

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Care One at Essex Park		STREET ADDRESS, CITY, STATE, ZIP CODE 265 Essex Street Beverly, MA 01915	
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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews and interviews, the facility failed to ensure one Resident (#14) was free from unnecessary antipsychotic medications by ensuring the psychiatric Nurse Practitioner recommendations for a gradual dose reduction (GDR) were communicated to the Resident's physician, out of a total sample of 35 residents. Findings include: Resident #14 was readmitted to the facility in January 2026 with diagnoses that included Post Traumatic Stress Disorder, anxiety, major depressive disorder, and cognitive communication deficit. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/12/26, indicated he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. Review of Resident #14's psychiatric Nurse Partitioner (NP) progress note, dated 3/21/26, indicated GDR Rationale(s): Recommend GDR decrease the Aripiprazole (antipsychotic medication) to 2.5 mg (milligrams) every other day for 1 week, then D/C (discontinue). Continue to monitor mood & behavior. Further review of the psych NP note indicated: Review/Discussion: Discussed with nursing; Reviewed Chart; This includes time spent on work such as documentation, chart review, discussion with patient, and other members of the care team. Review of Resident #14's physician order, dated 1/21/26, indicated Abilify (Aripiprazole) give 2.5 mg by mouth in the morning for depressive behavior. Review of Resident #14's March and April 2026 Medication Administration Record (MAR), indicated he/she received the Aripiprazole 2.5 mg daily as ordered. Review of Resident #14's behavior care plan, dated 3/31/25, indicated the following:-Attempt psychotropic drug reduction per physician orders.-Psych referral and treat as needed. Review of Resident #14's medical record failed to indicate that nursing updated the provider for the psych NP recommendations. During an interview and medical record review with the surveyor on 4/2/26 at 9:09 A.M. Unit Manager #1 said she gets the printed psych NP note and as soon as possible she would call the Resident's physician to get the recommendations approved to then put the new orders in. Unit Manager #1 said she has never had a physician decline a GDR. The Unit Manager said she does not remember these new recommendations from 3/21/26 and it was missed. During an interview on 4/2/26 at 9:11 A.M., Nurse #1 said Resident #14 has been receiving the Aripiprazole 2.5 mg every day and as far as she knows the order has no stop date. On 4/2/26 at 9:15 A.M., the Assistant Director of Nurses reviewed Resident #14's psych NP note from 3/21/26 with the surveyor and reviewed his/her physician orders and said the Resident is still on the Aripiprazole daily. During an interview on 4/2/26 at 9:18 A.M., Physician #1 said he was Resident #14's physician and nursing staff normally call him with new psych recommendations. The Physician said he was unaware of the new GDR recommendations made on 3/21/26 and does approve of the GDR of the Aripiprazole. During an interview on 4/2/26 at 9:33 A.M., Resident #14 said he/she had psych services, and the NP goes over the plan with him/her during their talks. During an interview on 4/2/26 at 9:44 A.M., the Director of Nurses said Resident #14's psych recommendations on 3/21/26 were missed by nursing staff.		

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, interviews and record review, the facility failed to implement a plan of care for one Resident (#143) out of a sample of 35 residents. Specifically, the facility failed to implement a sensory diet plan of care (a personalized, occupational therapist-designed activity plan providing specific sensory input (visual, auditory, olfactory, tactile, proprioceptive and gustatory). It helps regulate the nervous system, improving focus, behavior, and emotional control). Findings include: Review of the facility policy titled 'Care Plans, Comprehensive Person-Centered' revised in March 2022 indicated the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Review of the facility policy titled 'Dementia Care Unit Activities Program' with a revision date of 7/3/2018 indicated the following: The Activities program on the Dementia Care Unit is designed to meet the current and changing needs of individuals with Dementia. The Activities program is designed to maintain each resident's dignity and personal identity, enhance socialization and success and to accommodate the various cognitive and functional abilities of each resident either individually or in group settings. Review of the facility policy titled 'Behavioral Assessment, Intervention, and Monitoring' with a revision date of February 2025 indicated the following: Behavior is the response of an individual to a wide variety of factors. The factors may include medical, physical, functional, psychosocial, emotional, psychiatric, or environment causes. Behavioral interventions refer to individualized, nonpharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities as well as maintaining or improving a resident's mental, physical, or psychosocial well-being. Resident #143 was admitted to the facility in November 2022 with diagnoses including Dementia and anxiety disorder. Review of the most recent MDS (Minimum Data Set) assessment, dated 2/18/26, indicated a Brief Interview for Mental Status (BIMS) score of 00 out of 15 indicating severe cognitive