STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225275	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Rehab & Skilled Nursing Ctr - Westboro	3 Lyman Street Westborough, MA 01581

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure that two Residents (#11 and #6), out of a total sample of 30 residents, were free from significant medication errors. Specifically, the staff failed to: 1. For Resident #11, ensure that Seroquel (a medication used to help regulate mood, behaviors and thoughts) was accurately transcribed onto the Medication Administration Record (MAR), resulting in the Resident missing 19 doses of the prescribed medication, and increasing the risk for worsening mood and behavior patterns. 2. For Resident #6, ensure Metoprolol Tartrate (medication used to treat high blood pressure) and Midodrine (medication used to treat low blood pressure) were administered to the Resident in accordance with physician ordered parameters, increasing the Resident's risk for adverse medication reactions. Findings include: 1. Resident #11 was admitted to the facility in November 2023 with diagnoses including Dementia, Parkinson's Disease, and Adjustment disorder with depressed mood. Review of the Resident's written Physician's Order, dated 2/24/26, indicated: -Start Seroquel 12.5 milligrams (mg) by mouth daily at 2:00 P.M. Review of the Resident's February 2026 MAR failed to indicate the physician's order had been transcribed for Seroquel 12.5mg by mouth daily at 2:00 P.M. Review of the Resident's March 2026 MAR indicated that an order for Seroquel 12.5mg by mouth daily had been posted on 3/16/26 (19 days after the Physician order had been written). During an interview on 3/18/26 at 8:04 A.M., Nurse #2 said Resident #11 had a history of behaviors, anxiety, and restlessness. Nurse #2 said that on 3/16/26, Resident #11 had worsening behaviors, and the nursing staff contacted the Nurse Practitioner (NP) who evaluated Resident #11's medications and discovered that the written order from 2/24/26 for Seroquel 12.5mg po at 2:00 P.M., had never been transcribed. Nurse #2 said that the NP instructed the staff to implement the order for Seroquel 12.5mg at 2:00pm. Nurse #2 said it was important for Resident #11 to have received the correct dose of Seroquel to help reduce the Resident's behaviors and increase his/her comfort. During an interview on 3/18/26 at 8:27 A.M., Unit Manager (UM) #2 said the Seroquel medication transcription error was discovered on 3/16/26, when the nursing staff had contacted the NP for Resident #11's worsening behaviors. UM #2 said the NP identified there was an order for Seroquel 12.5mg at 2:00 P.M., that had been written on 2/24/26 but never transcribed onto the Resident's MAR. UM #2 said that the NP had written the order on 2/24/26 due to a pattern of behaviors that Resident #11 had been exhibiting, including agitation and restlessness. UM #2 said that written physician's order should have been transcribed on 2/24/26 but was not transcribed until 3/16/26. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/18/26 at 9:45 A.M., the Director of Nurses (DON) said that when the NP wrote the order for Seroquel 12.5mg to be administered at 2:00 P.M., the order should have been transcribed onto the Resident's MAR on 2/24/26 but was not and resulted in several days of missed doses for the Resident. The DON also said that the 11:00 P.M.-7:00 A.M. nurses were responsible for completing 24-hour chart checks to decrease the likelihood of transcription errors occurring and did not know why this error had not been identified. During an interview on 3/18/26 at 10:27 A.M., Physician #1 said that when the NP prescribed the 2:00 P.M. dose of Seroquel 12.5mg, the order should have been noted and posted onto the MAR the same day but was not. Physician #1 said that Resident #11 would have benefited from receiving the Seroquel as ordered at 2:00 P.M., to treat his/her worsening behaviors. 2. Resident #6 was admitted to the facility in July 2024 with diagnoses including End Stage Renal Disease (ESRD) and Hypertension. Review of Resident #6's Physician Order for Metoprolol Tartrate, dated 8/6/24, indicated the following: -Metoprolol Tartrate tablet; 50 mg oral twice a day. -Special instructions: Hold for systolic blood pressure (SBP: upper number of the blood pressure which shows the highest pressure reached in the arteries) lower than 110 . Review of Resident #6's Physician's Order for Midodrine, dated 12/15/25, indicated the following: -10 mg tablet oral. -Special instructions: . hold medication if SBP greater than 120. Review of Resident #6's MARs for January 2026 through February 2026 indicated the following relative to Metoprolol Tartrate administration: -1/7/26 SBP was 107. Metoprolol Tartrate was administered. -1/9/26 SBP was 101. Metoprolol Tartrate was administered. -1/17/26 SBP was 108. Metoprolol Tartrate was administered. -1/21/26 SBP was 109. Metoprolol Tartrate was administered. -2/22/26 SBP was 110. Metoprolol Tartrate was held. -2/25/26 SBP was 107. Metoprolol Tartrate was administered. Review of Resident #6's March 2026 MAR indicated the following relative to Midodrine administration: -3/2/26 SBP was 123. Midodrine was administered. -3/4/26 SBP was 124. Midodrine was administered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/26 at 11:20 A.M., Nurse #3 said Metoprolol Tartrate was ordered to be held when Resident #6's SBP was lower than 110 and that Midodrine was ordered to be held when Resident #6's SBP was greater than 120. During an interview on 3/13/26 at 11:26 A.M., Unit Manager (UM) #2 said Metoprolol Tartrate and Midodrine were ordered for Resident #6 to treat blood pressure. UM #2 said, for Resident #6, Nurses were required to hold administration of Metoprolol Tartrate when the Resident's SBP was lower than 110 and hold Midodrine when the Resident's SBP was greater