

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225134	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/30/2025
NAME OF PROVIDER OR SUPPLIER  Foremost at Sharon LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  259 Norwood Street Sharon, MA 02067	

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 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.  (continued on next page)

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who developed Moisture-Associated Skin Damage (MASD) to his/her coccyx, the Facility failed to ensure they notified his/her Physician of the Wound Nurse Practitioner's recommendations for wound care and as a result, the treatment recommendations were never implemented. Findings include: Review of the Facility's Policy titled, Change of Condition in a Resident Status, dated 03/2017, indicated the Facility would notify the resident's physician when there had been a need to alter the resident's medical treatment significantly. Review of the Facility Policy titled, Pressure Ulcer/Injury Risk Assessment, dated as revised 03/2022, indicated to document in medical record addressing MD notification if new skin alteration noted with change of plan of care. Resident #1 was admitted to the Facility in August 2025, diagnoses included unspecified dementia, seizures, syncope and collapse, hypertension muscle weakness and type 2 diabetes mellitus. Review of the Wound Nurse Practitioner's Initial Progress Note, dated 09/15/25, indicated that Resident #1 was seen for assessment and treatment recommendations for a MASD to his/her coccyx measuring 1.5 centimeters (cm) by 2 cm. The Note indicated to clean the coccyx wound with normal saline, pat dry, apply zinc (topical ointment used for wound healing) and collagen sprinkles (used for wound healing and stimulate new tissue growth) daily. Review of a Wound Nurse Practitioner's Progress Note, dated 09/22/25, indicated that Resident #1 was seen for assessment and treatment recommendations for a MASD to his/her coccyx. The Note indicated that MASD was improved and continue with the following treatment: clean the coccyx wound with normal saline, pat dry, apply zinc and collagen sprinkles daily. Review of Resident #1's Physician's Orders, for the month of September 2025, indicated there was no documentation to support that a Physician's order was obtained for the Wound Nurse Practitioner's recommendations for wound care. Review of Resident #1's Treatment Administration Record (TAR), dated 09/01/25 through 09/30/25, indicated there was no documentation to support that the Wound Nurse Practitioner's recommendations for treatment was implemented. Review of Resident #1's Nurse Progress Notes and Physician Progress Notes, dated 09/15/25 through 09/23/25, indicated there was no documentation to support that the physician was notified of the Wound Nurse Practitioner's recommendations for wound care for Resident #1's coccyx. During an in-person interview on 12/30/25 at 2:40 P.M. and a subsequent telephone interview on 01/12/26 at 9:41 A.M., Nurse #1 said that she was familiar with and was assigned to care for Resident #1 many times during his/her stay at the facility. Nurse #1 said that she was unaware that Resident #1 had been seen by the Wound Nurse Practitioner and that there were new recommendations for wound care to Resident #1's coccyx. Nurse #1 said that when a resident is seen by the Wound Nurse Practitioner and there are new treatment recommendations, the nurses notify the Physician of the recommendations made by the Wound Nurse Practitioner and the Physician gives an order for the new treatments. Nurse #1 said that nurses document in the nurse progress notes that the physician was notified and a physician's order is written by the nurse. Nurse #1 said she could not explain why the physician was not notified of the Wound Nurse Practitioners' recommendations. During a telephone interview on 01/05/26 at 12:32 P.M., Physician #1 said that Resident #1 had a wound to his/her coccyx and that the Facility has a Wound Nurse Practitioner who consults with the Facility and makes recommendations for wound care. Physician #1 said that she expects that the Facility notify her of the Wound Nurse Practitioners recommendations for wound care and said she could not recall if the Facility notified her of the recommendations for wound care for Resident #1's coccyx wound. Physician #1 said that she would have implemented the Wound Nurse Practitioner's recommendations for wound care for Resident #1's coccyx wound if she had been notified. During an interview on 12/30/25 at 3:30 P.M., the Director of Nurses (DON) said that Resident #1 was seen by the Wound Nurse Practitioner and new treatment recommendations were made for Resident #1's coccyx wound. The DON said that it is her expectation that nurses notify the physician of the Wound Nurse Practitioners recommendations and obtain an order from the physician to implement the wound treatment recommendations. The DON said she could not explain why the physician was not notified of the Wound Nurse Practitioners' recommendations and why the recommendations were not implemented.