

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/02/2025
NAME OF PROVIDER OR SUPPLIER  Ellis Nursing Home (the)		STREET ADDRESS, CITY, STATE, ZIP CODE  135 Ellis Avenue Norwood, MA 02062	
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 0658  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality.  (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/02/2025
NAME OF PROVIDER OR SUPPLIER  Ellis Nursing Home (the)		STREET ADDRESS, CITY, STATE, ZIP CODE  135 Ellis Avenue Norwood, MA 02062	
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)		
<p>F 0658</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 was re-admitted with multiple pressure injuries, the Facility failed to ensure nursing staff provided care and services that met professional standards of practice related to timely follow-up on provider recommendations for wound care and accurate transcription of treatment orders. Findings include: Review of the Facility Policy titled Consults: Health Drive, Wound MD, and other outside Consultants, dated as last updated 08/01/25, indicated that residents who have consultants will have recommendations reviewed by attending MD/NP/PA/LIP. The Policy further indicated the staff RN/LPN will review consultation reports and recommendations with the prescriber, prescriber will decide on if recommendations are followed and orders obtained, nursing will document new orders and order supplies if necessary, and nursing will document per house protocol. Review of the Facility Policy titled Verbal Orders, dated as last updated 08/01/23, indicated that the individual receiving the verbal order will read the order back to the practitioner to ensure that the information is clearly understood and correctly transcribed. Resident #1 was admitted to the Facility in March 2025, diagnoses include diabetes mellitus with neuropathy (weakness and numbness due to nerve damage), peripheral vascular disease, and hemiparesis (weakness on one side of the body). Resident #1 had an acute 10-day Hospital stay and was re-admitted to the facility on [DATE]. Review of Resident #1's Wound Evaluation and Management Summary, dated 05/29/25 (written by Wound Physician), indicated he/she had 4 separate pressure injuries with 4 recommended treatments as follows; 1) Unstageable due to necrosis (dead tissue) sacrum full thickness pressure injury with recommended treatment nursing to apply Calcium Alginate (promotes wound healing forming a gel and absorbs wound fluids) once daily and as needed and Santyl (removes dead tissue from wounds so they can heal) apply one daily and as needed (PRN). However, review of Resident #1's Treatment Administration Record (TAR) dated 05/28/25 through 07/02/25, indicated that nursing was providing a treatment to his/her sacrum according to the original physician's order from 05/13/25, indicating that nursing apply NSW followed by Calcium Alginate and cover with boarder gauze daily and PRN. Further review of Resident #1's Medical Record, including but not limited to the TAR, Medication Administration Record (MAR), Physician's Orders, and Care Plans, indicated that there was no documentation to support a new order had been obtained for Resident #1's Stage 4 sacral pressure injury upon readmission, even after the Wound Physician made new recommendations, and nursing continued to follow an old and incomplete Physician's Order, dated 05/13/25. Review of Resident #1's Physician's Orders, dated 06/03/25, indicated nursing to treat area with normal saline wash (NSW) followed by (F/B) Calcium Alginate and cover with border gauze daily and PRN to sacrum wound. Review of Resident #1's Physician's Orders, dated 07/03/25, indicated nursing to apply Santyl Ointment 250 units per gram (gm) to sacrum topically one time a day for wound care. Further review of Resident #1's Medical Record indicated that there was no documentation to support that the treatment that had been recommended on 05/29/25, had been accurately transcribed until 07/03/25. 2) Stage 3 (deep wound that extends through the layers of skin and subcutaneous tissue) pressure injury to the right heel full thickness with recommended treatment for nursing to apply Xeroform (allows hydration in the wound to promote healing) gauze applied once daily and as needed with gauze island border applied once daily and as needed. Review of Resident #1's Physician's Orders, dated 07/03/25, indicated nursing to treat area with a NSW, pat dry, apply Xeroform (cut to fit wound bed) and cover with boarded gauze once daily and as needed to his/her right heel. Review of Resident 1's Medial Record, including but not limited to the MAR, TAR, Physician's Orders, and Care Plans, indicated that there was no documentation to support the dressing that had been recommended by the Wound Physician on 05/29/25, had been obtained until 07/03/25. 3) Stage 3 pressure injury to the right buttocks full thickness with recommended treatment for nursing to apply Silver Sulfadiazine (used to prevent wound infections) once daily and as needed, peri (surrounding edges) wound treated with house barrier cream apply once daily and as needed; and 4) Stage 3 pressure injury to the left buttocks full thickness with recommended treatment for nursing to apply Silver Sulfadiazine once daily and as needed, peri wound treated with house barrier cream apply once daily and as needed. Review of Resident #1's Physician's Orders, dated 05/29/25, indicated nursing to treat area with Silver Sulfadiazine Cream 1 percent (%) to buttocks topically, on the day shift for wound care and mix with House Barrier Cream. Review of Resident #1's Physician's Orders, dated 06/05/25, indicated nursing to treat area with Silver Sulfadiazine Cream 1 percent (%) to left buttocks topically, on the</p>		