than 120. At this time, UM #2 reviewed Resident #6's January 2026 through March 2026 MARs and said Metoprolol Tartrate should have been held, not administered, on 1/7/26, 1/9/26, 1/17/26, 1/21/26, and 2/25/26, and that Metoprolol Tartrate should have been administered, not held on 2/22/26. UM #2 said Midodrine should have been held, not administered to Resident #6 on 3/2/26 and 3/4/26. During an interview on 3/13/26 at 2:26 P.M., the Director of Nursing (DON) said she reviewed Resident #6's Midodrine and Metoprolol Tartrate administration records for January 2026 through March 2026 and that the Midodrine and Metoprolol Tartrate had been administered to the Resident outside of the ordered parameters. The DON said Nurses were required to adhere to the ordered medication parameters set by the physician and that administering Midodrine and Metoprolol Tartrate to Resident #6 outside of the ordered parameters increased risks for adverse medication reactions.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records reviewed, the facility failed to provide food at safe and appetizing temperatures to residents from two out of three lunch meal carts on two Units ([NAME] Unit and [NAME] Unit) out of three total resident units.Specifically, the facility failed to provide food at safe and appetizing temperatures for the lunch meal for Residents eating lunch on the [NAME] Unit and [NAME] Unit, increasing residents' risks for reduced food/fluid intake. Findings include:Review of the facility's policy titled Food: Quality and Palatability, revised February 2023, included but was not limited to: -Food will be prepared by methods that conserve nutritive value, flavor and appearance. -Food will be palatable, attractive and served at a safe and appetizing temperature.-Food and liquids are prepared and served in a manner, form and texture to meet resident's needs.-Food should be at the appropriate temperature as determined by the type of food to ensure residents' satisfaction. Review of the facility's Resident Council Meeting Minutes for 2025-2026, indicated:-May 28, 2025: Cold vegetables; vegetables are crunchy and not cooked well. Ice cream was served melted on Mother's Day, cream of tomato soup and other soups are served cold, French fries are served cold, toast is cold.-June 25, 2025: Cold food discussed, no resolution documented from previous month.-November 24, 2025: Eggs are cold.-December 10, 2025: Old business reviewed, no resolution documented from previous month.-February 11, 2026: Breakfast can be cold at times. On 3/12/26 between 9:26 A.M. through 11:55 A.M., during the initial observations on the [NAME] Unit, multiple residents reported the following concerns to the survey team:-The food arrives cold and sometimes it takes the staff a long time to pass the food trays out.-The food is awful and they will not eat it.-Eggs are usually cold and they do not like the food.-The food does not taste good.-The food for breakfast, lunch and dinner is always cold.-The food is cold and staff offered to heat the food up for them in the microwave. On 3/17/26 at 12:33 P.M., once all resident meals trays were passed, Surveyor #1 completed a lunch meal test tray on the [NAME] Unit which indicated:-corned beef and gravy 105 degrees Fahrenheit (F), not hot.-minced carrots 108 degrees F, not hot.-butterscotch pudding 70 degrees F, not cold. On 3/17/26 at 12:50 P.M., once all resident meal trays were passed, Surveyor #5 completed a lunch meal test tray on the [NAME] Unit which indicated: -corned beef 100 degrees F, not hot.-boiled carrots, 87 degrees F, not hot.-boiled potatoes 90 degrees F, not hot. The two test trays validated the residents' concerns of cold food.During an interview on 3/17/26 at 1:57 P.M., the Food Service Director (FSD) and Surveyor #5 discussed the results of the two lunch meal trays conducted by Surveyor #1 and Surveyor #5. The FSD said that the hot items should have been served at least 120 degrees F and the cold items should have been served below 50 degrees F and they were not.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to make prompt efforts to adequately resolve grievances for two Residents (#82 and #7) out of a total sample of 30 residents.Specifically, the facility failed to:1. For Resident #82, -identify steps taken to investigate the Resident's grievance with respect to care not being provided.-summarize pertinent findings or conclusions regarding the Resident's concern with respect to care not being provided.-state whether the Resident's grievance with respect to care not being provided was confirmed or not confirmed.2. For Resident #7, the facility failed to adequately resolve the Resident's grievance for missing dentures in a timely manner when the Resident's lower dentures were missing. Findings include: Review of the facility's Grievance and Complaint Policy, dated October 1998 and revised 7/31/12, indicated the facility has a process that provides residents and families with a means to assure complaints or grievances regarding care or lack of care, lost possessions, . will be heard, investigated promptly, and resolved whenever possible. 