| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225067 | A. Building<br>B. Wing | 04/01/2026 |

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

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| F 0680<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure the activities program is directed by a qualified professional.<br><br>Based on interviews and review of the Activity Director's (AD) personnel file, the facility failed to ensure the activity program was directed by a qualified activities professional. Findings include:Review of the employee file for the Activity Director (AD) indicated the following: - she was offered and accepted the role of AD in January 2026;- she did not possess the completed training and qualifications of an AD;- she signed a job description indicating she was the AD on 1/6/26.Further review of the AD's personnel file on 4/1/26 failed to indicate she was a qualified therapeutic recreation specialist or an activities professional, who had two years of experience in a social or recreational program within the last five years, one of which was full-time in a therapeutic activities program, or was a qualified occupational therapist or occupational therapy assistant. During an interview on 4/1/26 at 7:46 A.M., the AD said she started her current role in January and worked full-time. She said she did not currently hold any certifications or education relevant to the position of AD. She said the vast majority of her career had been in the preschool setting. She also said she had worked in the activities department in a nursing home for five months prior to becoming this facility's AD. The AD said she had not applied for any education or training programs because she was awaiting a response from the facility to see if they would provide financial support for the program. She said she reached out to corporate last week for an answer. The AD said she did not collaborate with or receive oversight from an occupational therapist for her role. She said, prior to last week, she wasn't aware she did not hold the required qualifications for the position.During an interview on 4/1/26 at 8:07 A.M., Rehab Staff #1 said she was the only full time registered occupational therapist at the facility, and she had no involvement in the activity program.During an interview on 4/1/26 at 9:30 A.M., the Regional Nurse said she would expect the AD to be enrolled in an education or training program, have required oversight, or be fully qualified at the time of hire. During an interview on 4/1/26 at 3:30 P.M., the Administrator said, until last week, he was unaware the AD did not have the required qualifications for the role. |

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 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>Based on review of Resident Council Minutes, a resident group meeting, interviews, and record reviews, the facility failed to ensure grievances brought forward from the Resident Council were addressed and promptly resolved to ensure the residents felt their concerns were acted upon timely and included the facility response to the group.Findings include:Review of the facility's policy titled Resident Council, dated 2/24, indicated but was not limited to the following:-The Resident Council members will meet once each month or as desired.-The facility will provide a designated staff person who is approved by the resident group and facility who is responsible for helping and responding to written request formed at the group meeting.-Department heads must respond to grievances addressed in the minutes in writing before the next meeting.-The resident council may make recommendations for the improvement of resident services, and make recommendations, and serve as an advisory group between the residents and facility. Review of Resident Council Minutes held from October 2025 through March 2026 indicated, but were not limited to, the following: Review of Resident Council Minutes, dated 10/30/25, indicated: Old Business: (review each issue brought up as new business at last meeting. Read the department response that was submitted to show the resolution of the issue and attach the response to the meeting minutes) call bell response time-not resolved; -staff using cellphones, earbuds, and being unfriendly- not resolved. New Business: call light response time, staff often not friendly, staff being on their phones and using earbuds, food arriving cold, and staff speaking another language in common areas.ˆ There was no documentation indicating the facility followed-up on the unresolved old business or the new businessˆdiscussed at the Resident Council meeting on 10/30/25. Review of Resident Council Minutes, dated 11/12/25,ˆindicated: Old Business:-Call bell response time- not resolved; -staff using cellphones and earbuds- not improved; -reports of staff being unfriendly- not resolved; -residents report milk arrives warm; -staff frequently speak other languages in common areas. There was no Resident Council meeting held in December 2025. Review of Resident Council Minutes, dated 1/7/26, indicated: -Old Business- call bell response time not resolved, staff using cell phone and earbuds not resolved, reports of staff being unfriendly not resolved; New Business:-Residents report milk arrives warm- still occurring; -Residents report that staff frequently speak other languages in common areas- not resolved. Review of the Resident Council Minutes, dated 1/29/26, indicated: Old Business:-call light response time is too long- not resolved; -staff using cellphones and earbuds- not resolved; -reports of staff being unfriendly-not resolved; -food arriving cold- not resolved; -milk is warm. There was no Resident Council meeting held in February 2026. Review of Resident Council Minutes, dated 3/12/26, indicated: Old business:-call light response time is too long; -food is cold and milk is warm; -reports of staff being unfriendly -ongoing and not resolved; -staff using cellphones and earbuds. Further review of the Resident Council Minutes held from October 2025 through March 2026 indicated that:-No grievances were initiated through the Resident Council process despite concerns being raised each month; -Concerns regarding call bell response times were raised at each meeting; and-Concerns regarding staff treating residents with respect and dignity were raised at each meeting.ˆ On 3/31/26 at 11:00 A.M., the surveyor held a Resident Group meeting with 13 residents in attendance, and all units of the facility were represented. During the meeting,-12 out 13 residents acknowledged they felt call bells were not answered timely and nothing was being done about it. The residents confirmed this had been brought up previously at multiple meetings with no resolution or improvement.ˆ -12 out of 13 residents felt staff continued to be unfriendly and disrespectful. The residents were unable to state whether a resolution had been attempted.ˆ -12 out of 13 residents, including the Resident Council President, spoke about their food arriving cold and their milk arriving warm. They were unable to state whether a resolution had been made despite bringing it up at multiple meetings. During an interview on 3/31/26 at 2:37 P.M., the Activity Director said she would verbally tell the Administrator of the old and new business discussed at each the meeting. She said there was no form to communicate the Resident<br>(continued on next page) |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Council concerns to department heads. The Activity Director said she had never initiated a grievance since being hired in January. She said there was no Resident Council Group in February. The Activity Director said she had heard the same concerns being brought up at the Resident Council Group and had told the Administrator. She said common concerns included staff being unfriendly and speaking another language in front of residents, long call bell wait times, and food temperatures.ˆ During an interview at 4/1/26 at 3:31 P.M., the Administrator said he did not have a reason for these issues not being addressed each month. He said he reviewed the Resident Council Minutes but expects there to be a response form completed by the Activity Director after each meeting and provided to the department head responsible for the resolution. He expected the residents to receive, at the start of each meeting, follow-up regarding resolutions and outcomes of concerns and grievances initiated.ˆ He said the meeting that was supposed to occur in December was rescheduled for January, so two meetings were held in January, and no meeting was held in February. He said Resident Council meetings should be held monthly, and residents should be informed of changes and have input.Refer to F867 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a baseline care plan that included the instructions needed to provide effective and person-centered care of the resident was developed to include the minimum healthcare information necessary to properly care for a resident including, initial goals based on admission orders, and failed to ensure the resident and/or their representative were provided with a summary of the baseline care plan for three Residents (#21, #36, and #33), out of a total sample of 18 residents. Specifically, the facility failed:1. For Resident #21, to address a left femur fracture and surgical wound care on the Baseline Care Plan and failed to ensure the Resident and/or their representative were provided copies of the Medication list and Baseline Care Plan;2. For Resident #36, to address bilateral lower extremity contractures on the Baseline Care Plan and failed to ensure the resident and/or their representative were provided a copy of the Medication list; and3. For Resident #33, to address care and management of diabetes with a feeding tube and failed to ensure the Resident and/or their representative were provided copies of the summary of the Baseline Care Plan. Findings include: Review of the facility's policy titled Care Plans-Baseline dated as last revised 6/2025 indicated but was not limited to the following:<br><br>-A baseline care plan is developed to meet the residents' immediate needs.<br><br>-To assure the residents' immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of the residents' admission.<br><br>-The resident and/or their representative will be provided with a summary of the baseline care plan.