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on records reviewed and interviews for one of three sampled residents (Resident # 1), who developed a wound to his/her coccyx and required wound care, and required a sling to his/her left arm due to a fractured left clavicle, the Facility failed to ensure nursing developed and implemented a comprehensive person-centered care plan with interventions, treatment goals and outcomes that addressed, ) his/her wound care needs and 2) care and monitoring needs related to his/her fractured left clavicle. Findings include:Review of the Facility's Policy titled, Comprehensive Care Plans, dated as revised April 2022, indicated that: - a comprehensive, person-centered care plan that includes objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident;- the care planning process will include an assessment of residents' strengths and needs, reflect treatment goals, timetables and objectives in measurable outcomes;- assessments of resident's are ongoing and care plans are revised as resident's conditions change;-care plans shall be reviewed and updated when there is a significant change in the resident's conditionReview of the Facility's Policy titled, Pressure Ulcer/Injury Risk Assessment, dated as revised March 2022 indicated that:-conduct a comprehensive skin assessment with every risk assessment;-once inspection of the skin is completed, document the findings on a facility-approved skin assessment tool;-develop the resident-centered care plan and interventions based on the risk factors identified in the assessments, the condition of the skin and the resident's overall clinical condition;-interventions must be based on current, recognized standards of care;-effects of the interventions must be evaluated;-the care plan must be modified as the resident's condition changes or if current interventions are deemed inadequate.Resident #1 was admitted to the Facility in August 2025, diagnoses included unspecified dementia, seizures, syncope and collapse, hypertension muscle weakness and type 2 diabetes mellitus.1) Review of Resident #1's Norton Plus Pressure Ulcer Scale Assessment, dated 08/14/25, indicated that Resident #1 was assessed by nursing as being at high risk for the development of pressure ulcers.Review of Resident #1's Skin Observation Tools, dated 08/22/25, 08/27/25, and 9/12/25, indicated that a small open area was identified on his/her coccyx.Review of Resident #1's Nurse Progress Note, dated 09/12/25, indicated that a small open area was noted on his/her buttocks.Review of a Wound Nurse Practitioner's Initial Progress Note, dated 09/15/25, indicated that Resident #1 was seen for assessment and treatment recommendations for Moisture-Associated Skin Damage (MASD) to his/her coccyx measuring 1.5 centimeters (cm) by 2 cm. The Note indicated to clean the coccyx wound with normal saline, pat dry, apply zinc (topical ointment used for wound healing) and collagen sprinkles (used for wound healing and stimulate new tissue growth) daily.Review of Resident #1's Care Plan related to Actual Alteration in Skin Integrity, dated as initiated on 08/08/25 and revised on 10/19/25, indicated there was no documentation to support that nursing documented the location of the actual wound when an open area was observed on his/her coccyx on 08/22/25.Review of Resident #1's Medical Record from 08/22/25 through 09/23/25, indicated there was no documentation to support a Care Plan related to his/her new open area and MASD to the coccyx with interventions, treatment, goals and outcomes, had been developed and implemented by nursing to meet his/her wound care needs by nursing.During an in-person interview on 12/30/25 at 2:40 P.M. and a subsequent telephone interview at 9:41 A.M., Nurse #1 said that she was familiar with and was assigned to care for Resident #1 many times during his/her stay at the facility. Nurse #1 said that Resident #1 had an open area on his/her coccyx. Nurse #1 said that it was not the staff nurses' responsibility to develop and/or update the resident care plan. Nurse #1 said that it was the responsibility of the Minimum Data Set (MDS) nurse and the Director of Nurses to develop a resident care plan and update the care plan as needed.During an interview on 12/30/25 at 3:30 P.M., the Director of Nurses (DON) said that Resident #1 had an open area to his/her coccyx. The DON said that both the staff nurses and the MDS Nurse were responsible for developing the initial care plans and that the MDS nurse updates the care plans with any new interventions. The DON said it was her expectation that all care plans are comprehensive and any actual wound care plan identifies the location of the wound and be updated with new interventions.2) Review of a Nurse Progress Note, dated 08/22/25, indicated that an x-ray of Resident #1's left shoulder was obtained, showed a left clavicle fracture and Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation. Review of a Hospital ED Discharge summary, dated [DATE], indicated that Resident #1 was seen in the ED for evaluation of left shoulder pain after a fall. The Summary indicated that an x-ray of the left shoulder</p>		