1.Resident #82 was admitted to the facility in August 2014 with diagnoses including Multiple Sclerosis (MS), paraplegia, chronic pain, and anxiety disorder. Review of Resident #82's active Care Plan, last reviewed and revised 1/2/26, indicated: -has complaint forms at his/her bedside and has been encouraged to fill them out for care complaints (8/27/15). -Resident is bedbound and uses a trapeze (medical overhead bar designed to help individuals with limited mobility shift positions in bed [1/30/24]). -uses a bed pan and is able to position him/herself on the bed pan (1/30/24). -requires assist with toilet hygiene; dependent at times (1/30/24). -Resident will call for assist with the bed pan (7/5/24). Review of the Minimum Data Set (MDS) Assessment, dated 12/19/25, indicated Resident #82: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) Assessment of 15 out of 15 total possible points. -bilateral lower extremity range of motion (ROM) was impaired. -was dependent for toilet hygiene. -required partial/moderate assistance to roll in bed. During an interview on 3/13/26 at 12:00 P.M., Resident #82 said he/she had experienced a problem (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtaining assistance from the staff on the overnight (11:00 P.M. through 7:00 A.M.) shift, during the early morning hours of 3/10/26, to place and remove the bed pan. Resident #82 said he/she can place the bed pan under him/herself but that the contents of the bed pan would sometimes spill when he/she did not place it correctly. Resident #82 said the bed pan is positioned better when staff position it for him/her. Resident #82 said he/she called for assistance (on 3/10/26) and waited 30 minutes before positioning the bed pan under his/her body him/herself. The Resident said when he/she was done using the bed pan, he/she waited greater than 30 minutes for staff to respond to his/her request to have the bed pan removed and when staff did not respond, he/she called 911. Resident #82 said he/she felt marginalized. Resident #82 said he/she is familiar with the grievance process at the facility and knows how to file a grievance, and that he/she did not fill out a grievance form for this incident because staff at the facility are never able to substantiate his/her concerns. Review of a Grievance Form, dated 3/13/26, that was filled out and completed by the Administrator, indicated: -Resident #82 stated he/she was on the bed pan for an extended period of time leading him/her to call 911. -The department or person involved was Nrsg [nursing]. -Time of day and location (if applicable) was not filled in [blank]. -The Resident wanted an apology to resolve the problem. -The response of the Social Worker/Administrator/Department head portion of the form was not filled in. -Nsg apologized and the problem was resolved. During an interview on 3/17/26 at 8:54 A.M., the Administrator said she completed a grievance form for Resident #82 on 3/13/26 because Unit Manager (UM) #2 told her that the Resident told the surveyor he/she had been left on the bed pan for an extended period of time. The Administrator said UM #2 told her the Resident wanted an apology and that she (the Administrator) thought UM #2 apologized to the Resident. The Administrator said she did not speak with Resident #82 relative to the Resident's concern and that she did not conduct an investigation regarding the Resident's concern for being left on the bed pan for an extended period of time. During an interview on 3/18/26 at 7:09 A.M., UM #2 said she was aware Resident #82 called 911 during the early morning hours on 3/10/26 relative to personal care concerns and that she discussed this with the Administrator. UM #2 said she was not aware of the Resident wanting an apology to resolve his/her concern and that UM #2 did not provide an apology to the Resident. 2. Resident #7 was admitted to the facility in November 2024 with diagnoses including other sequalae of cerebral infarction, Type Two Diabetes, hemiplegia and hemiparesis. Review of Resident #7's facility clothing list dated 11/16/24 and updated on 11/21/24 indicated that (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Resident had both upper and lower dentures. Review of Resident #7's current Physician's orders indicated: -an order for upper and lower dentures, please place on every morning and off at hour of sleep, 8 A.M. and 8 P.M., start date 11/22/24. Review of Resident #7's Minimum Data Set (MDS) assessment dated [DATE], indicated: -the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of a possible score of 15. -has unclear speech and was rarely/never understood. -has experienced weight loss and was not on a physician weight loss regimen. -was dependent on staff for eating and all other activities of daily living (ADLs). -was receiving a therapeutic and mechanically altered diet. Review of Resident #7's clinical record indicated a Nursing Progress Note dated 11/26/25, which indicated that the Resident's bottom dentures were missing and that the Nursing Supervisor and Resident Representative had been notified. Review of the facility's 2025 Grievance Log indicated that a grievance form was completed on behalf Resident #7 for his/her missing dentures on 11/27/25, and the grievance was resolved by the Administrator on 12/2/25. Review of Resident #7's Treatment Administration Record (TAR) from11/28/25 through March 2026 indicated that the Resident had only their upper denture placed in their mouth by staff daily in the mornings and upper denture removed in the evenings. Further review of Resident #7's clinical record did not indicate that a grievance had been re-filed or that any follow-up had occurred for the Resident's missing lower dentures until it was brought to the facility's attention by the surveyor on 3/16/26. During an interview on 3/17/26 at 10:14 A.M., Unit Manager (UM) #1 said that she did not realize that Resident #7's lower dentures were still missing and that she assumed when her staff informed her that the dentures had been returned, that they were both the upper and lower dentures. UM #1 said she did not inspect the dentures herself and that the documentation had been inaccurate relative to the resolution of the grievance. During an interview on 3/17/26 at 10:53 A.M., the Administrator said that she had resolved Resident #7's grievance and did not specifically ask about the upper and lower dentures. The Administrator also said that she was unaware that the lower dentures remained missing and that another grievance should have been filed once the facility had identified that the lower denture remained missing and had not been.