<br><br>1. Resident #21 was admitted to the facility in January 2026 with diagnoses which included fracture of the left femur, surgical aftercare, and spastic quadriplegic cerebral palsy.<br><br>Review of the Minimum Data Set (MDS) Assessment, dated 2/12/26, indicated Resident #21 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact, had a surgical wound, and was a risk for pressure ulcers.<br><br>Review of the Hospital Discharge summary, dated [DATE], indicated Resident #21 had a femur fracture, had surgery on 1/15/26 to repair the fracture, and required monitoring and wound care to the incision.<br><br>Review of the Skilled Charting Evaluation, dated 1/30/26, indicated Resident #21 had two surgical incisions, was anxious, and required four staff to provide care.<br><br>Review of the Physician's Orders failed to indicate monitoring of the incisions and/or wound care orders per the Discharge Summary had been implemented.<br><br>Review of the Baseline Care Plan failed to indicate Resident #21 had a left femur fracture and two new surgical incisions requiring nursing care.<br><br>Review of the Initial Interdisciplinary Care Meeting Evaluation, dated 2/10/26, failed to indicate that the Resident or their representative was provided a copy of the summary of Medications or the Baseline Care Plan.<br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 3/31/26 at 2:33 P.M., Nurse #5 said post-op orders and how to care for the Resident should have been part of the initial plan of care.<br><br>During an interview on 3/31/26 at 2:47 P.M., Unit Manager #1 said the fracture and post-op wound care orders should have been part of the care plan to ensure staff knew how to care for him/her and they were not.<br><br>During an interview on 4/1/26 at 10:37 A.M., Physician #1 said he would expect the femur fracture and surgical wound care to have been part of the care plan since admission as that is basic care needs and the reason for admission.<br><br>During an interview on 4/1/26 at 1:23 P.M., the Staff Development Coordinator (SDC) said the baseline care plan should be developed within 48 hours and include all basic needs the staff need to know to care for the residents, including fractures and surgical wounds.<br><br>During an interview on 4/1/26 at 2:27 P.M., the Director of Nurses (DON) said the Baseline Care Plan is developed from the Nursing admission Assessment. She said it should be done within the first 48 hours and include resident care needs, including but not limited to fractures and surgical wound care. She said the Resident or family should have been given a copy of their medication list and care plan and she was unsure why they were not provided to the Resident.<br><br>2. Resident #36 was admitted to the facility in April 2025 with diagnoses which included chronic pain syndrome, unilateral osteoarthritis of the left hip, and failure to thrive.<br><br>Review of the MDS Assessment, dated 2/12/26, indicated Resident #36 scored 3 out of 15 on the BIMS indicating he/she had severe cognitive impairment, was dependent for care, was at risk for pressure ulcers, had impairment of the lower extremities, and had a diagnosis of orthopedic conditions.<br><br>Review of the Hospital Discharge summary, dated [DATE], indicated he/she could not walk, had progression of left hip arthritis, which was severe, and had pain.<br><br>Review of the Nurse's Note, dated 4/25/25, indicated Resident #36 had bilateral lower extremity contractures.<br><br>Review of the Baseline Care Plan failed to indicate Resident #36 had bilateral extremity contractures.<br><br>Review of the 72-hour Meeting Form, dated 6/10/25, failed to indicate the Resident and/or their representative were provided a copy of the summary of Medications with the Baseline Care Plan.<br><br>During an interview on 3/31/26 at 2:33 P.M., Nurse #5 said contractures should be part of the initial plan of care.<br><br>During an interview on 3/31/26 at 2:47 P.M., Unit Manager #1 said contracture management should be part of the care plan, and it was not. She said everything related to care needs should be on there.<br><br>During an interview on 4/1/26 at 1:23 P.M., the SDC said the baseline care plan should be developed within 48 hours and include all basic needs the staff need to know to care for the resident, including contractures.<br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/1/26 at 2:27 P.M., the DON said the Baseline Care Plan is developed from the Nursing admission Assessment. She said it should be done within the first 48 hours and include resident care needs, including but not limited to contracture management. She said the Resident or family should be given a copy of their medication list and care plan. She said they need to ensure the copies are provided unless they don't want them, and in that case, staff should be documenting that the Resident/family declined the copies when offered.<br><br>3. Resident #33 was admitted to the facility in February 2026 with diagnoses of type II diabetes and gastrotomy status (G-tube).<br><br>Review of Resident #33's medical record failed to indicate that Baseline Care Plans were in place within 48 hours of admission or that Comprehensive Care Plans were developed and implemented to address type II diabetes or G-Tube status.<br><br>Review of Resident #33's care plan indicated a care plan for Type II Diabetes was initiated nine days after the Resident was admitted and included but was not limited to the following:<br><br>Focus: diabetes: potential for hyperglycemia/hypoglycemia Type II Diabetes, date initiated 2/19/26<br><br>Goal: Resident's skin integrity will be maintained, and Resident will be free of symptoms of hyperglycemia and/or hypoglycemia, date initiated 2/19/26<br><br>Interventions: Administer insulin according to established parameters by a physician, date initiated 2/19/26; administer medications as ordered. See medication administration record. Monitor effectiveness and side effects, date initiated 2/19/26; check blood glucose levels per physician's order, date initiated 2/19/26, monitor for signs and symptoms of hyperglycemia and/or hypoglycemia, date initiated 2/29/26<br><br>During an interview on 3/31/26 at 10:57 A.M., Unit Manager #1 said the baseline care plans are initiated upon admission by the nurse completing the admission. She said then they are reviewed and revised within 48 hours of the resident being admitted . She said she wasn't sure who was responsible for giving a copy of the summary of the baseline care plan.<br><br>During an interview on 3/31/26 at 1:00 P.M., the DON said it is a team approach to completing the baseline care plans and not one person is responsible for ensuring it's completion. She said the social workers are responsible for offering a copy of the summary of the baseline care plan. She said she was not sure why Resident #33's was not completed and why there was no care plan for care and management of their type II diabetes specific to a resident with a feeding tube.<br><br>During an interview on 4/1/26 at 9:40 A.M., the Regional Nurse said she expects that baseline care plans are being completed within 48 hours of a resident's admission by the interdisciplinary team. She said she expects the nurses to initiate the baseline care plan.<br><br>During an interview on 4/1/26 at 10:57 A.M., Social Worker #1 said an evaluation titled IDT initial care plan meeting should have been initiated and it was not completed. She said she is not sure if the resident was offered a summary of the Baseline Care Plan, but everyone should be offered a copy. The summary provides information on care and management of the resident and goals of care.<br><br>During an interview on 4/1/26 at 11:40 A.M., the Resident Representative said she did not receive a<br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | copy of the Baseline Care Plan. She said even though she does not read English she has family members who do and would have liked a copy of the summary.<br><br>Refer to F684 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a person-centered individualized comprehensive care plan was developed and implemented for one Resident (#36), out of a total sample of 18 residents. Specifically, the facility failed for Resident #36, to develop a care plan to address bilateral lower extremity contractures for 11 months and to develop a care plan for the potential for skin breakdown for two months. Findings includeReview of the facility's policy titled Care Planning-Interdisciplinary Team (IDT), dated as last revised 3/2025, indicated the facility's Care Planning/IDT is responsible for the development of an individualized comprehensive care plan for each resident and the care plan is based on the residents' comprehensive assessment and is developed by the IDT. Resident #36 was admitted to the facility in April 2025 with diagnoses which included chronic pain syndrome, unilateral osteoarthritis of the left hip, and failure to thrive. Review of the Minimum Data Set (MDS) Assessment, dated 2/12/26, indicated Resident #36 scored 3 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had severe cognitive impairment, was dependent for care, was at risk for pressure ulcers, had impairment of the lower extremities, and had a diagnosis of orthopedic conditions. Review of the Hospital Discharge summary, dated [DATE], indicated Resident #36 could not walk, had progression of left hip arthritis, which was severe, and had pain. Review of the Nurse's Note, dated 4/25/25, indicated Resident #36 had bilateral lower extremity contractures. Review of the Comprehensive Care Plan failed to indicate Resident #36 had bilateral lower extremity contractures. Additionally, the Potential Alteration in Skin Integrity Care Plan was resolved in April 2025 (three days after admission), an Actual Alteration in Skin Integrity Care Plan was developed in April 2025 and resolved in January 2026, leaving him/her without a care plan for Skin Integrity for over two months (1/16/26 through 4/1/26). During an interview on 3/31/26 at 2:33 P.M., Nurse #5 said contractures, positioning, and skin care should be part of the care plan and the care plan does not indicate care needs related to the contractures or skin. During an interview on 3/31/26 at 2:47 P.M., Unit Manager #1 said contractures and skin care management should be part of the care plan, and it was not. She said everything related to care needs should be on there. She said he/she has been contracted since admission and cannot straighten their legs at all. She said they use pillows for positioning and that should all be on the care plan and it was not. During an interview on 4/1/26 at 1:13 P.M., Nurse #4 said contractures and skin care management should be on the care plan and they are not. During an interview on 4/1/26 at 1:23 P.M., the Staff Development Coordinator (SDC) said the contracture should have been there since admission with specific care needs and everyone should have a Potential Alteration in Skin Integrity Care Plan. During an interview on 4/1/26 at 2:27 P.M., the Director of Nurses (DON) said the contracture management should have been on the care plan since admission. Additionally, she said everyone should have a potential for skin breakdown care plan and that should not have been discontinued. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide activities to meet all resident's needs.<br><br>Based on observation and interview, the facility failed to provide an ongoing program of individual and group activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of Residents on 4 out of 4 units and for one Resident (#23), out of 18 sampled residents. Specifically, the facility failed:1. For Resident #23, to ensure that staff offered and encouraged engagement in activities according to their comprehensive assessment and identified preferences; and 2. To ensure staff provided a meaningful and engaging activity program, including materials for self-directed activity, for residents on Sunday in the month of March.Findings include:Review of the facility's policy titled Recreation Evaluation, last revised 11/24, indicated but was not limited to the following:-A recreation evaluation is conducted as part of the comprehensive assessment to develop an activities plan that reflects the choices and interests of the resident.-The recreation evaluation is used to develop an individual activities care plan that will allow the resident to participate in activities of his/her choice and interest.-Each activities care plan relates to his/her comprehensive assessment and reflects his/her individual needs.1. Resident #23 was admitted to the facility in April 2024 with diagnoses including dementia.Review of the Minimum Data Set (MDS) assessment, dated 1/16/26, indicated the Staff Assessment for Cognitive Impairment was conducted, and the Resident has severely impaired cognitive function.Review of the most recent Recreation Assessment indicated no recreation specific care plan was initiated. Review of Resident #23's care plan indicated the following:Focus: Resident has a potential for alteration in psychosocial well-being/coping mechanisms due to dementia with agitation, dated 4/29/24, last revised 10/15/25Goal: Resident will communicate with individuals outside of the facility through alternative modes through the next review, dated 5/7/25Intervention: Resident specific activities (left blank), date initiated 5/1/24During the following days and times, the surveyor observed Resident #23 in bed with their eyes open with no stimulation (radio or television on) while other facility activities were being offered:3/30/26 at 10:33 A.M. and 4:03 P.M.3/31/26 at 9:00 A.M.During an interview on 3/26/26 at 12:58 P.M., Resident #23's representative said there are rarely any activities for anyone with a cognitive impairment. She said she has seen the facility offer trivia and Bingo but there are very few things that appeal to someone with dementia within their skill level. She said the Resident spends a lot of time in his/her room or sitting in the small dining room in his/her wheelchair sometimes not even facing the television when she has visited the Resident.During an interview on 3/31/26 at 9:01 A.M., Certified Nursing Assistant (CNA) #1 said Resident #23 stays in bed most days until after breakfast, and then he/she will spend most of the morning in the dining room with the television on with other residents. She said he/she enjoys music activities but cannot recall if there have been any activities that included music in the month of March. During an interview on 3/31/26 at 9:32 A.M., the Activities Assistant said she does not really know the Residents that do not attend group activities. She said Resident #23 doesn't participate in group activities and she does not know how to offer activities with someone that can't participate. She said she passes out the daily chronicle, word searches, coloring pages, and snacks to residents but does not have anything available to offer Resident #23 unless the Resident Representative brings him/her to an activity. During an interview on 3/31/26 at 12:30 P.M., the Activity Director said there was no care plan initiated for Resident #23's specific interests. She said the Resident does enjoy music and there is one program in the month of March that includes musical entertainment. She said she is not sure how staff would know what the Resident's specific interests and preferences if information is not available on the recreation assessment or the care plan. She said she wasn't very familiar with the Resident or their interests. She said she uses other disciplines' information or hospital discharge paperwork to identify the Resident's interests. She said she previously recorded information that was on previous recreation assessments. During an interview on 4/1/26 at 9:31 A.M., the Regional Nurse said the Activity Director was hired in January and was encouraged to reach out to other sister homes for guidance of activity director duties. She said she (continued on next page) |

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| Wedgemere Healthcare | 146 Dean Street<br>Taunton, MA 02780 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | expects that Resident Recreation Assessments are completed and a recreation care plan is developed, implemented, and personalized for the Resident's specific activity interests. 2. During the initial screening process residents indicated the weekends can be boring at the facility and there are no activities offered on Sunday. Residents also indicated there were no cultural offerings for non-English speaking residents. There were no materials provided or available in other languages. During an interview on 3/26/26 at 10:12 A.M., the Activity Director said she does not have staff available on Sunday. She said she works Monday through Friday, and her assistant works Tuesday through Saturday. She said on Sunday the Resident Council President puts on a religious service in the dining room. She said residents have to be self-sufficient on that day and engage in activities independently on Sundays. She said she has no materials or activity programs available in other languages at this time, but it is something she could look into. She said she knows there are residents in the building whose primary language is Spanish, Portuguese, and Haitian Creole. There is no way to ensure they are being offered since there is no designated staff for Sunday. It would be up to the residents to coordinate amongst themselves. Review of the March activity calendar indicated the following for each Sunday:9:30 A.M.- Daily Chronicle, no designated staff responsible for distributing. 10:00 A.M.- Coffee Social, no designated staff responsible coordinating.11:00 A.M.- Religious Service, Resident Council president turns on Catholic mass.2:00 P.M.- Resident Choice, no designated staff to assist in facilitating or provide materials. During the Resident Group Meeting held on 3/31/26 at 11:00 A.M., residents reported the weekends felt long and boring. Residents reported there are no activities staff available to provide supplies to residents on Sunday. Residents said they have initiated an independent crochet group on Sunday, but they are not sure what other residents do who do not crochet or watch Catholic Mass. They said there are no materials available offered in other languages besides English. During an interview on 4/1/26 at 9:31 A.M., the Regional Nurse said she expects there are materials or activities provided to Resident's to meet their needs seven days a week across all cultures. She said she was aware there was an open activity position but unaware that revisions have not been made to the department to provide recreational activities for the residents every day. She said she would expect there to be staff designated to assist with the activities on the calendar to ensure they are being offered. Refer to F680 |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>Based on document review and interview, the facility failed to ensure that services were provided in accordance with professional standards for one Resident (#3) with a Gastrostomy tube (G-tube: a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition, fluids, and medication), out of a total sample of two residents with G-tubes in the facility, to maintain patency and prevent complications of the G-tube. Resident #3 had to have their G-tube replaced four times between January and March 2026 due to clogging. Findings include: Review of the facility's policy titled Enteral Nutrition, dated as revised 4/2024, indicated but was not limited to the following: - Nursing staff is assigned to specific enteral feeding responsibilities, including but not limited to flushing with water at appropriate intervals, monitoring for complications along with taking corrective actions if complications are identified Review of the facility's policy titled Administering Medications Through an Enteral Tube, dated as revised 9/2024, indicated but was not limited to the following: - request liquid forms of medications from the pharmacy- dilute medications and flush the tube with water- prepare medication - dilute powered or crushed medications at the bedside with 15-30 milliliters (ml) of water (or prescribed amount), if administering more than one medication flush with 5ml (or prescribed amount) of water in between each medication, after the last medication flush the tubing with 15ml or prescribed amount of water The facility did not have a policy on general care and management of G-tubes. Resident #3 was admitted to the facility in October 2025 with diagnoses including: Cerebral infarct (stroke), hemiplegia and hemiparesis affecting right side, diabetes mellitus type 2, protein-calorie malnutrition, dysphagia (difficulty swallowing), and gastrostomy status (presence of a G-tube). Review of the Minimum Data Set (MDS) for Resident #3, dated 2/6/26, indicated the Resident was severely cognitively impaired as determined by staff interview, received