STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225211	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellis Nursing Home (the)	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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure the call bell system was functioning properly in his/her room, when on 12/06/25 after family members complained his/her call light was not working, it was determined that the reset button had been taped down disabling the ability for the call light to function properly. Findings include: The Facility Policy, titled Call System, dated 08/01/23, indicated the following:-residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station.-each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.-call system communication may be audible or visual.-the resident call system remains functional at all times.-if audible communication is used, the volume is maintained at an audible level that can be easily heard.-if visual communication is used, the lights remain functional. Resident #1 was admitted to the Facility in December 2025, diagnoses included fracture of right pubis (break in the pubic bone; part of the pelvis), repeated falls, Parkinson's disease, and paraplegia. During a telephone interview on 01/14/26 at 2:25 P.M., Family Member #1 said on 12/06/25 Resident #1 told her that he/she had been calling for help, and no one answered his/her call light. Family Member #1 said she informed Nurse #2 that Resident #1's call light was not working and when Nurse #2 went to Resident #1's room she (Nurse #2) witnessed that his/her call light was not working. Family Member #1 said Nurse #2 informed her that a call was being placed to maintenance about Resident #1's call light not working, that Nurse #2 offered a Resident #1 handheld bell to use to call for staff, but said handheld the bell was never brought to Resident #1 to test out. Family Member #1 said she returned to the Facility later that afternoon, found out that maintenance had not been to Resident #1's room and that his/her call light was still not working properly. Family Member #1 said when Family Member #2 arrived she pushed Resident #1's call light several times and the light was not going off. Family Member #1 said Family Member #2 went to push the call light reset button and noticed it had been taped down with several pieces of clear tape. Family Member #1 said Family Member #2 informed Nurse #2 that Resident #1's call light was not working because someone had taped the reset button down. Family Member #1 said Nurse #2 came to Resident #1's room and removed the tape. During an in-person interview on 01/15/26 at 3:02 P.M., (which included review of her written statements) Nurse #2 said on 12/06/25 Family Member #1 called her to Resident #1's room because his/her call light was not working. Nurse #2 said she pulled both call light cords from the wall, plugged them back in and both call lights in the room were working. Nurse #2 said she told Family Member #1 that Resident #1's call light seemed to be working and if it was not working then she would call maintenance. Nurse #2 said she offered Resident #1 a handheld bell just in case and Family Member #1 adamantly refused the bell. Nurse #2 said later that afternoon, Family Member #2 showed her a video on her cell phone, and she (Family Member #2) said look at this someone taped the reset button. Nurse #2 said she went to 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1's room and observed that there was clear tape over the call light reset button and said she immediately removed the tape. Nurse #2 said she never called maintenance because when she checked it, Resident #1's call light system was working properly. Nurse #2 said she had no clue who or when the tape was placed over the reset button. During a telephone interview on 01/20/26 at 11:14 A.M., (which included review of her written statement) Nursing Supervisor #2 said Nurse #2 informed her that Resident #1's call light was not working, that there was something wrong with it and said she told Nurse #2 to call maintenance. Nursing Supervisor #2 said later that day (exact time unknown) Nurse #2 called her and said Resident #1's family was having an issue with his/her call light. Nursing Supervisor #2 said she went to Resident #1's room to speak to his/her family and they told her that the call light reset button had been covered with tape. The Supervisor said the tape had already been removed before she went to meet with Resident #1's family. Nursing Supervisor #2 said she tested the call lights in Resident #1's room and they were both working. Nursing Supervisor #2 said she notified the Director of Nursing (DON) that tape had been found over Resident #1's call light reset button. During an in-person interview on 01/15/26 at 1:58 P.M. and a follow-up telephone interview on 01/26/26 at 1:05 P.M., the Maintenance Director said on 12/08/25 he was informed there had been a problem with Resident #1's call light over the weekend because Resident #1's family said there was tape over the call light reset button. The Maintenance Director said that if tape or any pressure is placed over a call light reset button the call light would not work or light up, to call staff for assistance. During an in-person interview on 01/15/26 at 4:12 P.M. and a follow-up telephone interview on 01/26/26 at 2:18 P.M., the Director of Nurses (DON) said on 12/06/25 Nursing Supervisor #2 informed her that Resident #1's family was upset about his/her call light reset button being taped down. The DON said she called Nursing Supervisor #1 and asked him to do a call light audit on Resident #1's unit that day. The DON said she interviewed the Nurses and Certified Nurse Aides (CNAs) that worked on the unit on 12/06/25 and said that she and the Administrator watched the surveillance camera footage on the unit to see who entered and exited Resident #1's room. The DON said they could not determine how the tape got placed over Resident #1's call light reset button. The DON said it is her expectation that all staff notify maintenance if a resident's call light is not functioning properly. On 01/15/26, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction with an effective date of 12/10/25, which addressed the area(s) of concern as evidenced by:A. Resident #1 is no longer in the Facility.B. On 12/06/25, the Nursing Supervisor completed an audit on all residents' call lights on the unit that Resident #1 resided on.C. On 12/08/25, the Maintenance Director completed a full house audit on all residents' call lights, no issues were identified.D. On 12/08/25 through 12/15/25, The Maintenance Director and/or designee conducted daily call light monitoring audits on the unit Resident #1 had resided on.E. On 12/10/25, the Staff Development Coordinator provided education to all staff on call lights.F. The Maintenance Director and/or designee will conduct call light monitoring audits weekly for one month, and random audits will be on-going or until overall compliance is achieved. G. The results of the audits will be presented and reviewed at the monthly QAPI Committee meeting until compliance is achieved.H. The Director of Nursing and/or designee are responsible for overall compliance.