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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 interviews, and record review, the facility failed to implement the person-centered care plan relative to transfers for one Resident (#70) out of a total sample of 30 residents. Specifically, for Resident #70, the facility failed to ensure that two staff assists were utilized per his/her plan of care when transferring the Resident with the use of a mechanical lift, putting the Resident at risk for injury or falls. Findings include: Review of the facility policy titled, Care Planning, undated with revision date 11/28/18, indicated the following: -Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. -The care plan is based on the resident's comprehensive assessment and developed by a Care Planning/Interdisciplinary team . Review of the facility policy titled Safe Lifting and Movement, dated 3/30/11 with revision date 8/1/18, indicated the following: -This policy describes ways to ensure that employees use safe methods for lifting and moving elders in the nursing facility in order to prevent injury to both employees and elders. -All elders/residents who have any degree of dependency for transfers or movement will be assessed to determine the extent of assistance required and the safest method of assistance including the type of mechanical lifting device that should be used. The recommendation for transfers will be based on the safest technique or device for both caregiver and the elder. >new information and changes will be documented on the elder's/resident's individualized plan of care. >All transfers with lifts should be based on the care plan including level of assistance and number of staff. >Use mechanical lifting devices and other approved lifting or moving aids in accordance with instructions and training. Resident #70 was admitted to the facility in August 2020 with diagnoses including other specified disorders of bone density and structure, osteopenia spine/right upper extremity, dementia, and osteoarthritis. Review of the Minimum Data Set (MDS) Assessment, dated 1/23/26, indicated Resident #70: -rarely/never understood and the Resident was rarely/never understood by others. -should not have a Brief Interview for Mental Status (BIMS) conducted because the Resident was rarely/never understood. -A staff assessment for mental status was conducted which indicated long-term and short-term memory problems as well as severely impaired decision-making regarding tasks of daily life. -was dependent on others for personal hygiene. -was non-ambulatory. -was dependent on others to transfer to and from a chair/bed to chair. Review of Resident #70's person-centered Activities of Daily Living (ADL) Care Plan, dated 2/22/26 included but was not limited to: >Chair to bed to chair transfer - uses Hoyer (specific type on mechanical lift), two (2) assists. Dependent. Review of Resident #70's Profile Care Plan Approaches (Care Kardex) included the following: -Chair to bed to chair transfer; uses Hoyer two (2) assists, Dependent, effective 2/22/26. Review of the medical record indicated that Resident #70 had been transferred to the hospital on 3/6/26 for findings consistent with a fracture of his/her right femur. During an interview on 3/16/26 at 1:11 P.M., the Director of Nursing (DON) said an internal investigation was started immediately relative to the Resident's fractured right femur on 3/6/26. The surveyor and the DON reviewed the investigation records, and it was identified that two Certified Nurse Aides (CNA) #6 and #7 had not transferred Resident #70 in accordance with the Resident's plan of care prior to the injury being identified. The DON said that both CNA #6 and CNA #7 were placed on leave during the investigation then allowed to return to work after education and return demonstration competency. The DON said that CNA #6 and CNA #7 did not follow the Resident's care plan relative to transfers. During an interview 3/17/26 at 1:47 P.M., CNA #6 said he assisted Resident #70 back to bed on 3/3/26 at approximately 7:00 P.M. without using a mechanical lift or another staff member to assist with the transfer. CNA #6 said he knew he should have used the mechanical lift because he had taken care of Resident #70 many times and knows he should follow the Resident's Profile Care Plan. CNA #6 said the Resident was seated in a recliner chair and he reached to hold the back of the Resident's pants, lifted and turned the Resident to the left towards the bed and then sat the Resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the bed. CNA #6 said he then scooped the Resident with his two arms, one behind the Resident thighs and one behind the Resident's shoulders. CNA #6 said once the Resident was lying in bed, he provided the Resident with incontinence care by rolling the Resident side to side for cleaning without the Resident having any signs of discomfort. CNA #6 said that if the Resident was having pain he would have noticed because the Resident would have moaned louder but the Resident did not. CNA #6 said not using the mechanical lift to transfer Resident #70 put the Resident at risk of getting hurt. During an interview on 3/17/26 at 3:28 P.M., CNA #7 said she had worked with Resident #70 on many occasions and was familiar with the Resident's care needs. CNA #7 said she transferred Resident #70 out of bed and into a recliner chair on 3/2/26, between 5:00 A.M. and 6:00 A.M. after getting the Resident washed and dressed for the day, using a mechanical lift without assistance of another staff member. CNA #7 said she was aware that mechanical lift transfers should be done with two staff members. CNA #7 said the Resident did not exhibit any signs of pain prior to, during or after the transfer. CNA #7 said that by transferring the Resident with the mechanical lift by herself the risk was that the Resident could get hurt.