enteral G-tube feedings for 51% or more of their nutritional needs daily, had a history of stroke with hemiplegia/hemiparesis with impairment on one side affecting their upper and lower extremities, and was dependent on staff for care with bathing, dressing, mobility and toileting. On 3/26/26 at 8:18 A.M., the surveyor observed Resident #3 in bed with the head of the bed elevated approximately 30 degrees and his/her Nepro enteral feeding infusing without difficulty at 55ml per hour. Observation of the pump indicated the pump delivering the Nepro was also set up to deliver intermittent water flushes every four hours at 175ml. During an interview on 3/26/26 at 12:20 P.M., the Healthcare proxy (HCP) for Resident #3 said the Resident had been hospitalized a couple of times recently with a blocked G-tube. Review of the current orders for Resident #3 included but were not limited to the following: NPO (nothing by mouth) diet related to dysphagia (11/16/24)Enteral feed order: Nepro at 55ml per hour up at 8:00 A.M., down at 4:00 A.M. - 20 hour feed; every four hours provide free water flushes of 175ml (1/29/26)May crush medications (meds) within crushable guidelines and mix each med in 5ml of water (11/16/24)Flush tube with 5ml of water in between each med (11/16/24)May give 30ml of water by feeding tube before and after medication administration (11/16/24)Acidophilus oral capsule 100millligrams (mg) give two capsules by G-tube three times a day (9/19/25)Baclofen tablet 5mg two times a day by G-tube (12/30/25)Cyanocobalamin tablet 250micrograms (mcg) 1 tablet one time daily by G-tube (11/16/24)Eliquis oral tablet 5mg two times a day by G-tube (11/16/24)Ferrous-gluconate oral tablet 325mg 1 tablet by G-tube one time a day (2/25/26)Hydroxychloroquine sulfate oral tablet 200mg by G-tube every other day (alternating with 300mg) (11/16/24)Hydroxychloroquine sulfate oral tablet 300mg by G-tube every other day (10/15/25)Lansoprazole oral tablet delayed release disintegrating 30mg one time a day dissolve tab in 10ml of water and administer within 15 minutes of dissolving (3/27/26)Levothyroxine sodium oral tablet 150mcg give 0.5 tablet by G-tube in the morning - dose 75mcg (6/30/25)Lisinopril oral tablet 10mg by G-tube once daily (9/19/25)Melatonin 3mg tablet give one tab by G-tube at bedtime (11/16/24)Metformin HCl 500mg oral tablet one tab two times a day by G-tube (5/26/25)Metoprolol<br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | tartrate oral tablet 25mg one tab two times a day by G-tube (12/30/25)Mirtazapine oral tablet 15mg give at bedtime by G-tube (11/16/24)Prednisone tablet 2.5mg give once daily by G-tube - administer with 5mg tablet to equal 7.5mg (3/12/25)Prednisone tablet 5mg give one daily by G-tube - administer with 2.5mg tablet to equal 7.5mg (3/12/25) The medication orders indicated the Resident was receiving 16 pills scheduled daily through the G-tube and none in liquid formulation in accordance with the standard of practice and facility policy. Review of the medical record indicated the following transfers to the hospital for Resident #3 related to his/her G-tube being clogged: 1/11/26: G-tube clogged, transported to the hospital, returned with G-tube replaced while at the hospital1/12/26: G-tube blocked, transported to the hospital, returned with G-tube replaced while at the hospital3/15/26: G-tube blocked, transported to the hospital, returned with G-tube replaced while at the hospital3/27/26: G-tube blocked, transported to the hospital, returned with G-tube replaced while at the hospital Further review of the medical record failed to indicate that the facility had made attempts to request Resident #3's medications in liquid formulation. On 3/27/26 at 8:05 A.M., the surveyor observed Resident #3 in the process of being transferred to the hospital by emergency medical services (EMS). The surveyor observed Nurse #2 giving report to EMS and heard Nurse #2 tell EMS that that morning the Nurse had flushed the Residents' G-tube without difficulty, but upon administering the medications through the G-tube the tube became clogged, and she attempted to clear the clog with ginger ale but was unsuccessful. She informed EMS the Resident is NPO and requires enteral nutrition through the tube for 20 hours a day and that had not been started yet related to the tube being blocked. During an interview on 3/27/26 at 2:50 P.M., Nurse #2 said she sent the Resident to the hospital that morning with a clogged G-tube. She said she was flushing the G-tube without any problems and when she went to administer the third medication it wouldn't go in. She said she could feel a blockage in the tube and tried to massage the tube to get the blockage to move but was unsuccessful so she got advice from a more seasoned nurse to put ginger ale in the tube to see if that would help and it was also unsuccessful. She said she follows the advice of more experienced nurses because she is a new graduate and started at the facility about six months ago. She said she did not contact the provider prior to putting ginger ale in the Residents' tube and didn't tell them she had tried that specifically just told them the tube was clogged and then received an order to send the Resident to the hospital for evaluation. She said she wasn't aware she needed an order to put ginger ale in the Resident's G-tube to attempt to clear the blockage.Review of the Hospital After Visit Summary for Resident #3, dated 3/27/26, indicated but was not limited to the following:History: patient currently residing in a nursing facility, had his/her G-tube replaced here about two weeks ago for clogging, today his/her staff reports attempted to place meds and the G-tube was cloggedDischarge instructions: G-tube was clogged with a significant amount of pill fragments and particles, please make sure that you are appropriately flushing the tube after administering any medications or feeds. Tube has been replaced and confirmed in proper placement. During an interview on 3/31/26 at 11:55 A.M., the Staff Development Coordinator (SDC) said she had been in her role at the facility between 15 and 18 months and had not done any official competencies with the licensed nurses on management of a G-tube to prevent clogging of the tube. She said the nurses complete computerized learning and training. She said she wasn't aware that Resident #3 had gone to the hospital to have his/her G-tube replaced related to being clogged four times in the last three months. She said nurses should not be administering anything through a G-tube in an attempt to dislodge or dissolve the blockage of Resident #3's tube without an order from the physician or on call provider and making those decisions is outside of the nurses' scope in this setting. She said she is not aware of any current performance improvement plans, education plans or quality assurance activities for the prevention of clogged G-tubes at this time. During an interview on 3/31/26 at 12:43 P.M., the Dietitian said she knows Resident #3 well and is involved with their care. She said the Resident had been nutritionally stable even with the clogging of the G-tube. She said she did have a conversation at one point with the nursing staff related to thoroughly flushing the G-tube, but she isn't<br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | sure she documented that anywhere. She said in her experience and professional opinion a G-tube clogging is typically related to inadequate flushing or flushing not occurring correctly during medication administration. During an interview on 3/31/26 at 1:05 P.M., the Physician said in his opinion the Resident #3's issues with his/her G-tube clogging is related to the staff not being well trained and likely not thoroughly crushing the pills to a fine powder, dissolving them in water and then flushing the tube as ordered. He said he is aware the Resident had required multiple hospitalizations for a clogged G-tube and replacement of that tube and that is not acceptable. He said he was surprised and it is unfortunate that the pharmacy had not recommended or provided the facility with the liquid formulations of the prescribed medications, but he was looking into changing the Resident's medications today and determining the risk of each individual medication at being able to contribute to a clogged G-tube. He said he was not aware that the nursing staff were placing ginger ale into the Resident's G-tube in an effort to unclog it and it was scary to think they are attempting these techniques without speaking to the providers and obtaining orders. He said to the best of his knowledge the Resident does not have an anatomical or pathophysiological reason for his/her tube to be at high risk of clogging. Review of the monthly pharmacy medication regimen reviews from October 2025 through March 2026 failed to indicate any recommendations made by the pharmacy consultant for a change in the formulation of the Resident's medications from pill form to liquid form. During an interview on 3/31/26 at 2:26 P.M., the Pharmacy consultant said she had recently seen Resident #3 for a monthly regimen review. She said although Resident #3 receives all their meds through their G-tube and the medications are all provided in pill form, she would not necessarily recommend changes to the medications or their form if there had been no concerns with the tube and the Resident was tolerating them well. She said she was unaware the Resident had numerous episodes of a clogged G-tube in the last three months resulting in a tube change. She said she was unsure about any further information and would have to look up the Resident's information and call the surveyor back. At the time of exit the pharmacy consultant had not called with any further information. During an interview on 4/1/26 at 7:21 A.M., the Director of Nurses said the facility should have identified the ongoing issue of Resident #3's G-tube clogging off and intervened in some way in an attempt to prevent that but had not. She said no nurse should be putting anything into a G-tube without a physician's order and that was not in line with the facility practice. She said the facility had not provided any hands on or competency observations for G-tube management. Refer to F867 |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>Based on observation, interview, and document review, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) program with documentation of the development, implementation, and evaluation of corrective actions or performance improvement activities. Specifically, the facility failed to:1. Develop and implement appropriate plans of action for resident concerns communicated at Resident Council; and2. Identify, develop, and implement appropriate plans of action for one Resident (#3) hospitalized four times in the past three months due to a clogged feeding tube. Findings include:Review of the facility's policy titled Quality Assurance Performance Improvement (QAPI), last revised 6/24, indicated but was not limited to the following:-Our QAPI plan addresses: resident indicators, grievances, resident care, dining experience, activities, laundry, resident council, and resident and family feedback. -The information gathered is analyzed and compared to benchmarks and/or targets established by the facility.