STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225067	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wedgemere Healthcare	146 Dean Street Taunton, MA 02780

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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had a Physician's order for an x-ray of his/her sacrum/pelvis, the Facility failed to ensure that he/she was provided with radiology services consistent with his/her Physician's Orders, when the x-ray was not obtained.Findings Include:Review of Resident #1's Physician Progress Note, dated 12/07/25, indicated that his/her Stage 3 (full-thickness skin loss that extends through the dermis and into the subcutaneous tissue) sacral pressure injury appeared necrotic (tissue death within the wound) and to obtain an x-ray of his/her sacrum/pelvis to evaluate for osteomyelitis (serious bone infection).Review of Resident #1's Physician Orders, dated 12/07/25, indicated to obtain x-ray of the pelvis and sacrum.Review of Resident #1's Medical Record indicated that from 12/07/25 to 12/15/25 (when Resident #1 transferred to Hospital for evaluation) there was no documentation to support that the x-ray of his/her pelvis and sacrum had been completed as ordered by the Physician.During an interview on 01/06/26 at 3:45 P.M., Nurse #2 said that the Physician saw Resident #1 on 12/07/25 late in the evening and ordered an x-ray of his/her sacrum and pelvis. Nurse #2 said that she ordered the x-ray through their Radiology Providers portal site on the computer the same day that the Physician ordered the x-ray. Nurse #2 said that the x-ray was not completed before the end of her shift on 12/07/25 and that she was unaware that Resident #1's x-ray had not been completed. Review of Resident #1's medical record indicated there was no documentation to support nursing followed up on the x-ray to see if and when it had been conducted, or to obtain and report the results to the physician.During an in-person on 01/06/26 at 4:05 P.M. and a subsequent telephone interview on 01/12/26 at 3:32 P.M., the Director of Nurses (DON) said that if an x-ray is not ordered as STAT (without delay, immediately) it may take a few days for the x-ray to be completed.The DON said that she followed up with their Radiology (x-ray) Provider and was informed that they cancelled Resident #1's x-ray because they did not have a credentialed radiologist to read the x-ray results. The DON said that the x-ray provider did not inform anyone at the facility that they cancelled Resident #1's x-ray. The DON said that it was her expectation that x-rays be obtained as ordered by the Physician.

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: 225067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2026
NAME OF PROVIDER OR SUPPLIER Wedgemere Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 146 Dean Street Taunton, MA 02780	