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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 interviews, and record review, the facility failed to ensure that three Residents (#3, #11, and #15), out of a total sample of 30 residents was provided the right to participate in their care plan process.Specifically, for Residents (#3, #11, and #15), the facility failed to ensure that each Resident was invited to participate in their individual care plan meeting process and the facility also failed to provide rationale as to why the participation of the three Residents was determined not practicable for the development of the care plan.Findings include:Review of the facility policy titled Resident's Rights, dated 11/28/17 and revised 9/5/25, included the following:-The Federal and State laws guarantee basic rights to all residents of this facility:>be informed of, and participate in, his/her care planning and treatment. Review of the facility Patient and Resident Guide, dated 1/4/22, included the following:>We encourage you to participate in the development of your plan of care with our interdisciplinary team. Together we will develop goals based on your needs .>Regular care plan meetings will take place to which you and your family members will be invited for reviewing process and adjusting goals. Review of the facility policy titled Care Planning, revised 11/28/18, included the following:-Our facility's Care Planning/Interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident.>The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 1.Resident #3 was admitted to the facility in July 2025 with diagnoses including anxiety, Dementia, Heart Failure, and Diabetes. Review of the Minimum Data Set (MDS) Assessment, dated 2/20/26 indicated Resident #3: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 points out of a total possible 15 points. -was able to make him/herself understood and was able to understand others. Review of the Resident's medical record indicated:-Resident #3 had an invoked Health Care Proxy (HCP- person that is delegated to make informed health care decisions for another person when they are unable to do so themselves), effective 7/29/25.Further review of the Resident's medical record indicated that Care Plan meetings were held for Resident #3 on: 10/28/25, 2/3/26, and 3/4/26 without any evidence that the Resident was invited to or present at the care plan meetings. The medical record also did not include any documentation that the participation of the Resident was determined not practicable for the development of the Resident's care plan. During an interview on 3/12/26 at 10:18 A.M., Resident #3 said he/she was unable to recall being invited to attend his/her care plan meetings and would like to go if he/she could. 2.Resident #11 was admitted to the facility in November 2023 with diagnoses including Parkinsons Disease, Dementia, and weakness. Review of the MDS Assessment, dated 2/20/26 indicated Resident #11: -was cognitively intact as evidenced by a BIMS score of 15 points out of a total possible 15 points. -was usually able to make themself understood and was usually able to understand others. Review of the Resident's medical record indicated:-Resident #11 had an invoked HCP, effective 8/26/24.Further review of the Resident's medical record indicated that the Resident's Care Plan meetings were held on: 1/4/25, 4/15/25, 7/22/25, 10/14/25, and 1/13/26 without evidence that the Resident was invited or present at the care plan meetings, or included documentation that the participation of the Resident was determined not practicable for the development of the Resident's care plan. During an interview on 3/12/26 at 10:06 A.M., Resident #11 said he/she knew nothing about care plan meetings and was unable to recall being invited to any care plan meetings. Resident #11 said he/she would probably go if the staff were discussing his/her care. 3. Resident #15 was admitted to the facility in July 2025 with diagnoses including anxiety, weakness, and retention of urine. Review of the MDS Assessment, dated 2/16/26 indicated Resident #15: -was cognitively intact as evidenced by a BIMS score of 14 points out of a total possible 15 points. -was able to make him/herself understood and was able to understand others. Review of the Resident's medical record indicated:-Resident #15 had an invoked HCP, effective 12/15/25.Further review of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225275	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident's medical record indicated that the Resident's Care Plan meetings were held on: 2/2/26 and 10/28/25 without evidence that the Resident was invited to or present at the care plan meetings. The medical record did not include documentation that the participation of the Resident was determined not practicable for the development of the Resident's care plan. During an interview on 3/12/26 at 