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	05/14/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, record review and interviews the facility failed to identify and assess the use of an abdominal binder (wide compression belt that encircles the abdomen and is secured into place) as a potential physical restraint (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) for one Resident (#8) of 26 sampled residents. Findings include:Review of the facility policy titled Use of Restraints, dated as revised 8/1/23, indicated but was not limited to:-Restraints shall only be used for the safety and well-being of the resident's and only after other alternatives have been tried unsuccessfully,-Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience,-When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need of restraints will be documented; and-Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions that may improve the symptoms. Resident #8 was admitted to the facility April 2026 with diagnoses which included dementia, and gastrostomy status (stomach feeding tube/G-tube, a medical device inserted directly through the abdomen into the stomach used to deliver food, liquids, and/or medications). Review of the Minimum Data Set (MDS) Assessment, dated 4/24/26, indicated he/she had a short- and long-term memory problem per staff interview. Further review of the MDS failed to indicate the use of physical restraints. Review of Resident #8's physician orders indicated but was not limited to:-Keep G-tube under abdominal binder every shift, dated 4/18/26 Review of Resident #8's care plans failed to indicate he/she had been care planned for the use of a physical restraint. Review of Resident #8's medical record failed to indicate he/she had been assessed for the use of a physical restraint. Review of Resident #8's April and May 2026 (4/18/26 through 5/13/26) Treatment Administration Record (TAR) indicated the abdominal binder was signed off every shift as ordered. Review of Resident #8's progress notes, on the following dates, indicated his/her abdominal binder was in place:-4/17/26-4/19/26, -4/20/26,-4/21/26,-5/4/26, and-5/13/26 On 5/14/26 at 9:52 A.M., the surveyor observed Resident #8 in bed wearing an abdominal binder. During an interview on 5/14/26 at 9:54 A.M., Certified Nursing Assistant (CNA) #1 said Resident #8 wore an abdominal binder to prevent him her/her from pulling his/her G-tube. CNA #1 said Resident #8 was unable to remove the abdominal binder on their own. During an interview on 5/14/26 at 9:59 A.M., Nurse #1 said Resident #8 wears an abdominal binder because he/she grabs at the G-tube and tries to remove it. Nurse #1 said Resident #8 could not undo the abdominal binder independently. During subsequent interview on 5/14/26 at 12:47 P.M., Nurse #1 said Resident #8 had not been able to physically remove his/her abdominal binder in the past since his/her admission to the facility. Nurse #1 said Resident #8 came from another facility with the abdominal binder. Nurse #1 said she did not know if the abdominal binder had been assessed as a restraint because he/she came to the facility with it in place. Nurse #1 said she was not aware of an assessment or care plan that speaks to the abdominal binder but nurses (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sign off on the TAR that it was in place every shift. During an interview on 5/14/26 at 12:53 P.M., Unit Manager #1 said Resident #8's abdominal binder was in place to prevent him/her from pulling out their G-tube. Unit Manager #1 said she had seen the Resident attempt to remove the binder as a behavior because it may have been uncomfortable and because it was preventing him/her from pulling out the G-tube. Unit Manager #1 said she did not think Resident #8 could remove the abdominal binder but he/she could try to adjust it because it was uncomfortable and worn at all times except for with care in order to protect the G-tube. Unit Manager #1 said Resident #8 was admitted to facility with the abdominal binder in place and the facility did not assess the binder as a restraint or as the least restrictive device. Unit Manager #1 reviewed the medical record and said there was no assessment or care plan to address the use of the abdominal binder. On 5/14/26 at 1:23 P.M., the surveyor observed Unit Manager #1 ask Resident #8 to release the abdominal binder. Resident #8 was unable to release or remove his/her abdominal binder upon request. During an interview on 5/14/26 at 1:30 P.M., the covering Director of Nurses (DON) said when a resident was unable to easily release an abdominal binder on command it becomes a restraint. The covering DON said Resident #8 should have been assessed and care planned for a restraint.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on document review and interview the facility failed to ensure medical records were complete and accurate, containing evidence of completed pharmacy recommendations for review by the Pharmacy consultant monthly to verify recommendation completion for one Resident (#1) out of a total sample of 26 residents. Findings include: Review of the facility policy titled: Medical records and chart handling, last updated 8/1/23, indicated but was not limited to the following: -All resident records shall be maintained in an organized, legible, accurate and timely manner Review of the facility policy titled: Medication therapy, last updated 8/1/23, indicated but was not limited to the following: -the consultant pharmacist will review each resident's medication regimen monthly -all decisions related to medications shall include appropriate elements of the care process, such as: regular pharmacist's review and physician review Review of the facility policy titled: Consultant pharmacist reports, Medication regimen review, dated: 1/2024, indicated but was not limited to the following: -the consultant pharmacist identifies irregularities through a variety of sources including the resident's clinical record, pharmacy records and other applicable documents. The facility shall make available to the pharmacist all appropriate records. Review of the Pharmacy service agreement, provided by the facility, dated 