STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225268	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Newton	2101 Washington Street Newton, MA 02462

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on records reviewed, photographs reviewed, and interviews, for three of three sampled residents (Residents #1, #2, and #3), who were cognitively impaired and dependent on staff for care, the Facility failed to ensure they protected their rights to respect and dignity, when on 10/16/25 and 10/17/25, a staff member took pictures of them and sent them via text message to a non-staff person, without their knowledge or consent. Findings include: Review of the Facility's Policy titled, Videotaping, Photographing and Other Images of Resident, dated as revised February 2021, indicated that transmitting unauthorized images of any resident through email, internet, or social media is considered a violation of resident rights. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 12/20/25, indicated that someone from the Board of Registration of Nursing (BORN) called the Facility and notified them that they (BORN) opened a case against Nurse #1 after receiving an allegation that Nurse #1 took photographs of residents and sent them to a non-staff person via text message. The Report indicated that although Nurse #1 initially denied the allegation, after further conversations with BORN and Nurse #1, they (Facility) determined that Nurse #1 had taken pictures of Residents #1, #2, and #3 and texted them to a non-staff person. Review of the Facility's Internal Investigation, undated, indicated that Nurse #1 took pictures on 10/16/25 and 10/17/25 of Residents #1, #2, and #3 with her cell phone and sent them via text message to a non-staff person. The Investigation indicated that Nurse #1 initially denied taking photographs of the residents and sending them via text to a non-staff person, she (Nurse #1) then admitted she had, and agreed to delete the pictures from her cell phone. The Investigation indicated that upon review of the photographs, the Facility was able to determine that the photographs were of Residents #1, #2, and #3. Review of photographs from a cell phone text thread provided by BORN, indicated that Nurse #1 sent photographs of Residents #1, #2, and #3 to a non-staff person on 10/16/25 and 10/17/25. The Assistant Director of Nurses (ADON), who also saw the photographs, was able to confirm and identify the individuals for the surveyor, as being Resident #1, Resident #2, and Resident #3. The ADON described what was depicted in the photographs as the following:-Resident #1 standing in the hallway, fully clothed,-Resident #2 sitting on the floor in the hallway, wearing a johnny and brief, and -Resident #1 lying wearing a johnny and covered with bed linens. Resident #1 was admitted to the Facility in June 2025, diagnoses included dementia. Review of Resident #1's Minimum Data Set (MDS) Quarterly Assessment, dated 12/05/25 indicated that he/she had severe cognitive impairment and was dependent on staff to meet his/her care needs. Resident #2 was admitted to the Facility in June 2025, diagnoses included traumatic brain injury and vascular dementia. Review of Resident #2's Minimum Data Set (MDS) Quarterly Assessment, dated 12/05/25, indicated that he/she had moderate cognitive impairment and was dependent on staff to meet his/her care needs. Resident #3 was admitted to the Facility in June 2025, diagnoses included vascular dementia and failure to thrive. Review of Resident #3's Minimum Data Set (MDS) Quarterly Assessment, dated 10/31/25 indicated that he/she (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had severe cognitive impairment and was dependent on staff to meet his/her care needs. Residents #1, #2, and #3 were non-interviewable due to their cognitive impairment. The Surveyor was unable to interview Nurse #1, as she had retained legal counsel. During an interview on 02/10/26 at 11:26 A.M., the Assistant Director of Nurses (ADON) said that Nurse #1 allowed her to look through her (Nurse #1's) cell phone with her, and that she (ADON) was able to retrieve photographs of Residents #1, #2, and #3 from a text thread sent to a non-staff person. The ADON said she instructed Nurse #1 to immediately delete the photographs while in her presence and she (Nurse #1) did. During a telephone interview on 02/25/26 at 2:13 P.M., the Director of Nurses (DON) said that on 12/05/25, BORN notified the Facility that they had received an allegation involving Nurse #1. The DON said after several calls with BORN, it became evident that Nurse #1 took photographs of residents and sent them via text to a non-staff person The DON said that the ADON said she saw the photographs on Nurse #1's phone and instructed her (Nurse #1) to delete them immediately. The DON said that after Nurse #1 disclosed who she sent the photographs of Residents #1, #2, and #3 to, the Facility spoke with the recipient of the photographs and requested that the individual delete them and provide an email indicating that all resident photographs had been deleted from his phone, which he did. During a telephone interview on 02/10/26 at 2:35 P.M., the Administrator said she was not aware that Nurse #1 had taken photographs of residents and sent them via text, until BORN called and notified the Facility. The Administrator said they had several calls with BORN and received additional information about the allegation on 12/11/25. The Administrator said that the ADON said she saw the photographs on Nurse #1's cell phone and identified Residents 1, #2, and #3. The Administrator said Nurse #1 was suspended pending the investigation, was then re-educated and allowed to return to the Facility with the agreement that she must turn her cell phone into Administration prior to the start of her shift. The Administrator said that Nurse #1 had violated these residents' rights and had not followed Facility policy. On 02/10/26, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 12/23/25 which addressed the area(s) of concern as evidenced by:A. The Facility suspended Nurse #1 on 12/05/25, pending an investigation.B. The Facility provided support to Resident #1, #2 and #3, monitored them for changes in routine or changes in behavior patterns, and determined that they were not exhibiting any adverse effect associated with the deficient practice, due to their cognitive impairments.C. On 12/11/25, Residents on the unit where Nurse #1 worked and could have also been potentially affected by the deficient practice were interviewed, no concerns were reported.D. From 12/11/25 to 12/15/25, the ADON and/or designee conducted mandatory staff education on HIPAA, and the Facility's Resident Rights and Abuse Policies.E. The ADON and/or designee will conduct up to 10 random staff questionnaires weekly to ensure staff understands the education, to ensure compliance.F. On 12/11/25, an AD HOC Quality Assurance Performance Improvement (QAPI) meeting was conducted, and concern areas were discussed.G. On 12/19/25 the DON and/or designee initiated random audits/observations of staff phone usage on resident units, to continue for three weeks, and then monthly to monitor for compliance.H. On 12/23/25, Nurse #1 received additional training on Resident Rights, HIPAA, and Abuse before she was allowed to return to work, from the ADON and/or designee. Nurse #1 must also turn in her cell phone, to an administrative staff member, prior to the start of her shift and is not allowed to have it in her possession when on resident units.I. The results of the audits will be reviewed at the next monthly QAPI meeting.J. The Administrator and/or Designee are responsible for overall compliance