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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 - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on records reviewed and interviews, for one of three sampled residents, (Resident #1), who had developed open areas to his/her sacrum and left buttocks, and who was dependent on the physical assistance of staff with Activities of Daily Living (ADL), the Facility failed to ensure they maintained a complete and accurate medical record, when 1) there was conflicting nursing documentation related to his/her wounds and 2) Certified Nurse Aide (CNA) ADL Flow Sheets, daily documentation by CNA's (for all three shifts) were not consistently completed, with flow sheets left blank.Findings include:Review of the Facility's Policy tilted, Charting and Documentation, dated as revised November 2024, indicated the following:-services provided to the resident to the resident, progress toward the care plan goals or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record;-objective observations, treatments or services performed, are documented in the resident medical record;Resident #1 was admitted to the Facility in October 2025, diagnoses included cellulitis of left orbit, acute kidney failure with tubular necrosis, bipolar disorder, unspecified dementia, depression, muscle wasting and atrophy, anxiety and dysphagia.Review of Resident #1's Care Plan, titled ADL Self Care Deficit, dated 10/11/25, indicated he/she required maximal physical assistance of staff for transfers and bed mobility and was dependent on the physical assistance of staff for dressing, grooming, toileting and bathing.Review of Resident #1's admission Minimum Data Set (MDS) Assessment, dated 10/17/25, indicated that Resident #1 was dependent on the physical assistance of staff for bathing, dressing and personal hygiene, and required substantial/maximal physical assistance of staff for transfers.1) Review of Resident #1's Nurse Progress Notes, for the following dates indicated that Resident #1's skin was intact, and he/she does not have any pressure injuries. -October: 10/28/25, 10/29/25 and 10/30/25, -November :11/02/25 through 11/30/25, -December: 12/01/25 through 12/06/25, 12/08/25, 12/10/25, and 12/12/25.Review of Resident #1's Weekly Skin Evaluation, dated 11/14/25, indicated that his/her skin was clean and intact.However, documentation in the Nursing Progress Notes and one of the Weekly Skin Evaluation, conflicted with Nursing Documentation on Resident #1's Pressure Ulcer Evaluations, which indicated that he/she had multiple pressure injuries.Review of Resident #1's Pressure Ulcer Evaluations indicated the following:- 10/27/25, 11/03/25, 11/10/25, 11/17/25, 11/24/25, 12/01/25, and 12/08/25 indicated that he/she had a Stage 3 (full-thickness skin loss that extends through the dermis and into the subcutaneous tissue) pressure injury on his/her sacrum.-11/10/25, indicated he/she had a Stage 2 (partial-thickness skin loss that affects both the epidermis and the dermis) pressure injury on his/her right sacrum;-11/24/25, indicated he/she had a Stage 2 pressure injury on his/her left sacrum;-12/01/25, indicated he/she had a Stage 3 pressure injury on his/her left sacrum;-12/08/25, indicated he/she had a Stage 3 pressure injury left buttock;During an interview on 01/06/26 at 2:50 P.M., the Staff Development Coordinator (SDC) said that Resident #1 had a Stage 3 pressure injury to his/her sacrum. The SDC said there have been issues with the nurse's documentation regarding the skin condition of residents in the nurse progress notes and that nurses are checking off that the resident's skin is intact and that there are no skin issues when the resident has open areas or pressure injuries. The SDC said that the nurses are supposed to check off that the skin is not intact whenever a resident has an open area and then describe the wound in the progress notes and check off that the resident has a pressure injury in the Electronic Medical Record (EMR).During an interview on 01/06/26 at 3:29 P.M., Nurse #1, who wrote many of the Nurse Progress Notes in Resident #1's Medical Record, said that Resident #1 had a Stage 3 or 4 pressure area on his/her coccyx. Nurse #1 said that she documented in Resident #1's medical record that his/her (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skin was intact and that he/she did not have any pressure injuries. Nurse #1 said that she inaccurately documented in Resident #1's medical record and said she should have checked off that his/her skin was not intact and that he/she had pressure injuries when she documented Resident #1's skin condition.During an interview on 01/06/26 at 4:05 P.M., the Director of Nurses (DON) said that said that Resident #1 had a Stage 3 pressure injury to his/her sacrum. The DON said there have been issues with the nurse's documentation regarding the skin condition of residents in the nurse progress notes and that nurses were checking off that the resident's skin is intact and that there were no wounds when the resident had open areas or pressure injuries. The DON said that it was her expectation that the documentation in the resident medical record be accurate and that all the documentation is consistent.2) Review of Resident #1's CNA Documentation Record (ADL Flow Sheets), dated 10/11/25 through 10/31/25, indicated that for the following shifts, documentation on the flow sheets for all ADL care areas was incomplete:-7:00 A.M. to 3:00 P.M. - 3 days (out of 21) ADL care areas were left blank-3:00 P.M. to 11:00 P.M. - 1 day (out of 21) ADL care areas were left blank-11:00 P.M. to 7:00 A.M. - 6 days (out of 21) ADL care areas were left blankReview of Resident #1's CNA Documentation Record (ADL Flow Sheets), dated 11/01/25 through 11/30/25, indicated that for the following shifts, documentation on the flow sheets for all ADL care areas was incomplete:-7:00 A.M. to 3:00 P.M. - 2 days (out of 30) ADL care areas were left blank-3:00 P.M. to 11:00 P.M. - 2 days (out of 30) ADL care areas were left blank-11:00 P.M. to 7:00 A.M. - 5 days (out of 30) ADL care areas were left blankDuring an interview on 01/06/26 at 2:05 P.M., Certified Nurse Aide (CNA) #1 said that the documentation of ADL's is done in Point of Care (POC) in the Electronic Medical Record (EMR) and has to be completed by the end of the shift.During an interview on 01/06/26 at 2:25 P.M., CNA #2 said that the documentation of ADL's is done in POC in the EMR and has to be completed by the end of the shift.During an interview on 01/06/26 at 4:05 P.M., the Director of Nurses (DON) said CNA's document the ADL's they provided to the residents in POC in the EMR and that daily documentation should not be incomplete. The DON said it was her expectation that the CNA's should be documenting all care provided to residents by the end of every shift and should not be left blank.