impairment. Review of Resident #143's Occupational Therapy (OT) treatment encounter progress note, dated 1/23/26, indicated the following: Date of service: 1/23/26. Staff education provided on Resident's individualized sensory diet handout which details tactile, proprioceptive, gustatory, olfactory, visual and auditory sensations which have been beneficial for reducing Resident's anxiety/agitation. Copy provided for Resident's care plan; copy placed in room and a third copy provided to Activities staff on unit for continued carry over. Review of Resident #143's eye care progress note, dated 11/26/25, indicated the following: Glaucoma suspect, open angle with borderline findings, low risk; Both eyes; borderline IOP (Intraocular Pressure) OU (Oculus Uterque, meaning both eyes) on tensing. Glasses Required? No. Eyelid Care Required? No. New Orders? No. On 3/31/26 at 8:18 A.M., the surveyor observed Resident #143's sensory diet pinned on the bulletin board next to his/her bed. The sensory diet indicated the following: Visual- Avoid mirrors which can be distressing or confusing. The surveyor observed a vanity mirror above the dresser in Resident #143's room. The vanity mirror was permanently attached to the wall and the Resident had visual access to it. On 4/1/26 at 8:52 A.M., the surveyor observed the sensory diet pinned to the Resident's bulletin board. The vanity mirror above the dresser was permanently attached to the wall in the Resident's room. During an interview and observation on 4/1/26 at 11:19 A.M., the Activities Director said she worked in collaboration with Occupational Therapist (OT). The Activities Director said OT put up the sensory diet in the Resident's room. The Activities Director reviewed the visual sensory diet and said the vanity mirror above the dresser should not be in the Resident's room. During an interview and record review on 4/1/26 at 11:29 A.M., the Director of Rehabilitation/OT reviewed a copy of the sensory diet and said the visual sensory diet should be followed by staff providing care. The DOR said the sensory diet was placed in the Resident's room on 1/23/26 after the Resident was discharged from OT. During (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview and record review on 4/1/26 at 11:45 A.M., the Unit Manager #2 reviewed the sensory diet and said she was not aware the sensory diet was in the Resident's room. The Unit Manager said if OT put up the sensory diet in the Resident's room, she expects staff to implement it at all times. The Unit Manager said she was not made aware of the visual sensory diet in the Resident's room. The Unit Manager said based on the visual sensory diet, the Resident's room should be free of mirrors. During an interview and observation on 4/1/26 at 11:49 A.M., Certified Nurse's Assistant (CNA) #1 and the Surveyor went into the Resident's room. The sensory diet was on the Resident's bedside dresser. The CNA reviewed the visual sensory diet and said she was never made aware of the sensory diet in the Resident's room. The CNA said based on where the vanity mirror was placed, the Resident could see it at all times while in the room, while sitting up in bed and while leaving the room. During an interview on 4/1/26 at 11:57 A.M., the Director of Nurses (DON) said Resident #143's sensory diet should be implemented. The DON said the vanity mirror above the dresser should not be in the Resident's room.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review, the facility failed to reassess and revise a plan of care for one Resident (#143) out of a sample of 35 Residents. Specifically, the facility failed to revise a sensory diet plan of care (a personalized, occupational therapist-designed activity plan providing specific sensory input (visual, auditory, olfactory, tactile, proprioceptive and gustatory). It helps regulate the nervous system, improving focus, behavior, and emotional control). Findings include: Review of the facility policy titled 'Care Plans, Comprehensive Person-Centered' revised in March 2022 indicated the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition changes. Review of the facility policy titled 'Dementia Care Unit Activities Program' with a revision date of 7/3/2018 indicated the following: The Activities program on the Dementia Care Unit is designed to meet the current and changing needs of individuals with Dementia. The Activities program is designed to maintain each resident's dignity and personal identity, enhance socialization and success and to accommodate the various cognitive and functional abilities of each resident either individually or in group settings. On admission, with a change in status and annually, residents will have an activities assessment. Information gathered will be used to develop the activities component of the resident's comprehensive care plan. A review of the facility policy titled 'Behavioral Assessment, Intervention, and Monitoring' with a revision date of February 2025 indicated the following: Behavior is the response of an individual to a wide variety of factors. The factors may include medical, physical, functional, psychosocial, emotional, psychiatric, or environment causes. Behavioral interventions refer to individualized, nonpharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities as well as maintaining or improving a resident's mental, physical, or psychosocial well-being. Resident #143 was admitted to the facility in November 2022 with diagnoses including Dementia and anxiety disorder. Review of the most recent MDS (Minimum Data Set) assessment, dated 2/18/26, indicated a Brief Interview for Mental Status (BIMS) score of 00 out of 15 indicating severe cognitive impairment. Review of Resident #143's Occupational Therapy (OT) treatment encounter progress note dated 1/23/26 indicated the following: Date of service: 1/23/26. Staff education provided on Resident's individualized sensory diet handout which details tactile, proprioceptive, gustatory, olfactory, visual and auditory sensations which have been beneficial for reducing Resident's anxiety/agitation. Copy provided for Resident's care plan; copy placed in room and a third copy provided to Activities staff on unit for continued carry over. On 3/31/26 at 8:18 A.M., the surveyor observed Resident #143's sensory diet pinned on the bulletin board next to his/her bed. The sensory diet indicated the following: Visual- Avoid mirrors which can be distressing or confusing. The surveyor observed a vanity mirror above the dresser in Resident #143's room. The vanity mirror was permanently attached to the wall where the Resident had visual access to. On 4/1/26 at 8:52 A.M., the surveyor observed the sensory diet pinned to the Resident's bulletin board. The vanity mirror above the dresser was permanently attached to the wall in the Resident's room. During an interview and observation on 4/1/26 at 11:19 A.M., the Activities Director said she works in collaboration with OT. The Activities Director said OT put up the sensory diet in the Resident's room. The Activity's Director said the Resident's Dementia has worsened, therefore having a mirror in his/her room is not a concern. The Activities Director said the sensory diet in his/her room should be revised to reflect that change. During an interview and record review on 4/1/26 at 11:29 A.M., the Director of Rehabilitation/OT reviewed a copy of the sensory diet and said the sensory diet should be followed (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by staff providing care. The DOR said the visual sensory diet needs to be reassessed, revised and personalized with new information. During an interview and record review on 4/1/26 at 11:45 A.M., the Unit Manager #2 reviewed the sensory diet and said she was not aware the sensory diet was in the Resident's room. Unit Manager #2 said she expects OT to reassess and revise the sensory diet if the Resident has gone through a change in condition. Unit Manager #2 said OT should provide education to staff on the unit after the revisions are made to the visual sensory diet. During an interview on 4/1/26 at 11:57 A.M., the Director of Nurses said Resident #143's visual sensory diet should be reassessed and revised as needed. During an interview and record review on 4/2/26 at 8:45 A.M., Social Worker #1 said care plan meetings are held quarterly and change in condition conferences are held as needed. The Social Worker said family and responsible parties are invited. The Social Worker said the interdisciplinary team is invited as well. The Social worker said the Activities Director attends all quarterly care plan meetings and change in condition meetings. The Social Worker said the plan of care is discussed and if any revisions are required, they are made during the meeting. The Social Worker reviewed the medical record and said the last change in condition meeting held for Resident #143 was on 2/24/26. The meeting was held to address the Resident's change in condition; cognition was one of the topics discussed. The Social Worker said according to the meeting sign up list; the Activities Director attended the meeting. Further review of the 2/24/26 change in condition meeting conference failed to indicate that that the Resident's visual sensory diet was discussed and revised.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review and interview the facility failed to provide care and services consistent with professional standards of practice for one Resident (#11) with a pressure ulcer, out of a total sample of 35 Residents. Specifically, for Resident #11 the facility failed to implement wound treatment recommendations from the consulting wound physician. Findings include: Resident #11 was admitted to the facility in June 2025 with diagnoses that included muscle weakness, type 2 diabetes and dementia. Review of the Minimum Data Set (MDS) assessment, dated 1/1/26, indicated a Brief Interview for Mental Status (BIMS) score of 4 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident had one or more unhealed pressure ulcers, including one stage 4 pressure ulcer that was present on admission to the facility. Review of the most recent Norton Assessment (an assessment to assess a resident's risk for skin breakdown and the development of pressure ulcers), completed 7/23/25, indicated a risk score of 8 indicating high risk for pressure ulcer development. Review of the active skin care plan, dated 3/4/26, that indicated the following:-Actual skin breakdown related to pressure ulcer- Left Ankle.