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F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (continued on next page)

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who developed an open area to his/her coccyx and sustained a fracture to his/her left clavicle after a fall, the Facility failed to ensure he/she was provided with quality of care that met professional standards of practice when 1) he/she was not seen by the facility's Wound Nurse Practitioner in a timely manner and 2) treatment orders from the Hospital Emergency Department (ED) related to the left clavicle fracture were not implemented. Findings include: Resident #1 was admitted to the Facility in August 2025, diagnoses included unspecified dementia, seizures, syncope and collapse, hypertension muscle weakness and type 2 diabetes mellitus. 1) Review of Resident #1's Skin Observation Tools, dated 08/22/25, 08/27/25, and 9/12/25, indicated that a small open area was identified on his/her coccyx and would follow up with the Wound Nurse Practitioner. Review of Resident #1's Nurse Progress Note, dated 09/12/25, indicated that a small open area was noted on the buttocks. Further review of Resident #1's Medical Record indicated that although an open area on his/her coccyx was identified by nursing on 8/22/25, Resident #1 was not evaluated and assessed by the Wound Nurse Practitioner until 9/12/25, three weeks after nursing started documenting it on the Skin Observation Tool. Review of a Wound Nurse Practitioner's Initial Progress Note, dated 09/15/25, indicated that Resident #1 was seen for assessment and treatment recommendations for a MASD to his/her coccyx measuring 1.5 centimeters (cm) by 2 cm. The Note indicated to clean the coccyx wound with normal saline, pat dry, apply zinc (topical ointment used for wound healing) and collagen sprinkles (used for wound healing and stimulate new tissue growth) daily. During an in-person interview on 12/30/25 at 2:40 P.M. and a subsequent telephone interview on 01/12/26 at 9:41 A.M., Nurse #1 said that she was familiar with and was assigned to care for Resident #1 many times during his/her stay at the facility. Nurse #1 said that Resident #1 had an open area on his/her coccyx and he/she should have been seen and assessed by the Wound Nurse Practitioner in a timely manner. Nurse #1 said that the Wound Nurse Practitioner comes in weekly on Mondays and it should not have taken three weeks for Resident #1 to be seen and assessed by the Wound Nurse Practitioner. During an interview on 12/30/25 at 3:30 P.M., the Director of Nurses (DON) said that the Wound Nurse Practitioner comes in weekly on Monday's and nursing notifies the Wound Nurse Practitioner of any new residents with an open area. The DON said that it was her expectation that residents who have an open area be assessed by the Wound Nurse Practitioner the next time she was due at the facility. The DON said she was unaware that it took three weeks for the Wound Nurse Practitioner to assess Resident #1's wounds and said it should not have taken that long. 2) Review of Resident #1's Fall Risk Assessment, dated 08/07/25, indicated that nursing assessed him/her at High Risk for Falls. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 08/20/25, indicated that at 10:00 A.M. Resident #1 was observed by staff lying on the floor across from the nurses' station. The Report indicated that an x-ray was ordered and revealed an acute moderately displaced fracture of the left clavicle and Resident #1 was transferred to the Hospital ED for evaluation and treatment. Review of a Nurse Progress Note, dated 08/22/25, indicated that an x-ray of Resident #1's left shoulder was obtained, showed a left clavicle fracture and Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation. Review of a Hospital ED Discharge summary, dated [DATE], indicated that Resident #1 was seen in the ED for evaluation of left shoulder pain after a fall. The Summary indicated that an x-ray of the left shoulder showed a midshaft fracture of the left clavicle and to manage the fracture, wear a simple sling on the left arm. The Summary further indicated to check skin around the sling every day, loosen it if your fingers [NAME] or become numb, turn cold and blue and not to put weight on left arm until seen by an orthopedic doctor. Review of Resident #1's Medical Record which included but was not limited to his/her Treatment Administration Record (TAR), Medication Administration Record (MAR) and Nursing Progress Notes from 08/23/25 through 09/03/25, indicated there was no documentation to support that nursing monitored Resident #1's left arm, that non-weightbearing status was maintained, and that a sling was provided to him/her and implemented. Review of a Nurse Progress Note, dated 09/03/25, indicated that Resident #1 returned from an orthopedic appointment and had new recommendations for weight bearing as tolerated with a walker. During an in-person interview on 12/30/25 at 2:40 P.M. and a subsequent telephone interview on 01/12/26 at 9:41 