| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225288 | A. Building<br>B. Wing | 12/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care One at Lexington | 178 Lowell Street<br>Lexington, MA 02420 |

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 0576<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure residents have reasonable access to and privacy in their use of communication methods.<br><br>Based on record review and interviews the facility failed to ensure resident rights were maintained. Specifically, the facility failed to deliver mail from the US Postal Service on Saturdays, potentially impacting on the well-being of residents who are expecting mail. Findings include: Review of the facility's policy, dated revised May 2017, indicated the following: Residents are allowed to communicate privately with individuals of their choice and may send and receive personal mail, email and other electronic forms of communication confidentiality 4. Mail and packages will be delivered to the resident within twenty-four hours of delivery on premises or the facility's post office box (including Saturday deliveries). During the resident group meeting conducted by the surveyor on 12/23/25 at 11:00 A.M., and attended by 17 residents, three active participants said mail is delivered Monday through Friday and that no one from staff delivers mail on Saturday. The participating residents said outside of the facility they received U.S. postal mail on Saturdays. During an interview on 12/23/25 at 12:55 P.M., the Activities Director said he is responsible for delivering resident mail. The Activity Director said he typically delivers the mail at the end of the day every Monday through Friday. The Activity Director said the mail delivered on Saturday from the U.S postal Service is delivered on Mondays. The Activity Director said the residents never brought it up to him about getting their mail delivered on Saturdays. During an interview on 12/24/25 at 8:53 A.M., the Administrator said mail delivery should not be any different and mail should be delivered on Saturdays. |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225288 | A. Building<br>B. Wing | 12/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care One at Lexington | 178 Lowell Street<br>Lexington, MA 02420 |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a clean and homelike environment on one (the [NAME] Unit) of four resident units. Findings include:Review of the facility policy titled Homelike Environment, dated February 2021 indicated: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The surveyor observed the following on the [NAME] Unit on 12/23/25 at 10:31 A.M.: room [ROOM NUMBER]: Red stains on radiator and on chair. Large bowing stained ceiling tile. Large gouge in bathroom door. Room27: Deep scratches in flooring near the bed. room [ROOM NUMBER]: Stained flooring near toilet. room [ROOM NUMBER]: Stained floor by toilet, basin of water catching leaking water from the sink. room [ROOM NUMBER]: Stained window shade, broken handle on nightstand drawer, visibly dirty overbed table.room [ROOM NUMBER]: Basin catching water in sink due to leak in faucet. Deep gouge in door to bathroom. Towel on the floor wrapped around toilet. room [ROOM NUMBER]: Peeling laminate on the W bed dresser. Towel on floor around toilet. room [ROOM NUMBER]: Partial stained ceiling tile in the bathroom.room [ROOM NUMBER]: Torn and visibly soiled fall mat with dirt and debris with exposed foam. room [ROOM NUMBER]: Long black scuff mark along closet doors.room [ROOM NUMBER]: Missing handle of top drawer in dresser by D bed. room [ROOM NUMBER]: Missing handle on D bed nightstand drawer, stained top of dresser for window bed. room [ROOM NUMBER]: Missing handles on first and second drawers for D bed dresser, long black scuff marks along closet doors. room [ROOM NUMBER]: Two ripped fall mats with exposed foam, scrape in door to bathroom. room [ROOM NUMBER]: Scrape in door to bathroom, stained ceiling tile in bathroom. During an interview on 12/23/25 at 11:12 A.M., Unit Manager #1 said environmental issues are relayed to the Maintenance Director verbally or on the TELS system. Unit Manager #1 said she was not aware of any environmental issues on the unit. During an interview on 12/23/25 at 2:01 P.M., the Administrator said she expects staff to report any environmental concerns to the Maintenance Director so they could be addressed. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225288 | A. Building<br>B. Wing | 12/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care One at Lexington | 178 Lowell Street<br>Lexington, MA 02420 |

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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure the physical environment accommodated the needs of one Resident (#90) out of a total of 31 sampled Residents. Specifically, the facility failed to provide Resident #90 with a bed that fit him/her appropriately. Findings include: Review of the facility's policy titled Accommodation of Needs dated March 2021 indicated: Policy Statement: Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. 2. The resident's individual needs, and preferences, including the need for adaptive devices and modifications to the physical environment are evaluated upon admission and reviewed on an ongoing basis.3. In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom as well as the common areas in the facility. Resident #90 was admitted to the facility in July 2024 with diagnoses including stroke, vascular dementia and reduced mobility. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #90 is moderately cognitively impaired as evidenced by a score of 8 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). The MDS also indicated Resident #70 is dependent on staff for positioning and transfers. Additional review of the MDS indicated Resident #90 is 76 inches (6ft 3 inches) tall. During an interview on 12/22/25 at 9:08 A.M., the surveyor observed Resident #90 resting in bed with his/her ankles and feet hanging off the end of the bed. Resident #90 said that his/her feet and ankles have been sliding off the edge of the bed forever. When asked if staff were aware or if he/she had reported it, Resident #90 said nobody cares.On 12/22/25 at 11:13 A.M., the surveyor observed Resident #90 resting in bed with his/her ankles and feet hanging off the foot of the bed.On 12/23/25 at approximately 7:45 A.M., the surveyor observed Resident #90 resting in bed with his/her ankles and feet hanging off the foot of the bed.During an interview on 12/23/25 at 7:55 A.M., Unit Manager #2 said that Resident #90 is tall and slides down in his/her bed. Unit Manager #2 said that she put in a request a couple weeks ago for a longer bed for Resident #90 with the maintenance department. Unit Manager #2 showed the surveyor a text message requesting a longer bed for Resident #90 dated 12/4/25. During an interview on 12/23/2025 at 8:02 A.M., Nurse #1 said that Resident #90's feet have always hung over the edge of the bed for about a year.During an interview on 12/23/2025 at 8:11 A.M., Nurse #2 said that Resident #90 slides down his/her bed which results in his/her feet dangling off the end of the bed. Nurse #2 said it takes 2-3 staff to boost him/her back up, but he/she slides back down again. Nurse #2 said it's been an ongoing issue for a couple of months. During an interview on 12/23/2025 at 8:29 A.M., the Maintenance Director said he was not sure when the request for a longer bed for Resident #90 was placed but he/she would obtain a longer bed for him/her today (12/23/25). During an interview on 12/23/2025 at 12:25 P.M., Consultant Nurse #2 said that if a resident's bed does not fit him/her appropriately, a new one should be provided. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225288 | A. Building<br>B. Wing | 12/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care One at Lexington | 178 Lowell Street<br>Lexington, MA 02420 |

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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the grievance process was followed for one Resident (#70) out of a total of 31 sampled residents. Specifically, the facility failed to follow the grievance process and complete a grievance form after Resident #70 reported he/she was missing a robe. Findings include: Review of the policy titled Grievances/Complaints, Recording and Investigating dated April 2017 indicated: Policy Statement: All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance. Policy Interpretation and Implementation: 1. The Administrator has assigned the responsibility of investigating grievances and complaints to the grievance officer. Upon receiving a grievance and complaint report, the grievance officer will begin an investigation into the allegations. 5. The grievance officer will record and maintain all grievance and complaints on the Resident Grievance Complaint log. The following information will be recorded and maintained in the log: The date grievance/complaint was received, the name and room number of the resident filing the grievance/complaint (if available) The Resident Grievance/Complaint investigation report form will be filed with the administrator within five working days of the incident. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within five working days of the filing of the grievance or complaint. Resident #70 was admitted to the facility in September 2025 with diagnoses including altered mental status and essential hypertension. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #70 is cognitively intact as evidenced by a score of 14 out of a possible 15 on the Brief Interview for Mental Status Exam. During an interview on 12/22/25 at 8:47 A.M., Resident #70 said that he/she had a bathrobe that went missing from his/her room. Resident #70 said he/she brought it to the attention of staff, but Unit Manager #2 said there's nothing I can do about it. Resident #70 said staff did not offer a grievance form for him/her to complete.Review of grievance book/log failed to include any grievance related to missing items for Resident #70.During an interview on 12/23/25 at 7:54 A.M., Unit Manager #2 said that she had heard about Resident #70's missing robe about a month ago and that she spoke with the Resident's Health Care Proxy, who reported he/she was missing a robe. Unit Manager #2 said she did not complete a grievance form, but she should have.During an interview on 12/23/25 at 9:51 A.M., the Administrator said she reviews all grievances and was not aware of any concerns for Resident #70. The Administrator said that a grievance should have been completed for Resident #70 after he/she reported he/she had a missing robe. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225288 | A. Building<br>B. Wing | 12/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care One at Lexington | 178 Lowell Street<br>Lexington, MA 02420 |