-Interventions included: wound consult as needed and follow-up care with physician as ordered. Review of the Wound Consultant Notes, dated 3/17/26, 3/24/26 and 3/31/26 indicted the following recommendation for the treatment of a stage 4 pressure wound to the left, lateral ankle full thickness wound:-Dressing treatment plan: Primary Dressing(s) Collagen sheet w/silver apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days: Apply on wound base; Alginate calcium, apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days Secondary Dressing(s) Tubi-grip apply once daily and as needed: if saturated, soiled, or dislodged. For 23 days; Foam, apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days Review of active physician's orders, dated 2/10/26, indicated the following:-Left lateral ankle pressure injury POA (present on arrival): cleanse w/ NS (normal saline), pat dry, apply skin-prep to intact peri-wound skin, apply Anasept soaked gauze, boarder foam, wrap with ACE bandage daily and as needed. May use silver hydrogel if waiting for Anasept to be delivered. Review of the March 2026 Treatment Administration Record (TAR) indicated that the active order, dated 2/10/26, as listed above was implemented every day in March. Review of the medical record failed to indicate that when the treatment recommendation was changed on 3/17/26, it was implemented into the Resident's plan of care. During an interview on 4/1/26 at 12:44 P.M., Nurse #1 said that when a consulting provider sees residents on the unit, they will report off to the nurses or unit manager at the end of rounding. She said that if they were making any changes, they will let the staff know, but they also upload their consult note into the electronic medical record (EMR) for review. She said that they would call the primary providers to confirm orders and implement them. During an interview on 4/1/26 at 1:10 P.M., Unit Manager #1 said that a nurse rounded with the consulting wound physician and provided any newly recommended treatments to the Unit Managers. She said the Unit Managers consulted with the facility providers and implemented the recommendations. She said that the facility providers generally did not go against the wound physician's recommendation and implement any changes that were recommended. The Unit Manger and the surveyor reviewed the recommendations and the medical record, and she said that Resident #11's recommendations should have been implemented immediately following the change in treatment plan on 3/17/26 but they were not. During an interview on 4/1/26 at 2:23 P.M., the Director of Nurses said that the Assistant Director of Nurses rounded with the consulting wound physician generally. She said the wound physician lets her know any changes that will be recommended to the plan of care. She said the wound consultant's note is uploaded into the EMR where it is reviewed by facility staff, and changes should be implemented as indicated.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and interviews, the facility failed to ensure that medications were accurately implemented by nursing for one Resident (#11), out of a total sample of 35 residents, to ensure he/she was free from a significant medication error. Specifically, the facility failed to accurately implement a medication recommendation from Behavioral Health Services. Findings include: Resident #11 was admitted to the facility in June 2025 with diagnoses that included anxiety, insomnia and dementia. Review of the Minimum Data Set (MDS) assessment, dated 1/1/26, indicated a Brief Interview for Mental Status (BIMS) score of 4 out of 15 indicating severe cognitive impairment. The MDS failed to indicate any behaviors were present during the look back period. The MDS further indicated that the Resident received antidepressant medications. Review of the Behavioral Health Note, dated 2/20/26, indicated the following: -Plan/ Recommendations: -Increase the Trazodone (antidepressant medication) to 50 mg HS (milligrams at bedtime) for insomnia. -Continue to monitor his/her mood & behavior. -Provide structured daily routine & maintain sleep routine. Review of active physician's orders, as of 4/1/26, indicated the following: -Trazodone tablet, give 25 mg by mouth in the morning for anxiety AND Give 25 mg by mouth at bedtime for insomnia give with 50mg = 75mg AND Give 50 mg by mouth at bedtime for insomnia give with 25mg = 75mg AND Give 25 mg by mouth every 12 hours as needed for agitation for 14 Days, dated 3/4/26. Review of discontinued physician orders indicate the following: -Trazodone 50 mg at bedtime (8:00 P.M.), active from 2/20/26 to 3/3/26. -Trazodone 25 mg by mouth one time a day (at 8:00 P.M.) for insomnia, active from 6/7/25 to 3/3/26. -Trazodone 25 mg one time a day (at 9:00 A.M.) for anxiety disorder, active from 9/2/25 to 3/3/26. Review of the February and March 2026 Medication Administration Record (MAR) indicated that the Resident received Trazodone 75 mg at bedtime from 2/2/26 through 3/31/26. During an interview on 4/1/26 at 12:44 P.M., Nurse #1 said that when a consulting provider sees residents on the unit, they will report off to the nurses or unit manager at the end of rounding. She said that if they are making any changes, they will let the staff know, but they also upload their consult note into the electronic medical record (EMR) for review. She said that they will call the primary providers to confirm orders and implement them. During an interview on 4/1/26 at 12:57 P.M., Unit Manager #1 reviewed the medical record and the behavioral health recommendation with the surveyor. She said that a transcription error had occurred resulting in a medication error because the Resident had been receiving 75 mg of trazodone at bedtime instead of the recommended 50 mg. She said that the facility does not currently have a process for anyone to double check and ensure that orders have been entered or transcribed correctly. During an interview on 4/1/26 at 2:19 P.M., the Director of Nurses said the recommendation was not implemented correctly resulting in a medication error.		