2/21/23 indicated but was not limited to the following: the facility shall: - provide the consultant pharmacist with access to the resident charts (and/or access to electronic medical record portal)-respond to issues reported by the consultant pharmacist through corrective actions that resolve such issues as warranted Resident #1 was admitted to the facility in December of 2023 and had the following diagnosis: Adjustment disorder with mixed anxiety and depressed mood, type 2 diabetes mellitus with polyneuropathy, and chronic kidney disease stage 4 (severe). Review of the current physician orders, on 5/14/26, indicated the Resident was on Amitriptyline HCl (antidepressant) 10 milligrams (MG) for anxiety at bedtime. Review of the monthly pharmacy reviews in the medical record, conducted by the pharmacy, indicated the following:8/27/25: MD Rec: risk versus (vs.) benefit of Amitriptyline9/23/25: MD Rec: risk vs. benefit of Amitriptyline10/22/25: MD Rec: risk vs. benefit of Amitriptyline11/17/25: MD Rec: risk vs. benefit of Amitriptyline12/15/25: MD Rec: risk vs. benefit of Amitriptyline1/16/26: MD Rec: risk vs. benefit of Amitriptyline2/19/26: MD Rec: risk vs. benefit of Amitriptyline3/18/26: MD Rec: risk vs. benefit of Amitriptyline4/20/26: MD Rec: risk vs. benefit of Amitriptyline Review of the Physician and Nurse Practitioner notes from August 2025 to April 2026 failed to indicate the physician documented the risks vs. benefits of the Amitriptyline use. Review of the electronic and paper portions of the medical record failed to indicate the recommendation left by the pharmacist was addressed by the physician During an interview on 5/14/26 at 1:12 A.M., Unit manager #3 said the pharmacist comes in and reviews the medical record and then sends the recommendations (recs) to the Director of Nurses (DON) and they are handed out to the units for completion. She said once she receives the recs she reviews them with the Physician or Nurse Practitioner (NP) and places them in their folder and then once they are signed and complete sends them back to the DON who keeps them in her office. She said the recs are not part of the medical record and are not available on the unit. She said she's surprised this rec is incomplete for so long since she addresses them so quickly, but she would have to go request the information from the DON to find out what the situation is. She reviewed the medical record for Resident #1 and said there was no information for this rec available in the record, she also checked the Physician folder and said no information was available there as well. On 5/14/26 at approximately 11:30 A.M., the covering DON provided the survey team with a signed MD rec from the pharmacy regarding the risk vs. benefit of Amitriptyline dated 10/7/25. During an interview on 5/14/26 at 11:44 A.M. the covering DON said the process for pharmacy recs is that they are emailed to the DON and then distributed to the unit managers for completion and then returned to the DON and filed, and in this case in the DON office. He said the recs are not part of the medical record and unavailable for the consultant pharmacist to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review each month. He said the Pharmacist not having access to the completed recs and them not being part of the medical record is clearly a process issue that needs correction. He said the expectation is the medical record should be complete and accurate and that is a necessity for the Pharmacy consultant to be able to complete their job correctly. During an interview on 5/14/26 at 12:19 P.M., the Lead pharmacy consultant said the facility's consultant completes the monthly medication regimen reviews onsite each month, so they have access to the full medical record. She said the consultants review all orders, progress notes, medication administration records, labs, psych, Physician & NP notes and previous pharmacy recs. She said while onsite the consultant sends the report to facility designated person. She said this Resident having the same MD recommendation for the risk vs. benefit of Amitriptyline from August 2025 to April 2026 would indicate either the recommendation had not been addressed or is not part of the medical record. She said the pharmacy contract indicated that the consultant must have access to the medical record to complete their responsibilities and that completed recommendations are supposed to be part of the medical record in the same way the pharmacy consultant documents directly into the medical record that they completed the review and have left recs or not. She said without accurate and complete medical records there is no guarantee the consultant pharmacist could identify issues or provide guidance in accordance with long term care and pharmacy professional guidelines. She said the expectation by the pharmacy is that the facility maintains complete and accurate medical records, including the completed and signed recommendations previously made so the consultants can complete reviews correctly each month. During an interview on 5/14/26 at 1:26 P.M., the medical records staff said part of her role is to ensure the medical records are complete and accurate. She said she files things left on the unit into the record and anything else she is asked to put in there and will check with different departments if they have any pieces of the medical record they need filed, such as rehab. She said she does not ask the DON if they have any pieces of the medical record that should be filed, because she figures there is no reason for the DON to maintain any part of a residents' medical record in their office since that would make the record incomplete. During an interview on 5/14/26 at 1:40 P.M., the Administrator said he was not fully aware that the completed pharmacy recs were not part of the medical record and being stored in the DON's office. He said every part of the medical record, including the completed recommendations, should be in the record and available for the Pharmacy consultants to review. He said his expectation is for the medical record to be complete and without those documents being available for review by the Pharmacy consultant it is not.