8:59 A.M., Resident #15 said he/she was unaware of what a care plan meeting was and was unable to recall being invited to any care plan meetings. During an interview on 3/16/26 at 12:17 P.M., the MDS Nurse said the facility did not have a policy on Care Plan Meetings. The MDS Nurse said the Residents with an invoked HCP did not get invited to their own care plan meetings because the Resident is not considered their own person. The MDS Nurse said it was the responsibility of the HCP to invite the Resident to his/her care plan meetings when the invitations were sent out to the HCP's from the facility staff.During an interview on 3/16/26 at 1:07 P.M., the MDS Nurse said Resident's (#3, #11 and #15) should have been invited to their care plan meetings by the facility staff so the Residents could be made aware of their plan of care and provided opportunity for self-advocacy if they had concerns with the delivery of care and could discuss desired changes. During an interview on 3/16/26 at 2:22 P.M., the Administrator said that the Residents (#3, #11, and #15) should have been invited to their care plan meetings so that they (the Residents) can have a voice in their delivery of care. The Administrator said that if the team thought the Residents should not attend the meetings a reason should be included in the care plan notes.

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	225275	A. Building B. Wing	03/18/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide treatment and services related to an indwelling urinary catheter (thin, flexible tube inserted into the bladder to drain urine outside the body) for two Residents (#93 and #51), out of a total sample of 30 residents.Specifically, the facility failed:1. For Resident #93, to implement the physician's orders relative to the correct indwelling urinary catheter size as ordered by the Physician, increasing the Resident's risk for indwelling urinary catheter complications.2. For Resident #51, to ensure that the urinary catheter drainage bag was not placed directly on the floor, placing the Resident at risk for contamination and infection. Findings include: Review of the facility's policy titled, Reception and Transcription of Physician Orders, revised, 5/16/24, included but limited to:*Is to provide guidelines for the safe and effective means to receive, transcribe and implement physician's orders. -Attending physician (MD-medical doctor), nurse practitioner (NP) or physician assistant (PA) may issue orders for a resident either in writing, verbally, or directly into the electronic health record if available. The order is received and processed by individuals who are qualified by their scope of practice. Orders may also be received from the MD, NP, PA via facsimile (Fax) or encrypted email. -All orders, whether written, verbal or computer entered, are to be noted and posted only by a licensed nurse. -Noting and posting consists of all activities necessary to implement and execute the order. This includes but is not limited to ordering medication, arranging referrals, transcribing orders to the medication administration record (MAR) or treatment administration record (TAR), obtaining consent, notifying interested parties, etc. 1. Resident #93 was admitted to the facility in December 2025 with diagnoses including retention of urine and essential primary hypertension. Review of the Minimum Data Set (MDS) Assessment, dated 2/13/26, indicated Resident #93:-has severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of two out of a possible 15 points. -has an indwelling urinary catheter. On 3/13/26 at 7:59 A.M., the surveyor observed Certified Nurse Aide (CNA) #3 standing next to the Resident's bed in his/her bedroom providing activities of daily living care (ADLs- personal care activities including but not limited to, eating, grooming, and personal hygiene) for Resident #93. The surveyor observed the Resident had a urinary catheter in place that was size 16 French (Fr) with a 10 milliliter (mL) [NAME]. Review of Resident #93's March 2026 Physician orders indicated: -Catheter: Silicone (specific type), 14Fr/Balloon size -10 mL. May use leg bag when out of bed, initiated 12/27/25.-Catheter: Silicone (specific type), 14Fr/Balloon size -10 mL. Change monthly once a day on the 25th of the month, 7:00 A.M. - 3:00 P.M., initiated 1/14/26. Review of Resident #93's Care Plan initiated 1/7/26, included but was limited to:-a need for an indwelling urinary catheter due to retention. -intervention to see MD orders for size. Review of Resident #93's Treatment Administration Record (TAR), for January 2026 and February (continued on next page)