A.M., Nurse #1 said that she was familiar with and was assigned to care for Resident #1 many times during his/her stay at the facility. Nurse #1 said that she was unaware that Resident #1</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on records reviewed and interviews, for one of three sampled residents, (Resident #1), who had developed an open area to his/her coccyx, and was non-weight bearing, required the use of a sling and monitoring by nursing due to a left clavicle fracture, the Facility failed to ensure they maintained a complete and accurate medical record, when 1) there was no nursing documentation related to his/her coccyx wounds characteristics and progress towards healing and 2) there was no nursing documentation on his/her Treatment Administration Record (TAR) or Nurse Progress Notes to support nursing monitored Resident #1's left arm per Hospital Discharge Summary recommendations. Findings Include:Review of the Facility's Policy titled, Charting and Documentation, dated as revised April 2022, 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;-documentation of treatments will include care-specific details including: the date and time the treatment was provided, the assessment data and/or any unusual findings obtained during the treatment;Review of the Facility's Policy titled, Medical Record, dated as revised April 2022, indicated that the Medical Record reflects an interdisciplinary approach to assessment, Care Planning, care delivery and documentation should include the provision of and response to nursing care and treatment provided.Review of the Facility's Policy titled, Pressure Ulcer/Injury Risk Assessment, dated as revised March 2022, indicated the following:-conduct a comprehensive skin assessment with every risk assessment;-once inspection of the skin is completed, document the findings on a facility-approved skin assessment tool;-document in the resident's medical record, the condition of the resident's skin, the size and location of any red areas;-initiate a pressure or non-pressure form related to the type of alteration in skin if new skin alteration noted.Resident #1 was admitted to the Facility in August 2025, diagnoses included unspecified dementia, seizures, syncope and collapse, hypertension muscle weakness and type 2 diabetes mellitus.1) Review of Resident #1's Skin Observation Tools, dated 08/22/25, 08/27/25, and 9/12/25, indicated that a small open area was identified on his/her coccyx.Review of a Medication Administration Record (MAR), dated 08/22/25 through 09/23/25, indicated he/she had a physician's order to apply silver sulfadiazine cream 1% (topical antimicrobial medication used primarily for the prevention of wound sepsis) topically every shift to coccyx.Review of a Nurse Progress Note, dated 09/12/25, indicated that a small open area was noted on the buttocks.Review of Resident #1's Medical Record and MAR from 08/22/25 through 09/23/25, indicated there was no documentation to support that nursing assessed Resident #1's coccyx wound, that nursing documented the condition of the resident's skin, the size of the open area, the wounds characteristics and that a pressure form related to the type of alteration in skin was implemented.During an in-person interview on 12/30/25 at 2:40 P.M. and a subsequent telephone interview on 01/12/26 at 9:41 A.M, Nurse #1 said that Resident #1 had an open area on his/her coccyx and had a treatment for silver sulfadiazine cream. Nurse #1 said that whenever a treatment order is written for a wound, the nurses document the assessment and description of the wound on the Medication Administration Record or Treatment Administration Record when they complete the treatment of the wound. Nurse #1 could not explain why there was no documentation in Resident #1's medical record that described the characteristics of Resident #1's coccyx wound.During an interview on 12/30/25 at 3:30 P.M., the Director of Nurses (DON) said that Resident #1 had a small open area to his/her coccyx and had a treatment for the wound. The DON said that it is her expectation that the nurses assess the wound and document the description of the wound in the Medical Record after they perform the treatment to the wound.2) Review of a Nurse Progress Note, dated 08/22/25, indicated that an x-ray of Resident #1's left shoulder was obtained, showed a left clavicle fracture and Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation.Review of a Hospital ED Discharge summary, dated [DATE], indicated that Resident #1 was seen in the ED for evaluation of left shoulder pain after a fall. The Summary indicated that an x-ray of the left shoulder showed a midshaft fracture of the left clavicle and to manage the fracture, wear a simple sling on the left arm. The Summary further indicated to check skin around the sling every day, loosen it if your fingers [NAME] or become numb, turn cold and blue and not to put weight on left arm until seen by an orthopedic doctor.Review of Resident #1's Physician Orders, dated August 2025 and September 2025, indicated there was no documentation to support that a Physician's order</p>		