-Daily interdisciplinary team (IDT) notes are reviewed for adverse events/concerns. -If the change to the process have not results in the goal of the performance improvement project (PIP), further changes are made and monitoring of the process takes place again. 1. Review of the Resident Council Minutes for November 2025 through March 2026 indicated that when asked, the residents responded that they could not get help or care without waiting a long time and call lights were not always answered in a timely manner. The minutes also indicated that when asked, the residents responded the staff does not treat them with respect and dignity.During a group meeting with 11 residents on 3/31/26 at 11:00 A.M., the residents said they did not feel call lights were being answered timely with varying response times from 30 minutes to two hours. Eleven out of 11 residents felt the call light wait times were too long. Eleven out of 11 residents felt the staff do not treat them with respect and dignity, and 9 out of 11 residents referred to the staff as unfriendly. During an interview on 3/31/26 at 1:30 P.M., the Activities Director said sometimes during Resident Council meetings the residents would say they waited a long time for call lights to be answered and residents felt the staff were unfriendly. She said she verbally provided the information to the Administrator.During an interview on 4/1/26 at 3:00 P.M., the Administrator said the resident's input was used for the QAPI process through resident conversations, grievances, and Resident Council. He said residents had voiced concerns with long call light wait times for about five months and he was aware of the customer service concerns since November. He said call light wait time was an active QAPI, but he did not have a PIP for the surveyor to review since data was still being collected through audits which were implemented last week. He reviewed the facility form utilized for PIPs and said there was not one for call light wait times. He said that staff education was being completed to improve customer service satisfaction and reduce call bell wait times. He said staff have been educated multiple times, but no other plans were implemented. He said there have been no revisions despite the issues persisting since November. He said he had begun collecting data, but it has not been analyzed, and no plans of action have been developed. During an interview on 4/1/26 at 3:50 P.M., the Regional Nurse said she is a member of the governing body and expects that the facility is identifying repeat trends and using feedback from residents to develop interventions to improve areas of concern identified during Resident Council. She said she expects that if the issue persists then there should be a reevaluation of the project and interventions.2. Resident #3 was admitted to the facility in October 2025 with diagnoses including Cerebral infarct (stroke) and gastrostomy status (presence of a G-tube).Review of Resident #3's medical record indicated he/she was transferred to the hospital related to his/her G-tube being clogged four times over the past three months on 1/11/26, 1/12/26, 3/15/26, and 3/27/26. During an interview on 3/31/26 at 11:55 A, M., the Staff Development Coordinator (SDC) said she wasn't aware of a pattern occurring regarding hospitalizations of a resident related to a clogged G-tube. She said there is currently no QAPI on G-tubes or preventing their clogging. She said it was not identified as a concern despite the multiple<br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | hospitalizations. She said it would seem like there is a problem with providing care and management of a resident with a G-tube since this one Resident has been hospitalized four times.During an interview on 4/1/26 at 7:21 A.M., the Director of Nursing (DON) said the facility should have identified the ongoing issue of the G-tube clogging and reviewed the manner in which they were clogging to identify the root cause for the hospitalizations. She said there was no QAPI identified for the care and management of residents being hospitalized with a clogged feeding tube. During an interview on 4/1/26 at 3:50 P.M., the Regional Nurse said she is a member of the governing body and expects there should be identification of the care and management of feeding tubes related to multiple hospitalization. She said she expects that adverse events are reviewed and a root cause is identified. |

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| F 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give the resident's representative the ability to exercise the resident's rights.<br><br>Based on record review and staff interview, the facility failed to ensure the Resident Representative (Guardian) was not extended authority of decision making beyond the extent required by the court to consent to the administration of an antipsychotic medication for one Resident (#33), from a total sample of 18 residents. Specifically, Resident #33 was administered Olanzapine (Zyprexa) after the legal guardian did not retain authority to consent to the medication. Findings include:Resident #33 was admitted to the facility in January 2026 with a diagnosis of dementia without behavioral disturbance. Review of the medical record indicated Resident #33 had a family member appointed as their permanent legal guardian and a Treatment Plan for the use of antipsychotic medications was implemented. Review of the court approved Treatment Plan for Resident #33 indicated if not sooner extended, it shall expire on 1/21/26.Review of the Informed Consent for Psychotropic Administration form indicated the Guardian of Resident #33 consented to the use of Zyprexa on 2/10/26.Review of the medical record included a Physician's Order to start Zyprexa 2.5 milligrams on 2/10/26.Review of the medical record, including progress notes, failed to indicate the facility had submitted any documentation to the court to change the Treatment Plan to be extended past the expiration date of 1/21/26. During an interview on 3/30/26 at 12:34 P.M., Social Worker #1 said the Resident should not receive an antipsychotic medication without the Roger's Treatment plan being active and updated. She said she wasn't sure how this was missed during the Resident's admission to the facility. She said the nurses are responsible for obtaining the orders and perhaps one of them did not have the knowledge about the process for a resident with a legal guardian and antipsychotic medication. She said there was not an updated Treatment Plan in progress.During an interview on 3/30/26 at 2:00 P.M., the Regional Nurse said she expects there to be a process in place for ensuring residents with court appointed legal guardians have the authority to consent for antipsychotic use. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on observation, interview, and document review, the facility failed to ensure the call bell device was operational and in reach on the Resident's functional side for one Resident (#3), out of 18 sampled residents. Findings include: Review of the facility's policy titled Answering Call Lights, dated as revised 1/2024, indicated but was not limited to the following: -demonstrate call light use as needed-when a resident is in bed provide the call light within easy reach of the resident-report all defective call lights to the nurse promptly Resident #3 was admitted to the facility in October 2025 with diagnoses including cerebral infarct (stroke) and hemiplegia (complete paralysis) and hemiparesis (partial weakness) affecting right side. Review of the Minimum Data Set (MDS) assessment for Resident #3, dated 2/6/26, indicated but was not limited to the following: -Section C: Cognition was severely impaired, according to a staff interview-Section GG: Impairment on one side of the body for both upper and lower extremities, dependent for upper body dressing-Section I: Diagnosis of stroke, hemiplegia/hemiparesis - yes Review of the current care plans for Resident #3 indicated the Resident suffers from right sided hemiplegia. On 3/26/26 at 8:18 A.M., the surveyor observed Resident #3 lying in bed with his/her call light button tied to the 1/4 siderail on the Resident's right side. The Resident smiled at the surveyor and followed requests but did not verbally respond to the surveyor. Resident #3 was unable to move his/her right side upon prompting by the surveyor and could not reach the call light with his/her left hand when prompted. Upon further inspection of the call light cord, it was found to be broken with the exposed wire on the floor, detached from the plug that remained in the wall socket. The call bell cord was not functioning. During an interview on 3/26/26 at 12:20 P.M., the Healthcare Proxy for Resident #3 said he believed the Resident could use the call light if it were by his/her left side, but likely inconsistently due to their cognitive decline. Throughout the survey, the surveyor made the following observations of Resident #3's availability of a functioning call device:3/27/26 at 7:51 A.M., the Resident was in bed with the broken call light attached on the Resident's right upper siderail and at 11:51 A.M., the broken call light device was attached to the right upper 1/4 siderail.3/31/26 at 7:44 A.M. and 10:34 A.M., the Resident was in bed with the broken call light device attached on the Resident's right side to the upper siderail.3/31/26 at 12:06 P.M., 1:49 P.M., and 3:09 P.M., the Resident was out of bed in his/her wheelchair with their broken call light out of reach and no alternative device available for the Resident to be able to call for assistance if needed. During an