in bed with the call light clipped to itself and hanging against the wall, not within the Resident's reach, with no hand-held device (i.e., hand bell) observed: -11/12/24 at 10:53 A.M., -11/12/24 at 3:35 P.M., -11/13/24 at 9:11 A.M., -11/13/24 at 11:36 A.M., -11/13/24 at 2:08 P.M., -11/13/24 at 4:40 P.M., -11/14/24 at 8:05 A.M., and -11/14/24 at 3:18 P.M. (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: 225058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER: Royal Braintree Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 95 Commercial Street Braintree, MA 02184	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On the following dates and times, the surveyor observed Resident #101 without a means of directly contacting caregivers. The surveyor observed Resident #101 in bed with the call light cord draped over a wall mounted monitoring device above the headboard, not within the Resident's reach, with no hand-held device observed: -11/12/24 at 10:52 A.M., -11/12/24 at 3:35 P.M., -11/13/24 at 9:11 A.M., -11/13/24 at 11:36 A.M., -11/13/24 at 2:08 P.M., -11/14/24 at 8:05 A.M., and -11/14/24 at 3:18 P.M. 3. On the following dates and times, the surveyor observed Resident #49 without a means of directly contacting caregivers. The surveyor observed Resident #49 in bed with the call light cord draped over a wall mounted monitoring device above the headboard, not within the Resident's reach, with no hand-held device observed: -11/12/24 at 10:06 A.M., -11/12/24 at 3:34 P.M., -11/13/23 at 9:12 A.M., -11/13/23 at 11:34 A.M., -11/13/23 at 2:14 P.M., -11/13/23 at 4:43 P.M., and -11/14/24 at 3:19 P.M. 4. On the following dates and times, the surveyor observed Resident #148 without a means of directly contacting caregivers. The surveyor observed Resident #148 in bed with the call light cord clipped to itself and hanging against the wall, not within the Resident's reach, with no hand-held device observed: -11/12/24 at 9:57 A.M., -11/12/24 at 1:46 P.M., -11/12/24 at 3:36 P.M., and (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11/13/24 at 4:44 P.M. 5. On the following dates and times, the surveyor observed Resident #65 without a means of directly contacting caregivers. The surveyor observed Resident #65 in bed with the call light cord draped over a wall mounted monitoring device above the headboard, not within the Resident's reach, with no hand-held device observed: -11/12/24 at 10:03 A.M., -11/12/24 at 1:39 P.M., and -11/12/24 at 3:30 P.M. 6. On 11/12/24 at 9:57 A.M., the surveyor observed Resident #102 without a means of directly contacting caregivers. The surveyor observed Resident #102 in bed with the call light cord clipped to itself and hanging against the wall, not within the Resident's reach, with no hand-held device observed. 7. On 11/12/24 at 9:52 A.M., the surveyor observed Resident #93 without a means of directly contacting caregivers. The surveyor observed Resident #93 in bed with the call light cord clipped to itself and hanging against the wall, not within the Resident's reach, with no hand-held device observed. During an interview on 11/14/24 at 4:08 P.M., Certified Nursing Assistants (CNA) #2, #3, and #4 said the facility staff know a resident needs help when they ring the call light. CNAs #2, #3, and #4 said all residents should be able to reach their call light when in their room. During an interview on 11/14/24 at 4:06 P.M., Nurse #1 said she knew when a resident needed help because they used the call light. Nurse #1 said residents should always have access to a call light. During an interview on 11/14/24 at 5:03 P.M., the Assistant Director of Nurses (ADON) said residents should always have the call light within reach. The surveyor and the ADON observed Residents #101, #150 and #49 in bed with their call lights out of reach. The ADON said the call lights should have been within reach. During an interview on 11/14/24 at 5:07 P.M., Regional Nurse #2 said all residents should have access to their call lights and a means of contacting staff when in their rooms.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49424 Based on observation and interview, the facility failed to ensure the residents' environment was clean, comfortable, and homelike. Specifically, the facility failed to ensure the resident rooms were maintained in good repair (without holes, painted) and homelike on one unit (K2) out of seven. Findings include: Review of the facility's policy titled Royal Health Group Preventative Maintenance Program, undated, indicated but was not limited to: -A preventative maintenance program shall be developed and implemented to ensure the provision of a safe, functioning, sanitary, and comfortable environment for residents, staff, and the public. -The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner. On 11/13/24 at 8:30 A.M. on the K2 unit, the surveyor observed: -room [ROOM NUMBER]-B: Missing a privacy curtain; and a hole in the wall with paint cracking -room [ROOM NUMBER]-B: Blinds with four areas of brown stains -room [ROOM NUMBER]-B: Ripped floor mats exposing the foam inside; and a broken footboard on the bed -room [ROOM NUMBER]-B: A hole in the windowsill with paint chipping and peeling; and a broken window that would not close with four towels placed in the open window to decrease a cold draft in the room During an interview on 11/13/24 at 8:59 A.M., Certified Nurse Aide (CNA) #5 said maintenance requests for repairs are written in a logbook on the unit for someone from maintenance to review. During follow-up visits to the unit on 11/14/24 at 9:54 A.M., and 11/14/24 at 3:10 P.M., the same observations were made by the surveyor on the K2 unit as during the initial tour on 11/13/24. During an interview on 11/14/24 at 9:43 A.M., the Maintenance Director said he recently just started at the facility, and they have begun rolling out the implementation of the TELS system as of 11/11/24. He said he rounds on the units regularly and he wasn't aware of any issues on the K2 unit. Review of the TELS log indicated the need for repairs were not reported. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/24 at 9:49 A.M., Nurse #2 said she was not aware there were any repairs that needed to be requested on the unit. She said if she notices something she will put it in the log and she depends on the staff providing care in resident rooms to report issues. During an interview on 11/14/24 at 12:06 P.M., the Administrator said he was aware the building needed repairs and there were quite a few unfinished work orders from the previous maintenance director. He said the current Maintenance Director has only been in the role for a week. During an interview with observation on 11/14/24 at 3:10 P.M., the Administrator and Regional Nurse #2 toured the K2 unit with the surveyor. The Administrator and Regional Nurse #2 agreed that the fall mats, walls, windows, and other broken items should have been identified and repair. The Administrator said one possibility for the lack of repairs could be fatigue from the staff from making multiple requests to the previous maintenance director with no follow-up. He said sometimes we just get used to how something appears. The Regional Nurse #2 said the environment should be sanitary and in good repair for the residents to experience a homelike environment.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15214 Based on observation, interview, and record review, the facility failed to ensure that for two Residents (#86 and #232), of a total sample of 34 residents, that Minimum Data Set (MDS) assessments accurately reflected the residents' status. Findings include: 1. Resident #232 was admitted to the facility in September 2024 with diagnoses which included a fall requiring rehabilitation. Review of the MDS assessment, dated 9/26/24, indicated, under the Physical Restraint section, P0100, that bed rails were not used. Review of the Physician's Orders, dated 9/16/24, indicated that bed rails were to be used daily. From 11/12/24 to 11/14/24, the surveyor observed each day of the survey that Resident #232's bed rails were in place and up, on the left and right upper part of the Resident's bed. During an interview on 11/13/24 at 10:52 A.M., Nurse #4 said that the Resident used bed rails daily. Nurse #4 reviewed the assessment dated [DATE] and said it was inaccurate because bed rails were used daily and the assessment should have been coded 2 Used daily instead of 0, Not used. 2. Resident #86 was admitted to the facility in January 2022 with diagnoses which included cerebrovascular accident (CVA). Review of the MDS assessment, dated 10/7/24, indicated, under Bowel and Bladder Section H, that the Resident did not have an indwelling catheter. On 11/12/24 at 11:30 A.M., the surveyor observed Resident #86 to have a Foley catheter in place. Review of Resident #86's record indicated that he/she utilized a urinary catheter for urinary drainage. Review of the current Physician's Order indicated: -16 French Foley catheter with a 10 milliliter (ml) balloon -Nursing to perform catheter care every shift, fluid output monitoring every shift, and irrigate with normal saline as needed. During an interview on 11/14/24 at 10:45 A.M., Unit Manager #3 said the MDS assessment, dated 10/7/24, was inaccurate, as it did not code the Resident for having an indwelling Foley catheter. Unit Manager #3 said Resident #86 has had the Foley catheter in place for months, going back to when the Resident developed a Stage 2 coccyx pressure ulcer following a hospitalization in April 2024.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 36542 Based on observation, interview, and record review, the facility failed to ensure one Resident (#67) was provided a therapeutic diet as ordered, in a total sample of 34 residents. Specifically, Resident #67, with weight loss, was not provided fortified food as ordered. Findings include: Review of the facility's policy titled Fortified Food Program, undated, indicated the following: -the goal of the fortified food program is to provide a higher calorie and higher protein food item to residents -a fortified food is typically a food from the regular diet with additional ingredients which provide extra calories and/or protein without increasing the volume of food offered to the resident Resident #67 was admitted to the facility in April 2024 with diagnoses of dementia and failure to thrive. Review of the care plan indicated Resident #67 had a nutritional problem related to decreased appetite with a goal of maintaining adequate nutritional status. The care plan interventions included having fortified foods with