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	225275	A. Building B. Wing	03/18/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2026 indicated that the urinary catheter was changed by Nursing staff on the following dates:-1/25/26.-2/25/26. Review of Resident #93's Nursing Progress notes dated 2/21/26, indicated but was not limited to:-urinary catheter was replaced secondary to leaking. -urinary catheter was placed with size 16 Fr with 10 ml balloon. Further review of Resident #93's clinical records failed to indicate a Physician's order for a 16 Fr/ 10 mL urinary catheter. On 3/17/26 at 7:33 A.M., the surveyor and Nurse #4 observed that Resident #93 's urinary catheter size was 16 Fr and 10 mL balloon. On 3/17/26 at 7:37 A.M., the surveyor and Nurse #4 reviewed Resident #93's active Physician orders which indicated the Resident's urinary catheter size was 14Fr with 10 mL balloon. During an interview at the time, Nurse #4 said the size of Resident #93's urinary catheter did not match the Physician orders, and it should match. Nurse #4 said the risk for Resident #93 having an inaccurate urinary catheter size inserted could be increased infection due to leakage of urine. Nurse #4 also said the Nurses should follow the Physician 's orders for urinary catheter size during insertion. Nurse #4 further said Resident #93's urinary catheter was changed monthly in the facility by the Nurses on the 25th of every month. During an interview on 3/17/26 at 10:00 A.M., the Director of Nursing (DON) said the risk of having the wrong size urinary catheter inserted for Resident #93 was trauma and risk of increased infection. During an interview on 3/17/26 at 2:00 P.M., Nurse Consultant #1 said that Nurses should follow the Physician order for Resident #93 when inserting a foley catheter as ordered. During an interview on 3/18/26 at 9:05 A.M., the Infection Preventionist (IP) said she recently had competency training with the Nurses on the process for inserting urinary catheters. The IP said the Nurses should have followed the Physician orders for urinary catheter size when inserting the urinary catheter for Resident #93. 2. Review of the CDC guidelines for the Prevention of Catheter Associate Urinary Tract Infections (CAUTI). Retrieved from: https://www.cdc.gov/infection-control/hcp/cauti/summary-of-recommendations.html, revised 3/25/24, indicated the following: - If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment. - Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. Resident #51 was admitted to the facility in May 2025 with Acute Kidney Failure and Urinary Retention. Review Resident #51's most recent MDS assessment dated [DATE] indicated that: -The Resident had a severe cognitive impairment as evidenced by a BIMS score of 5 out of a total (continued on next page)

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	225275	A. Building B. Wing	03/18/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible score of 15. -Resident #51 had an indwelling urinary catheter. -Resident #51 required substantial maximal assistance (the helper does 50% or more of the effort to complete the activity) for toileting and personal hygiene. Review of Resident #51's March 2026 Physician's orders included but was not limited to: -Urinary Catheter size: 16 French (5.3 milliliters [ml])/10 ml ^balloon to drainage bag, every day, start date 3/27/25. -Catheter care every shift, every shift for catheter, with a start date of 3/27/25. -Check catheter every shift for patency. Change as needed for blockage/removal with a start date of 3/27/25.^ -Document urine output from catheter every shift, with a start date of 3/27/25.^ -Foley catheter care twice daily and as needed, with a start date of 3/27/25. Review of Resident #51's person-centered Indwelling Urinary Catheter Care Plan, effective date 3/20/25 included but was not limited to: >Goal: Foley catheter will remain patent >Interventions: Maintain enhanced barrier precautions every shift (an infection control intervention designed to reduce the transmission of multi-drug-resistant organisms) ^ On 3/17/26 at 8:02 A.M., the surveyor observed Resident #51 lying in bed with his/her urinary catheter drainage tubing hanging freely over the edge of the bed and the drainage bag system tangled between the Resident's comforter and resting flat on a floor mat on the floor next to his/her bed. During an observation and interview at the same time, Nurse #1 said that the catheter drainage bag should not be on the floor to prevent the risk of infection to the Resident. On 3/18/26 at 7:15 A.M., the surveyor observed Resident #51 lying in bed with his/her urinary catheter drainage tubing hanging freely over the edge of the bed and the drainage bag system resting on the floor next to his/her bed. During an observation and interview at the same time, Unit Manager (UM) #1 said that the catheter drainage bag resting on the floor was an infection control concern, that it should not be on the floor but in a clean basin to prevent infection. During an interview on 3/18/26 at 9:15 A.M., the Infection Control Nurse said that Certified Nursing Assistants (CNAs) and Nurses were educated on the appropriate care of urinary catheters and that urinary catheter drainage bags should not be on the floor to prevent the spread of infections.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to adhere to infection control standards of practice for one Resident (#93), out of a total sample of 30 residents. Specifically, for Resident #93, the facility failed to ensure that Enhanced Barrier Precautions (EBPs - the use of protective gowns and gloves during high contact care activities that may provide opportunity for transmission of medication resistant organisms through staff hands and/or clothing), were appropriately utilized when providing high contact care for the Resident, to mitigate the risk of organism transmission and the spread of infection to the Resident and other residents within the facility. Findings include:Review of the facility's policy titled Enhanced Barrier Precautions, dated 4/6/2023, included but was not limited to:*Enhanced Barrier Precautions expand the use of personal protective equipment (PPE: items such as gowns and gloves worn to prevent the spread of infection) and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of multi-drug-resistant organisms (MDROs) to staff hands and clothing. MDROs may be indirectly transferred from resident to resident during these high contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. >The use of gown and gloves for high contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Implementation of PPE use in nursing homes to prevent spread of MDROs.