interview on 3/27/26 at 7:29 A.M., the Maintenance Director said there is a process for preventative maintenance rounds and nursing is supposed to report any issues to him verbally or through the TELS system (a comprehensive facility management and maintenance computer system to manage work orders and environmental compliance in healthcare facilities). Review of the facility TELS work history report from 12/1/25 through 3/31/26 failed to indicate any issues were reported to the Maintenance Director through the TELS system. During an interview on 3/31/26 at 8:31 A.M., Certified Nursing Assistant (CNA) #2 said all residents have some type of device to call for assistance whether it be a button, call pad, or hand bell. She said call bells are supposed to be in reach of the resident whether or not they are capable of using it. She said she isn't sure if Resident #3 consistently used his/her call device. During an interview on 3/31/26 at 8:33 A.M., CNA #3 said all residents are required to have some type of call bell available and in reach to use. She said Resident #3 would be able to use a call bell if he/she wanted to, but she has experienced the roommate call for the Resident in the past. She said in the event that any type of equipment is broken or not functioning in the residents' rooms needs to be reported to the Maintenance man either verbally or through the computer system which the CNAs can access through POC (the facility computer program in which the CNAs document). During an interview on 3/31/26 at 8:34 A.M., CNA #4 said all residents are required to have a call bell within reach at all times when they are in their rooms. She said she believed Resident #3 would be able to use the call bell, but she doesn't see that happen too often. During an observation with interview on 3/31/26 at 10:34 A.M., the surveyor observed CNA #3 in<br>(continued on next page) |

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| Wedgemere Healthcare | 146 Dean Street<br>Taunton, MA 02780 |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #3's room preparing to get the Resident ready for the day. CNA #3 said the Resident wouldn't be able to use the call bell since it was positioned on the Resident's right side and the call bell should be on the Resident's left side since he/she cannot use their right arm. Upon attempting to move the call bell, she said the bell was broken and the cord had broken away from the wall. CNA #3 said Maintenance would need to be made aware and she reported the broken call bell to Nurse #3 while the surveyor was present. During an observation with interview on 3/31/26 at 10:36 A.M., the surveyor observed Nurse #3 enter Resident #3's room and attempt to reinsert the cord. Nurse #3 said the cord was broken and he would have to alert Maintenance so it could be repaired or replaced. Nurse #3 said the Resident should have some type of call bell available to them at all times while in the room and the device would have to be placed on his/her left side since their right side was non-functioning. On 3/31/26 at 12:06 P.M., 1:49 P.M., and 2:52 P.M., the surveyor observed that Resident #3 continued to have no functioning call bell in reach since it was brought to the staff's attention at 10:34 A.M. this morning. During an interview on 3/31/26 at 3:09 P.M., CNA #5 said she knows Resident #3 very well and works with them frequently. She said the Resident is not capable of using his/her right arm at all because it is paralyzed, but the Resident can use their left arm and could only use a call bell if it was within reach of the Resident's left arm/hand. She said all residents are supposed to have a call bell in reach at all times while they are in their rooms. During an interview on 3/31/26 at 3:11 P.M., Nurse #3 said he had forgotten to notify Maintenance of Resident #3's call bell being broken and he did not provide an alternative device to the Resident to use. Therefore, the Resident did not have access to a call device all day. During an interview on 3/31/26 at 3:47 P.M., the Administrator observed Resident #3's call bell cord with the surveyor and was informed the surveyor had made these observations throughout the survey. He said, Oh my god, that is a huge safety concern and that shouldn't be like that, he continued to say his expectation was staff should ensure residents have the availability of a functioning call bell in reach at all times while they are in their rooms and that if the residents don't have a functioning device in reach, they cannot alert the staff to potential needs and that was a problem. He said when the issue was identified by staff earlier today, he would expect staff report it immediately and provide an alternative device on the resident's functioning side so he/she would have something available to use. He said that wasn't what occurred in this instance. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>Based on observation, document review, and interview, the facility failed to ensure for one Resident (#14), out of a total sample of 18 residents, that their wheelchair was maintained in a clean and safe manner. Findings include: Resident #14 was admitted to the facility in April 2018 and had diagnoses including diabetes mellitus type 2 and muscle wasting and atrophy.Review of the Minimum Data Set (MDS) assessment, dated 2/13/26, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status score of 14 out of 15 and used a manual wheelchair for mobility. Review of the current care plans for Resident #14 indicated but was not limited to the following: PROBLEM: Activities of daily living deficit as evidenced by weakness, decreased strength and endurance, fatigues easily, muscle weakness and impaired balance. INTERVENTION: Locomotion: Wheelchair - supervisionDuring an observation with interview on 3/26/26 at 8:01 A.M., the surveyor observed Resident #14 sitting on the edge of his/her bed in their room with their wheelchair locked beside the bed. The upper left backrest of the wheelchair was torn away from the wheelchair base with a screw and metal circle washer exposed. The right side of the wheelchair sheet was worn and frayed with no vinyl covering the threading and tearing away from the wheelchair base. The right and left arm rests on the wheelchair were cracked and torn exposing the foam underneath the vinyl covering. The Resident said he/she uses the wheelchair daily and it isn't in good condition. The Resident said he/she hopes that someone will fix it because the cracked arm rests pinch their arms at times. The surveyor observed Resident #14's wheelchair as follows: -3/27/26 at 8:23 A.M., Resident sitting in his/her wheelchair in their room; wheelchair remains with damaged back rest, seat, and arm rests.-3/31/26 at 2:56 P.M., Resident sitting in his/her wheelchair, wheelchair remains in disrepair with frayed torn backrest and hardware exposure, a worn frayed seat, and cracked/torn arm rests.During an interview on 3/27/26 at 7:29 A.M., the Maintenance Director said there is a process for preventative maintenance rounds and nursing is supposed to report any issues with resident equipment to him verbally or through the TELS system (a comprehensive facility management and maintenance computer system to manage work orders and environmental compliance in healthcare facilities). He said monthly environmental rounds are completed with the Administrator and any identified issues are corrected. He said the Director of Rehabilitation (DOR) monitors resident equipment and will let him know if any parts need to be ordered and for whom and he will fix resident assistive devices at that time. During an interview on 3/31/26 at 8:33 A.M., Certified Nurse Assistant (CNA) #3 said if something is found broken or there is a problem with equipment in the resident's room staff are to notify Maintenance, either verbally or by putting it into the computer system, to correct the issue. She said specifically for wheelchairs that they are cleaned on a schedule by Housekeeping and she believes Housekeeping would also report any issues of equipment in bad condition. During an interview on 3/31/26 at 10:53 A.M., the Housekeeping Director said there is a schedule followed for Housekeeping to clean all wheelchairs in the facility once a month and they are all completed in one week. She said if her staff tell her about an issue with a wheelchair that is in poor condition with rips, tears, or things of that nature she reports that verbally to the DOR so he can look at it and speak with Maintenance to get it taken care of. Review of the facility TELS work history report from 12/1/25 through 3/31/26 failed to indicate any issues were reported to the Maintenance Director through the TELS system. Review of the monthly environmental rounds provided by the facility from January 2026 through March 2026 failed to indicate that any assistive devices in use by residents, such as wheelchairs, were observed or evaluated during the environmental round process. During an interview on 4/1/26 at 8:04 A.M., the DOR said he does not have a formalized or scheduled process for looking at resident assistive devices like wheelchairs for any repairs. He said there is no defined process, but he looks while he is out on the units in the process of his normal day and if he notices something he notifies the Maintenance Director so it can<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | be repaired or replaced. During an interview on 3/31/26 at 3:47 P.M., the Administrator said once a month himself and the Maintenance Director complete environmental rounds to identify any safety issues and they walk the building and look to ensure the rooms look like rooms they would be willing to sleep in. He said looking at resident equipment or assistive devices is not completed during this time by him. He said he believed that quarterly the DOR was also looking at resident assistive devices, including wheelchairs, and any identified problems like the equipment being in poor condition would be reported to Maintenance through the TELS system and then repaired or replaced. He said reports of resident equipment being in disrepair was also something they discuss at morning meeting. He observed Resident #14's wheelchair with the surveyor and said the condition of the wheelchair was a safety hazard with the backrest pulling away from the frame and the seat fraying at the connection and the cracked torn arm rests are also a concern. He said it seemed the facility was not picking up on these things as they should and no piece of equipment should get in this condition without being reported by staff for repair. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on interviews and record review, the facility failed to ensure that one Resident (#23), out of a total sample of 18 residents, was provided the right to participate in their care plan process. Specifically, the facility failed to ensure that Resident #23 was invited to participate in their individual care plan meeting or provide a rationale as to why the participation of the Resident/Resident Representative was determined not practicable for the development of the care plan.Findings include:Review of facility's policy titled Care Planning- Interdisciplinary Team, last revised 3/2025, indicated but was not limited to the following:-The facility's care planning interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. -The resident, the resident's family and/or the resident's legal representative are encouraged to participate in the development of and revisions to the resident's care plan. Resident #23 was admitted to the facility in April 2024 with diagnoses which included dementia.During an interview on 3/26/26 at 12:58 P.M., Resident #23's Representative said she has not been invited to a care conference since the fall. She said she knows they are supposed to occur quarterly but there has been a revolving door of staff and she still hasn't met with the new team. She said she has not been able to provide input into Resident #23's plan of care.During an interview on 3/26/26 at 10:12 A.M., the Activities Director said she has not attended a care plan meeting since her hire date in January and was unsure of the process or who was responsible. During an interview on 3/31/26 at 9:16 A.M., Social Worker #1 said her agency identified on 3/26/26, the first day of the recertification survey, that care plan invitations were not being sent to the resident representatives or residents. She said she has conducted care plans without the interdisciplinary team because it is difficult to identify who is responsible for attending. She said there has been some turnover in the department which has resulted in inconsistency of care plans and meetings. She said she lets the team know in morning meeting when the care plan meetings are but cannot physically be responsible for getting someone there. She said she believes everyone is very busy and once staff knew family members or residents were not attending, they felt like they didn't need to be present. During an interview on 3/31/26 at 9:40 A.M., the Director of Nurses said the interdisciplinary team is expected to participate in care plan meetings. She said she knows there have been three social workers responsible for ensuring attendance so there may be some inconsistency. She said she expects someone from nursing is attending, there is not one designated nursing representative to attend weekly, but whoever is available to go. She said sometimes the meetings are on Wednesday and sometimes they are on Thursday; she is not sure the team is always aware. She said she is aware of the inconsistency with the care planning process. She said she cannot provide any additional documentation to support that meetings were held with the interdisciplinary team and resident/resident representatives were invited.During an interview on 4/1/26 at 9:36 A.M., the Regional Nurse said her expectation is the care plans are interdisciplinary and that residents and families are invited to participate in the development and review of the care plan. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure for one Resident (#21), out of a total sample of 18 residents with an alteration in skin integrity, specifically post-op surgical incisions, received necessary treatment and services to promote healing. Specifically, the facility failed to transcribe and implement wound care per the Hospital Discharge Summary, to develop and implement a care plan for the alteration in skin integrity, to ensure specific bathing/showering requirements related to the surgical incision were on the Kardex, to complete accurate admission, re-admission, and weekly skin assessments, and to monitor, assess and identify signs/symptoms of an infection until he/she was seen by the Wound Care Physician two weeks after admission for unrelated wounds and the clinical signs of infection were identified and a treatment implemented. Findings include: Review of the facility's policy titled Prevention and Management of Pressure Ulcers/Injuries, dated as last revised 11/2024, indicated but was not limited to the following:-The purpose of this policy is to ensure a resident receives care consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing.-Conduct a skin assessment on admission, including skin integrity, any evidence of existing or developing ulcers or injury, any other skin issues, and areas of impaired circulation due to pressure, positioning, or medical devices.-Licensed nurses conduct weekly skin evaluations.-Develop the resident centered care plan and interventions based on risk factors identified, the condition of the skin, and the resident's overall clinical condition.-Monitor wound for changes or complications and notify the provider if noted.-At least weekly, an evaluation should be documented. Including at minimum the location, size, drainage, pain, description of the wound bed, description of wound edges and surrounding tissue.DEFINITIONS:-Exudate/Drainage: Purulent: thick or thin, opaque, tan, or yellow product of inflammation that contains pus (e.g., leukocytes (white blood cells), bacteria, and liquified necrotic (dead tissue) debris).-Infected: refers to the presence of micro-organisms in sufficient quantity to overwhelm the defense of viable tissues and produce the signs and symptoms of infection.-Debridement: the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process. Review of the facility's policy titled Charting and Documentation, dated as last revised 11/2024, indicated but was not limited to the following:-The following information is to be documented in the resident medical record as warranted: Objective observations, treatments or services performed, changes in the resident's condition, and progress toward or changes in the care plan goals and objectives.-Documentation in the medical record will be objective, complete, and accurate. Resident #21 was admitted to the facility in January 2026 with diagnoses which included fracture of the left femur, surgical aftercare, and spastic quadriplegic cerebral palsy. Review of the Minimum Data Set (MDS) Assessment, dated 2/12/26, indicated Resident #21 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact, had a surgical wound, and was at risk for pressure ulcers. Review of the Nursing admission Evaluation and progress note, dated 1/29/26, indicated Resident #21 refused to have a skin assessment completed. Review of the Skilled Charting Evaluation, dated 1/30/26, indicated Resident #21 had two surgical incisions with medi-strips ((steri-strips) adhesive wound closure strips to secure, close, and support incisions) 7 centimeters (cm) and 2cm, was anxious, and required four staff to provide care. The evaluation failed to indicate the number of medi-strips in place and failed to include a description of the wound/incision lines or surrounding tissue. Review of the Hospital Discharge summary, dated [DATE], indicated Resident #21 had a femur fracture, had surgery on 1/15/26 to repair the fracture, and required monitoring and wound care to the incision. Specifically, the Hip Fracture Discharge Instructions indicated the following:-The dressing will stay on until 7 days post-op. It can then be removed, and the incision can be left open to air. It is ok to shower once the dressing is removed UNLESS there is wound drainage. Orthopedics should remove the staples in 12-14 days, then secure the wound with<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | benzoin and steri-strips.-If there is wound drainage, you should have a dressing on.-You may shower after discharge.-Do not soak, take tub baths, use hot tubs, or swimming pools for six weeks after surgery.-For showers, after the dressing is removed: Do not get wound wet IF there is active wound drainage. Allow the water to run over the incision, but DO NOT apply any soaps or lotions to the incision area. Do not scrub the incision. Pat dry gently with a towel.-Follow up with the surgeon in two weeks.-Please call the surgeons office with fever >101.4, increasing wound redness or swelling, drainage from the incision, persistent calf pain, operative extremity pain not controlled by an increase in pain medications, or any questions or concerns. Review of the Physician (MD)/Nurse Practitioner (NP) progress notes indicated but were not limited to the following:-1/30/26: New admission for Left Hip Fracture status post open reduction and internal fixation (ORIF-surgical repair) with trochanter nail insertion on 1/15/26. Plan: Surgical Site to be monitored for signs/symptoms of infection.-1/31/26: He/she reports persistent pain in the left hip/thigh region. Plan of Care: Monitor the incision. Review of the Physician's Orders failed to indicate monitoring of the incisions and post-op orders per the Discharge Instructions had been implemented. Review of the Care Plan failed to indicate Resident #21 had a left femur fracture and two surgical incisions requiring assessment and monitoring, or specific bathing/showering instructions per the Discharge Instructions. Review of the Resident Care Card (Kardex) failed to indicate specific bathing/showering instructions per the Discharge Instructions. Resident #21 was transferred to the hospital on 2/4/26 and returned on 2/9/26 for medical concerns unrelated to the surgical wound. Review of the Hospital Discharge summary, dated [DATE], indicated Resident #21 had recently had surgery to repair hip fracture at a different hospital and declined to have the discharging provider evaluate his/her wounds. Review of the Medical Record failed to indicate a Nursing re-admission Evaluation had been completed and failed to indicate a skin assessment had been completed. The facility failed to evaluate the post-op incisions and failed to ensure post-op orders were obtained and implemented upon his/her return from the hospital. Review of the Skilled Charting Evaluations for January and February 2026 indicated femur fracture 2 surgical incisions with medi-strips in place. First Incision 7cm in length and second incision 2cm in length. Each evaluation contained this exact same notation from the initial evaluation on 1/30/26. The evaluations failed to describe the current status of the wound/incision and surrounding tissue. Review of the Nursing Progress Notes for January and February 2026 indicated but were not limited to the following:-Resident #21 occasionally would refuse care and education was provided.