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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observations, interviews, and record review, the facility failed to ensure that services provided met professional standards for one Resident (#55), out of 31 total sampled residents. Specifically, for Resident #55 the facility failed to ensure that nursing removed the correct medication patch during the medication pass observation. Nurse #4 removed a clonidine patch (medicated patch applied once a week used to treat hypertension) instead of a nicotine patch (medicated patch applied once a day used to treat nicotine cravings). Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated:- Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Review of the facility policy titled, Administering Medications, dated as revised April 2019, indicated that medications are administrated in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. Resident #55 was admitted to the facility in December 2025 with diagnoses including urine retention, alcohol dependence, hypertension, and chronic obstructive pulmonary disorder. Review of Resident #55's most recent Minimum Data Set (MDS) assessment, dated 12/17/25, indicated moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 12 out of 15. Review of Resident #55's physician's orders, dated 12/10/25, indicated:- clonidine transdermal patch weekly 0.2 milligrams (mg)/24 hour, apply 1 patch transdermally in the morning every Monday for hypertension and remove per schedule.- nicotine transdermal patch 24 Hour 14 mg/24 hour, apply 1 patch transdermally in the morning for smoking cessation and remove per schedule. Review of Resident #55's Medication Administration Record, dated 12/22/25, indicated nursing administered/applied a new clonidine patch to his/her left arm. On 12/23/25 at 8:41 A.M., during the medication administration pass the surveyor observed Nurse #4 remove a peach-colored patch from Resident #55's left arm. The patch was dated 12/22/25. Nurse #4 crumpled the peach-colored patch, and she put the patch in the trash. Nurse #4 then applied a nicotine patch that was clear (not peach-colored) on Resident #55's right chest wall. The surveyor asked Nurse #4 what patch she had removed from Residents #55's left arm, and she said that it was the old nicotine patch. On 12/23/25 at 8:46 A.M., the surveyor reobserved the peach-colored patch that Nurse #4 removed from Resident #55's left arm. The patch was labeled clonidine 0.2mg/day. On 12/23/25 at 1:24 P.M., the surveyor, Nurse #4, and the Facility Educator (FE) were unable to locate Resident #55's clonidine patch that was documented as applied to the left arm on 12/22/25. Nurse #4 said that she was unaware she removed the clonidine patch from Resident #55's left arm during the medication administration observation, and she said that she didn't realize that Resident #55 had a clonidine patch ordered. During an interview on 12/23/25 at 1:25 P.M., the FE said that Nurse #4 should have verified the correct mediation patch before removing Resident #55's clonidine patch. During an interview on 12/23/25 at 2:06 P.M., Nurse Consultant #2 said that Nurse #4 should have verified that she removed the nicotine patch during the medication administration. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225288 | A. Building<br>B. Wing | 12/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care One at Lexington | 178 Lowell Street<br>Lexington, MA 02420 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observations and interviews, the facility failed to identify and eliminate all known and foreseeable accident hazards in the resident's environment for one Resident (#46), out of 31 total sampled residents. Specifically, for Resident #46 the facility failed to remove a portable oil-filled radiator heater from his/her room. Findings include:Review of the facility policy titled, Electrical Appliances, dated as revised January 2019, indicated that portable space heaters are not allowed in resident areas. Resident #46 was admitted to the facility in December 2024 with diagnoses including Diabetes, chronic pain, and anemia. Review of Resident #46's most recent Minimum Data Set (MDS) assessment, dated 9/26/25, indicated intact cognition as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15. On 12/22/25 at 8:16 A.M., the surveyor observed Resident #46 lying on his/her bed with an electric heater next to his/her bed. The surveyor also observed that next to the heater was an electric power strip. During an interview on 12/23/25 at 9:07 A.M., the Maintenance Supervisor said that electric heaters are not allowed to be used in resident's rooms and was going to remove it immediately. He said that the risk of having an electric heater in a Resident's room was that it could cause a fire. During an interview on 12/23/25 at 9:22 A.M., the Maintenance Supervisor said that when he went to Resident #46's room he found that the electric heater had already been removed by another staff member. During an interview on 12/24/25 at 7:46 A.M., Unit Manager #3 said she had removed the electric heater when she had noticed it in Resident #46's room on 12/22/25. She said that there was a risk of causing a fire if an electric heater was in a resident's room. She said she had not seen the electric heater in Resident #46's room before. During an interview on 12/24/25 at 7:50 A.M., Certified Nursing Aide #2 said she had never seen the electric heater in Resident #46's room before. During an interview on 12/24/25 at 7:45 A.M., Resident #46 said that his/her son had brought in the heater to use in the summer when the air conditioning had been too cold, but that since the heat had been turned on in the building, he/she had been warm enough and no longer needed to use the electric heater. During an interview on 12/24/25 at 8:01 A.M., the Administrator said she was not aware that Resident #46 had an electric heater and his/her room and that the facility has a policy that electric heaters are not to be used in residents' rooms due to risk of fire. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225288 | A. Building<br>B. Wing | 12/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care One at Lexington | 178 Lowell Street<br>Lexington, MA 02420 |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, record review and interview, the facility failed to ensure food items were stored appropriately in the reach-in refrigerator in the main kitchen. Findings include: Review of the facility's policy titled, Food Receiving and Storage undated, indicated: Food shall be received and stored in a manner that complies with safe food handling practices. 