>Examples of high contact resident care activities requiring gown and gloves use for enhanced barrier precautions include:>dressing>bathing/showering>transferring>providing hygiene>changing linens>changing briefs or assisting with toileting>device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilatorReview of the facility's policy titled Specific Personal Protective Equipment, undated, included but was not limited to:>Hand hygiene is recognized as the most important way to prevent the transmission of infection. All employees are to wash hands after every unprotected contact with blood or other potentially infectious materials and after removing gloves.>Protective clothing, such as aprons, gown, or similar garments, will be provided by the employer to protect employee's clothing as needed. Resident #93 was admitted to the facility in December 2025 with diagnoses including Retention of Urine and Essential Primary Hypertension.Review of Resident #93's Person-Centered Care Plan, initiated 1/28/26, indicated interventions for the following: -on Enhanced Barrier Precautions related to urinary catheter.-PPE for high contact care.-wash hands when entering and exiting room.-Enhanced Barrier precaution sign.Review of the Minimum Data Set (MDS) Assessment, dated 2/13/26, indicated Resident #93:-had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 2 out of a possible 15 points.-had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine outside the body).Review of Resident #93's March 2026 Physician's Orders indicated: -Maintain Enhanced Barrier Precautions (EBP) every shift related to urinary catheter every shift; Days 7:00 A.M.-3:00 P.M., Evenings 3:00 P.M.-11:00 P.M., Nights 11:00 P.M.-7:00 A.M., initiated 1/28/26.On 3/13/26 at 7:19 A.M., the surveyor observed a sign posted outside of Resident #93's door. The signage indicated:-STOP ENHANCED BARRIER PRECAUTIONS >EVERYONE MUST: -clean their hands including before entering and when leaving the room. > providers and staff must also: -wear gloves and a gown for the following high contact resident care activities: -dressing -bathing/showering -transferring -providing hygiene -changing brief or assisting with toileting -device care or use: central line, urinary catheter, feeding tube, tracheostomy On 3/13/26 at 7:59 A.M., the surveyor observed Certified Nurse Aide (CNA) #3 standing next to Resident #93's bed while providing activities of daily living care (ADLs- personal care activities including but not limited to, eating, grooming, and personal hygiene) to the Resident. CNA #3 was wearing gloves but did not have a gown on during the observation. Resident #93's urinary (continued on next page)

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	225275	A. Building B. Wing	03/18/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter was draining clear yellow urine, and the catheter tubing was secured on the Resident's left thigh. During an interview on 3/13/26 at 8:12 A.M., CNA #3 said he forgot to wear a gown when providing ADL care for Resident #93. CNA #3 also said it was important for him to wear a gown when providing ADL care for Resident #93 because the Resident has a urinary catheter and that he should wear a gown to protect Resident #93 from infections and to also prevent the potential of transferring germs to other residents. On 3/17/26 at 7:26 A.M., CNA #4 entered Resident #93's room with no hand hygiene observed by the surveyor and closed the door behind him.On 3/17/26 at 7:33 A.M., Nurse #4 and the surveyor together entered Resident #93's room. CNA #4 was observed standing next to the Resident's bed while providing ADL care. CNA #4 was wearing gloves but did not have a gown. During an interview on 3/17/26 at 7:37 A.M., Nurse #4 said that CNA #4 should have worn a gown when caring for Resident #93 because the Resident has a urinary catheter and was on EBP. Nurse #4 said that staff caring for Resident #93 should wear a gown to prevent the transmission of infection to the Resident and to other residents. During an interview on 3/17/26 at 7:41 A.M., CNA #4 said that he should have washed his hands prior to entering the Resident 's room, but he did not. He also said that he should have worn a gown when providing ADL care for Resident #93 because the Resident had a urinary catheter to prevent the transmission of infection from him to the Resident and vice versa, but he did not. CNA #4 said that the sign posted outside the Resident's door informed him of what to do prior to entering the Resident's room, and that he did not follow the sign. During an interview on 3/17/26 at 10:00 A.M., the Director of Nursing (DON) said staff not wearing the required PPE (gown and gloves) when caring for Resident #93 on EBP risked the transference of pathogens from the staff's clothing and hands to the Resident who has an indwelling device as well as to other residents.