-Resident #21 had other non-surgical wounds.-The notes failed to indicate any description of the surgical incisions.-2/12/26: The nurse spoke to Resident #21 about wound care services and that he/she had previously refused them and consent was obtained.-The notes failed to indicate Wound Physician services were offered and declined previously.-2/13/26: Resident #21 was seen by the Wound Physician and the post-surgical wound to the left hip was cultured and care plan was updated. The note failed to indicate a description of the wound.-2/18/26 Resident #21 went to an Orthopedic Appointment and was prescribed Doxycycline (antibiotic) for surgical wound infection.-The notes failed to indicate any description of the infected surgical incisions. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) failed to indicate any orders had been implemented for the left hip incisions and failed to indicate any assessment/monitoring for signs/symptoms of infection from 1/29/26 through 2/11/26.-2/11/26 at 3:50 P.M: New Order: Monitor left hip incision site steri-strips in place for signs/symptoms of infection every shift. Review of the Weekly Skin Evaluations, dated 2/12/26 and 2/19/26, failed to indicate Resident #21 had a surgical wound on his/her left hip. Review of the Wound Physician Evaluation, dated 2/13/26, indicated but was not limited to the following:-Resident #21 has wounds on his/her left posterior calf, left hip, and right lateral ankle. Status post left hip surgery in January and now has mild dehiscence (premature separation of the edges of a surgical incision often occurring 1-2 weeks post-operation caused by infection, tension, or poor healing, symptoms include pain, drainage and visible gaps) with purulent drainage of the incision. He/she has a follow up with the<br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | surgeon.-Focused Wound Exam: Post-Surgical Wound of the Left HipEtiology: post-surgicalDuration: greater than three daysSize: 1 x 0.5 x 0.4cmExudate (drainage): moderate purulentPain: ModerateInfection Assessment: One or more signs of clinical infection.Estimated time to heal: 4-6 monthsCare Goals: decrease wound area, improve granulation (new healing tissue, manage pain, manage exudate, maintain skin integrity.Investigations/Recommendations: Deep wound culture. Review of the Non-Pressure Ulcer Evaluation, dated 2/13/26, indicated Resident #21 had a surgical incision on their left hip, he/she had been seen by the Wound Physician, and a treatment was in place. Review of the Orthopedic Appointment Referral, dated 2/18/26, indicated left hip surgical site infection. New orders: Obtain a Computed Tomography (CT) Scan of left femur (3D imaging used to diagnose internal injuries/infections) and Doxycycline 100 milligrams (mg) twice daily for empiric Methicillin-resistant Staphylococcus Aureus (MRSA) coverage. Review of the MD/NP progress note, dated 2/18/26, indicated: According to the Patient and the surgeon's recommendations, the surgical site on the left hip is showing signs of a superficial infection. The surgeon recommended starting antibiotic therapy. The left hip was examined and has no drainage, but the surrounding skin is erythematous (red) and warm to the touch. I concur with the surgeon's recommendations, start Doxycycline 100mg twice daily for 10 days for possible MRSA. Order a CT to rule out a deeper infection. During an interview on 3/26/26 at 10:25 A.M., Resident #21 said they had trauma from the fall/fracture at the other facility and did not really want to talk about it. He/she said they like to keep to themselves and would prefer the staff not bother him/her so much. Resident #21 said sometimes they refuse care because someone else was just in here and it is a lot to move and it's painful, so he/she wished the staff would coordinate with each other better. Resident #21 was seen by the Wound Doctor on 3/27/26 and the wound was resolved. During an interview on 3/31/26 at 2:33 P.M., Nurse #5 said post op orders and how to care for the Resident should have been obtained from the physician on admission. She said monitoring the incision for signs/symptoms of infection, monitoring the dressing, specific showering instructions all should have been in the care plan and on the TAR. She said the TAR is where all the orders go, so staff knew how to care for the resident. Additionally, she said the bathing/showering instructions should have been on the Kardex for the aides and they were not. During an interview on 3/31/26 at 2:47 P.M., Unit Manager #1 said the fracture and post-op wound care orders should have been part of the care plan to ensure staff knew how to care for him/her and they were not. Additionally, she said the orders from the discharge instructions should have been written and put onto the TAR, so the nurses must sign off on them and they were not. She said she didn't think he/she had a dressing on the left hip on admission, but they were doing daily dressing changes when care was done. She said it doesn't look like there was an order for a dressing until he/she was seen by the Wound Doctor, but they had been covering it. She was unsure why the orders were not implemented. During an interview on 4/1/26 at 10:37 A.M., Physician #1 said he would expect the femur fracture and surgical wound care to have been part of the care plan since admission as that was basic care needs and the reason for admission. He said his expectation is for the Discharge Instructions from the hospital to be followed, orders written and implemented, and if the orders were unclear or needed clarifying the nurses should reach out. He said there should always be post-op monitoring for signs/symptoms of infection orders written. Additionally, he said every resident with a wound (surgical and non-surgical) is referred to the Wound Physician and he would expect if one declined that service the facility would notify him to ensure the wounds were evaluated by a clinician for appropriate treatment. He said wound descriptions and signs of infection should have been identified and documented by the staff and a call placed to the MD/NP for orders, it should not have waited until the Wound Doctor was in to be evaluated. He said the documentation can be an issue and that needs to improve. During an interview on 4/1/26 at 11:03 A.M., Nurse #4 said she did not recall when they started putting a dressing on the left hip. Additionally, she said the wound/incisions should have been described in the evals or notes and they were not and on re-admission a new Nursing Evaluation and Skin Check should have been done and orders written per<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225067 | A. Building<br>B. Wing | 04/01/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wedgemere Healthcare | 146 Dean Street<br>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.

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the discharge orders and they were not. During an interview on 4/1/26 at 1:23 P.M., the Staff Development Coordinator (SDC) said the baseline care plan should be developed within 48 hours and include all basic needs the staff need to know to care for the residents, including fractures and surgical wounds and his/her care plan did not include that information. She said the post-op orders from the Discharge Instructions should have been written and on the TAR and the Kardex should have the information the aids need to know to care for the resident and they were not. She said the Admit, Re-Admit Evaluations and weekly skin checks should include all wounds and description of them and they do not. Additionally, she said a non-pressure evaluation should be done on every non-pressure wound, including surgical wounds, on admission and weekly and was not sure why there was not one done until he/she was seen by the Wound Doctor. She said she only does the evaluations for the residents that are seen by the Wound Doctor. She said they refer everyone with wounds to the Wound Doctor, except surgical wounds. She said the referral to the Wound Doctor was for his/her other wounds and the Wound Doctor evaluated the hip incision on the initial visit too. She said the Wound Doctor identified that the wound was infected and dehiscing, but we (facility staff) should have identified that and obtained treatment orders first. During an interview on 4/1/26 at 2:27 P.M., the DON said the Baseline Care Plan is developed from the Nursing admission Assessment. She said it should be done within the first 48 hours and include resident care needs, including but not limited to fractures and surgical wound care and it did not include that information. She said the Nursing admission Evaluation should have been done and included wound information on Admit and Re-Admit, the skin checks and non-pressure evaluations should also have included wound descriptions and they did not. She said the discharge orders should have all been implemented and they were not. She said there was one order written on admission, but it was entered a lab order, and it did not contain all the instructions anyhow. She said the documentation of the wound/incision should have included size, color, number of staples/sutures/steri-strips, dressing, and the plan and the only thing documented was the length of the incisions if anything. She said anytime orders are unclear or need to be clarified the provider should be called to obtain orders and the orders should be put on the TAR. She said they review all the admission and re-admissions for accuracy and was not sure how/why this was missed. She said there were not any orders on TAR until 2/11 and then after he/she was seen by the Wound Physician and the wound was determined to be infected a dressing was ordered. She said Resident #21 did refuse care sometimes, but the orders for this surgical wound were never implemented, so the refusal of care was for other wounds and/or personal care. She said this should have been identified by our staff and orders implemented prior to the Wound Doctor's evaluation. |