1. All Foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). 7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen or discarded. On 12/22/25 at 6:54 A.M., the surveyor observed the following in the reach-in refrigerator during the initial kitchen walk through:-Two undated and unlabeled sandwiches. -One sandwich labeled Chicken dated use by 12/21/25.-19 containers of pudding, undated and unlabeled. -One sandwich labeled Chicken Salad dated used by 12/19/25.-One sandwich labeled Peanut Butter dated use by 12/15/25. During an interview on 12/22/25 at 11:32 A.M., the Food Service Director (FSD) said all items should be dated and labeled in the refrigerator. The FSD said that the pudding cups had been used for the previous night's dinner meal and sandwiches should be discarded after three days. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225288 | A. Building<br>B. Wing | 12/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care One at Lexington | 178 Lowell Street<br>Lexington, MA 02420 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and observation, the facility failed to ensure complete and accurate medical records for two Residents (#34, #51) of 31 sampled residents. Specifically:For Resident #34, the facility failed to document weekly skin checks ordered by the physician.For Resident #51, the facility failed to accurately transcribe physician treatment orders. Findings include:<br><br>Review of the Charting and Documentation policy dated July 2017 indicated: Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate.<br><br>1. Resident #34 was admitted to the facility in December 2025 and had diagnoses which included heart disease and anxiety disorder.<br><br>Review of Resident #34's baseline care plan dated 12/12/25 indicated he/she was at risk for skin breakdown and that staff should regularly assess the Resident's skin.<br><br>Review of Resident #34's medical record on 12/22/25 indicated Facility staff had not yet completed the Minimum Data Set assessment or the Brief Interview for Mental Status examination.<br><br>Review of Resident #34's Clinical Nursing admission assessment dated [DATE] indicated staff assessed his/her skin on this date and bruising was noted on both arms and thighs.<br><br>Review of Resident #34's physician order dated 12/13/25, indicated:<br><br>- Weekly skin check, complete skin check under Forms tab every evening shift every Saturday.<br><br>Review of Resident #34's Treatment Administration Record indicated weekly skin checks were not completed on 12/13/25 and 12/20/25, as ordered by the physician. Review of the Resident's medical record indicated there was no reference to staff attempting to provide skin checks on these dates.<br><br>On 12/22/25 at 8:49 A.M., the surveyor observed bruising on Resident 34's forearms and wrists. The Resident said he/she was unsure if the bruises were caused by a fall at home, or if he/she sustained these at the facility. The Resident said he/she did not know if staff had assessed his/her skin since admission to the facility.<br><br>During an interview with the Infection Preventionist and Consulting Nurse #1 on 12/23/25 at 11:00 A.M., they said they were unable to find documentation in Resident #34's medical record to indicate staff attempted skin assessments on 12/13/25 or 12/20/25.<br><br>Review of a written statement provided to the surveyor by Nurse #3, who was assigned to complete Resident #34's skin checks on 12/13/25 and 12/20/25, indicated the Resident was very anxious and refused skin checks on these dates. The statement did not reference if Nurse #3 documented these refusals in the medical record.<br><br>2. Resident #51 was re-admitted to the facility in October 2025 with diagnoses including chronic obstructive pulmonary disease and traumatic hemorrhage of the cerebrum.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225288 | A. Building<br>B. Wing | 12/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care One at Lexington | 178 Lowell Street<br>Lexington, MA 02420 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #51 is moderately cognitively impaired as evidenced by a score of 9 out of a possible 15 on the Brief Interview for Mental Status Exam.<br><br>a. Review of Resident #51's Dermatology Report dated 12/10/25 indicated: Impression/Plan: Scabies; a scabies prep was performed on the left palmar ring finger, showing mites and stool. Plan: Ivermectin 3 mg tablet, take 6 pills at once then again after 24 hours and repeat again after 8 days. Permethrin 5% topical cream: apply neck down to feet, Wash off after 12 hours. Repeat every 7 days for 3 weeks.<br><br>Review of physician orders, Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated December 2025 failed to indicate permethrin was applied.<br><br>During an interview on 12/23/25 at 8:14 A.M., the Infection Preventionist said that Resident #51 was treated for the scabies per the orders from the dermatologist, but the order was not appropriately transcribed into the clinical record.<br><br>b. Review of Resident #51's current physician orders indicated the following: apply to whole body for itch, 11/19/25.<br><br>The order failed to indicate what specifically staff should be applying to Resident #51's body.<br><br>Review of the Medication Administration Record and Treatment Administration record for November 2025 and December 2025; indicated nursing staff signed off on the above order.<br><br>During an interview on 12/23/25 at approximately 9:30 A.M., Unit Manager #1 said that the order should have specifically identified what treatment staff should be applying to Resident #51 and nursing staff should have attempted to clarify the order with the physician. |