all meals. Review of the Physician's Orders indicated that an order was written on 10/16/24 for a house diet, regular texture, with fortified foods with all meals and Magic Cup (high calorie, ice cream-like nutritional supplement) with lunch and dinner. Review of the weights for Resident #67 indicated the Resident weighed 109.5 pounds (lbs.) on 7/10/24 and 99.5 lbs. on 8/28/24, a loss of 9.13% in six weeks. Review of the weights indicated the Resident weighed 102.0 lbs. on 9/3/24 and 99.8 lbs. on 10/1/24. Review of the medical record indicated Resident #67 had been hospitalized for five days in October 2024. Review of the Quarterly Nutritional Assessment, dated 10/18/24, indicated Resident #67 was at nutritional risk related to a diagnosis of dementia and variable intake of food and the Resident would continue to have fortified foods at all meals. On 11/13/24 at 1:18 P.M., the surveyor observed Resident #67 in the unit dining room having lunch of seasoned fish, noodles, and cauliflower. Review of the meal ticket indicated Resident #67 was to have fortified mashed potatoes. There were no fortified foods observed with the Resident's meal. On 11/14/24 at 9:18 A.M., the surveyor observed Resident #67 in the unit dining room having breakfast of pancakes, sausage link, cold cereal and fruit cup. Review of the meal ticket indicated Resident #67 was to have fortified hot cereal of choice. There were no fortified foods observed with the Resident's meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 1:24 P.M., the surveyor observed Resident #67 in the unit dining room having lunch of seasoned chicken, macaroni and cheese, and brussels sprouts. Review of the meal ticket indicated Resident #67 was to have fortified mashed potatoes and Magic Cup. There were no fortified foods or Magic Cup observed with the Resident's meal. During an interview on 11/14/24 at 1:25 P.M., Nurse #3 said fortified foods were usually the oatmeal in the morning and the mashed potatoes. The Nurse observed the meal for Resident #67 and said she could not be sure if anything on the plate was fortified because there were no mashed potatoes. She said she had no way of knowing if the kitchen made additional food items fortified. She said she noticed the Resident's meal did not come with a Magic Cup and she had called down to the kitchen for them to send some up to the unit. During an interview on 11/14/24 at 2:26 P.M., the Registered Dietitian said the facility utilized oatmeal/hot cereal for a fortified food at breakfast and mashed potatoes for lunch and dinner. She said the facility did not have any other fortified foods. She said Resident #67 was a high nutritional risk and had been experiencing weight loss and should be getting fortified foods. She said the kitchen should be putting the fortified foods on to the meal trays as indicated on the tray tickets. She said the kitchen was responsible for putting the Magic Cups on the meal trays and this should be included if indicated on the tray ticket.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 36542 Based on interview and record review, the facility failed to assess triggers for a Resident (#22) with a history of trauma, to avoid potential re-traumatization, out of a total sample of 34 residents. Findings include: Review of the facility's policy titled Trauma Informed Care, dated as revised in November 2023, indicated the following: -the commitment to recognize events in resident's past that may have been traumatic and may continue to have a negative, upsetting or emotionally difficult impact on their lives -as part of the admission process a specific assessment will be done consisting of several questions that are worded to assesses past experiences and not trigger the episode -once the initial assessment has been completed by Social Services a choice can be made to proceed or not to proceed to a psych referral based on responses -if a resident has a history of trauma that is documented or if they have triggered from the assessment the Social Worker (SW) and Interdisciplinary team (IDT) need to immediately formulate a plan of care to assist the resident in coping within the facility -the plan of care needs to be specific and include anything that has been shared that could trigger a memory of the incident -staff education should be done to identify any resident reactions that may indicate past trauma and what to do with that information Resident #22 was admitted to the facility in June 2015. Review of the medical record indicated a new diagnosis of post-traumatic stress disorder (PTSD- a mental health condition that is triggered by an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being) in December 2023. Review of the care plans indicated Resident #22 had a trauma history with a goal of being comfortable during their stay. The interventions included: staff assistance with referral to psychiatric services as needed, assistance with monitoring for signs and symptoms of anxiety, hyperarousal or panic and requiring staff assistance with monitoring for signs and symptoms of depression including low self-esteem and trust issue. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress note, dated 12/18/23, indicated Resident #22 had reported a sexual assault to his/her daughter and the daughter informed staff that Resident #22 had a history of sexual assault. Review of the social service progress note, dated 12/19/23, indicated Resident #22 said something happened a long time ago and emotional support was provided. Review of the Trauma Assessment, dated 12/26/23, indicated the following responses: Have you ever had a life-threatening medical condition: No Have you ever experienced something that made you feel threatened in the past or present: yes Have you ever had nightmares about something that happened to you or that you witnessed happen to someone else: yes What was your childhood like: ok If married or in serious relationship, what was that relationship like: NA Do you often feel on edge or that you are outside looking in on yourself: no Proceed to referral: Yes Review of the Follow-up Psychiatric Evaluation from the consultant Psychiatrist indicated delusional, believes foster staff may be here trying to harm him/her. During an interview on 11/15/24 at 9:05 A.M., Social Worker #1 said she had completed the Trauma Assessment for Resident #22 and had met with the Resident in December 2023. She said the Social Workers were responsible for completing the Trauma Assessment to determine if there was a history of trauma and then refer to psych services if needed, but did not inquire about triggers that may re-traumatize a Resident. She said the nurses would inquire about triggers for trauma, especially when related to sexual assault. She said Resident #22 was very conversant and was able to make his/her needs known. She said she did not inquire with the Resident if there was anything in particular which may be upsetting or trigger the trauma and would have to check with nursing to see if this was done. The surveyor and the Social Worker reviewed the Psychiatric Evaluation from 12/21/23. The Social Worker said she did not know what foster staff meant or if the Resident was ever in foster care. During an interview on 11/15/24 at 9:45 A.M., the Assistant Director of Nurses said the process for trauma informed care was for the Social Workers to complete the assessment to determine if there was a history of trauma and if there were triggers so that staff could be aware. She said if a resident has trauma, the triggers need to be identified so that staff can be educated on the triggers to avoid any additional re-traumatization. She reviewed the Trauma Assessment for Resident #22 and said the assessment did not indicate the type of trauma or the triggers and was not elaborate. She reviewed the care plan for Resident #22 and said the care plan did not include the trauma information or triggers. She said the facility staff would need to know what to do to keep the resident safe and the information wasn't available in this assessment or care plan.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49428 Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to ensure thickened beverage items were properly dated and stored in three of seven kitchenettes. Findings include: 1. Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. Review of the facility's policy titled Food Receiving and Storage, undated, indicated but was not limited to: Policy: Food shall be stored in a manner that complies with safe food handling practices. Policy interpretation and implementation: Food items and snacks kept on the nursing units must be maintained as indicated below: -All food items to be kept below 41 degrees Fahrenheit must be placed in the refrigerator located at the nurses' station and labeled with a use by date; -Beverages must be dated when opened and discarded after 24 hours; -Other opened containers must be dated and sealed or covered during storage. The surveyor made the following observations: 11/12/24 at 10:37 A.M. (Windsor 1 Unit): (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-one opened thickened cranberry juice container, undated. Manufacturer label stated: after opening, may be kept up to seven days under refrigeration; 11/12/24 at 2:55 P.M. (Kensington 1 Unit): -two opened containers of thickened dairy beverage, undated. Manufacturer label stated: Discard if not used within four days of opening; 11/13/24 at 9:02 A.M. (Kensington 1 Unit): -three opened containers of thickened apple juice, undated. Manufacturer label stated: after opening, may be kept up to seven days under refrigeration; -two opened containers of thickened dairy beverage, undated. Manufacturer label stated: Discard if not used within four days of opening; 11/13/24 at 9:13 A.M. (Windsor 1 Unit): -one opened thickened cranberry juice container, undated. Manufacturer label stated: after opening, may be kept up to seven days under refrigeration; 11/14/24 at 12:45 P.M. ([NAME] Unit): -two opened containers of thickened juice, undated. Manufacturer label stated: after opening, may be kept up to seven days under refrigeration. During an interview on 11/14/24 at 3:45 P.M., the Food Service Director (FSD) and surveyor observed one opened container of thickened juice on the Windsor 1 Unit. The FSD said he expected the staff member who opened the thickened juice container to have written the date the beverage was opened. Additionally, the FSD said he expected all thickened beverage to be dated with an opened date and for staff to utilize the manufacturer's recommendations for length of storage.