STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225300	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation & Nursing Center at Everett (the)	289 Elm Street Everett, MA 02149

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to implement personalized care plans for two Residents (#78 and #128) out of a total sample of 34 residents. Specifically:1. For Resident #78, the facility failed to prevent the Resident from having knives at meals.2. For Resident #128, the facility failed to have a fall mat in place. Findings include:1. Resident #78 was admitted to the facility in September 2020 with diagnoses including schizophrenia, bipolar disorder and anxiety.Review of Resident #78's most recent Minimum Data Set (MDS) dated [DATE] had a Brief Interview for Mental Status score of 6 out of a possible 15, which indicated he/she has severe cognitive impairment. The MDS also indicated Resident #78 requires supervision for feeding tasks. Review of Resident #78's physician orders indicated the following orders: May use real utensils while in supervised area at lunch and plastic utensils at breakfast and dinner, every shift for Suicidal ideation with no plan, initiated on 6/30/24.Review of Resident #78's activities of daily living care plan last revised 6/17/25, indicated the following intervention: Eating: I (the Resident) require occasional supervision to use suitable utensils to bring food and/or liquid to my mouth and swallow food and/or liquid once the meal is placed before me. On 8/5/2025 at 8:28 A.M., and 12:10 P.M., Resident #78 was observed eating meals in his/her room with no staff present in the room or in the hallways to supervise. The Resident was provided with regular utensils, including a knife. On 8/6/25 at 8:23 A.M. and at 12:20 P.M., Resident #78 was observed eating meals in his/her room with no staff present in the room or in the hallways to supervise. The Resident was provided with regular utensils, including a knife. Review of Resident #78's care card (a form indicating the level of assistance required and any special equipment a resident may need) indicated the following under the behavior section: Plastic ware only unless supervised. No knife or razor blade in room. During an interview on 8/6/2025 at 12:22 P.M., Certified Nursing Assistant (CNA) #6 said the staff use the care cards to communicate the level of assistance each resident on the unit would require and to add any special equipment needs. CNA #6 said if a resident's status changes, the Assistant Director of Nursing updated the care cards. CNA #6 said Resident #78 is independent with meals and can use regular utensils, including a knife. During an interview on 8/6/2025 at 12:36 P.M., Nurse #5 said Resident #78 has behaviors of threatening to self-harm but that she does not feel these are actual threats and are made to just get attention. Nurse #5 said the knives in the facility are blunt, so the Resident is safe to use them. During an interview on 8/6/2025 at 2:22 P.M., the Assistant Director of Nursing said care cards are in place for all residents to provide communication for the level of care each resident requires. The Assistant Director of Nursing said Resident #78 should not have a knife provided to him/her at meals and all orders and care plans should be followed as written. During an interview on 8/6/25 at 6:54 A.M., the Food Service Director said he was unaware of the physician order that Resident #78 should not have regular utensils or knives provided at meals. During an interview on 8/7/25 at 7:50 A.M., the Director of Nursing said Resident #78 had made a threat of self-harm a while ago and the intervention of not having regular utensils or a knife was put in place at that time. The Director of Nursing said the order and care plan should be followed as written. 2. Resident #128 was admitted to the facility in August (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225300	A. Building B. Wing	08/07/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2023 with diagnoses including a stroke. Review of Resident #128's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status which indicates the Resident is cognitively intact. The MDS also indicated Resident #128 is dependent on staff for all self-care and mobility tasks and has adequate vision with corrective lenses. On 8/5/2025 at 8:33 A.M., and at approximately 12:30 P.M., Resident #128 was observed lying in his/her bed. A fall mat was observed folded against the wall at the foot of the bed. Resident #128 said the fall mat is often folded against the wall and is only sometimes placed next to his/her bed. On 8/6/2025 at 8:18 A.M., Resident #128 was observed lying in his/her bed. A fall mat was observed folded against the wall at the foot of the bed. On 8/7/25 at 4:32 A.M., Resident #128 was observed lying in his/her bed. A fall mat was observed folded against the wall at the foot of the bed. Review of Resident #128's fall risk care plan indicated an intervention for a fall mat to be placed next to the bed while the Resident is in bed. During an interview on 8/6/2025 at 12:22 P.M., Certified Nursing Assistant #6 said Resident #128 only needs a fall mat next to his/her bed overnight. During an interview on 8/6/2025 at 12:36 P.M., Nurse #5 said Resident #128 should have a fall mat next to his/her bed as an active fall intervention. During an interview on 8/6/2025 at 2:22 P.M., the Assistant Director of Nursing said Resident #128 fell out of bed a year ago and a new care plan intervention initiated at that time was a fall mat to be placed next to the bed. The Assistant Director of Nursing said the fall mat should be in place next to the bed whenever Resident #128 is lying in bed and care plans should be followed as written. During an interview on 8/7/25 at 7:10 A.M., the Director of Nursing said Resident #128 had fallen out of bed a year ago and a fall mat was placed next to bed as a fall intervention. The Director of Nursing said all care plans should be followed as written, including Resident #128 having a fall mat next to his/her bed while lying in bed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, record review, and interviews the facility to ensure that services provided met professional standards for one Resident (#61), out of 34 sampled residents. Specifically, the facility failed to obtain and implement physician's orders to discontinue Resident #61's CAM boot (medical walking shoe, is a type of orthopedic footwear used to immobilize the foot and ankle after an injury or surgery. It is designed to provide support, stability, and protection to the foot and lower leg during the healing process) and advance his/her weight bearing status after his/her surgical specialty (podiatrist) follow up on 5/19/25. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following:- Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers 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. Resident #61 was admitted to the facility in January 2025 with diagnosis including atherosclerosis of the native arteries (narrowing and blocking blood flow) of the right leg, diabetes mellitus, right foot drop, peripheral vascular disease, and failure to thrive. Review of Resident #61's most recent Minimum Data Set (MDS) assessment, dated 7/25/25, indicated he/she had a severe cognitive impairment evidence by a Brief Interview of Mental Status exam score of 3 of 15. This MDS indicated Resident #61 had an impairment of the lower extremity on one side and Resident #61 required supervision or touching assistance with lower body activities of daily living. Review of Resident #61's active physician's orders included the following:-Non-weight bearing (NWB) to right lower extremity (RLE), dated as initiated 1/29/25.-Use CAM boot when out of bed. Offload Heels while in bed, dated as initiated 4/11/25.On 8/5/25 at 8:09 A.M., the surveyor observed Resident #61 sitting in his/her wheelchair. He/she was bearing weight on his/her right foot, and he/she was wearing sandals. There was no CAM boot in his/her room. On 8/6/25 at 6:47 A.M., the surveyor observed Resident #61 in the bathroom. He/she was sitting in his/her wheelchair, he/she was bearing weight on his/her right foot, and he/she was wearing sandals. There was no CAM boot in his/her room. Review of Resident #61's Surgical Specialties Consultant form, dated 5/19/25, indicated: The post-operative site is healing well, with the tibial corticotomy (surgical incision into the bone) healed beautifully. He/she can transition from the boot to a regular shoe. Review of Resident #61's nursing note, 5/19/25, indicated: Patient returned from his/her appointment today at approximately 1:30 P.M., with new order to discontinue right heel treatment due to wound healing and follow-up appointment at surgical specialties, provider made aware. Review of Resident #61's physical therapy note, dated 6/2/25, indicated: Resident ambulated with rolling walker 50 feet with stand by assist (SBA) weight bearing as tolerated (WBAT) right.Review of Resident #61's, Medication Administration Records, dated between 5/19/25, June 2025, July 2025, and through August 6, 2025, indicated that nursing continued to document that Resident #61 was non-weight bearing.During an interview on 8/6/25 at 11:04 A.M., Certified Nursing Assistant (CNA) #6 said Resident #61 walks on his/her feet, and he/she has no weight bearing restrictions. CNA #6 said that Resident #61 wears sandals and she said she isn't aware that he/she required a CAM boot.During an interview on 8/6/25 at 11:02 A.M., Nurse #5 said that Resident #61 does not use a CAM boot, and she said that Resident #61 is weight bearing as tolerated. During an interview on 8/7/25 at 8:53 A.M., Nurse #4 said that she was the nurse on duty when Resident #61 returned from his/her surgical specialist consult on 5/19/25. Nurse #4 said that she reviewed the consult form and called the Nurse Practitioner with the surgical specialist recommendations. Nurse #4 said she could not remember reading recommendations about Resident #61's weight bearing status or the use of the CAM boot, but Nurse #4 said that if she needed any clarification she would follow up with the surgical specialist consultant for additional information if needed. During an interview on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225300	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/7/25 at 7:57 A.M., the Physical Therapist said that she spoke with the surgical specialist physician, and she was made aware that Resident #61 was weight bearing as tolerated when she worked with the Resident on 6/2/25. During an interview on 8/6/25 at 11:16 A.M., the Assistant Director of Nursing said that Resident #61 went to a follow up appointment back in May of 2025 and his/her CAM boot and weight bearing restrictions were removed. During an interview on 8/7/25 at 5:44 A.M., the Director of Nursing said that the nurse who reviewed Resident #61's consult from 5/19/25 should have updated the physician's orders based on the recommendations.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide supervision and assistance with meals for two Residents (#56 and #28) out of a total of 34 sampled Residents. Findings include: Review of the facility policy titled Activities of Daily Living (ADL's), dated 9/20/24, indicated the following: -It is The Rehabilitation and Nursing Center at Everett's policy that based on the comprehensive assessment of a resident as outlined in regulatory grouping 483.24, and consistent with the resident's needs and choices, care and services will be provided to maintain their current ADL status. -Care and services for the following ADL's include: Dining-eating, including meals and snacks. -If a resident's ADL status is noted to have a decline, nursing will monitor the resident's status and send a referral to the appropriate department; appropriate department is determined by how the resident is presenting clinically (i.e. if eating difficulty is noted a referral would be made to Speech Therapy). 1. Resident #56 was admitted to the facility in August 2021, with diagnoses including cerebral infarct, hemiplegia and hemiparesis affecting right dominant side, dysarthria (difficulty articulating words), and dysphagia (difficulty swallowing). Review of Resident #56's most recent Minimum Data Set (MDS) assessment, dated 5/2/25, indicated the Resident had a Brief Interview for Mental Status exam score of 14 out of a possible 15, indicating he/she has intact cognition. Further review of the MDS indicated Resident #56 requires supervision or touching assistance for self-feeding. On 8/5/25 at 12:47 P.M., and on 8/6/25 at 8:50 A.M., 9:00 A.M., 9:14 A.M., 12:42 P.M. through 12:52 P.M., and 12:59 P.M., Resident #56 was observed seated upright in his/her bed eating with food spilled on his/her clothing protector. There was no staff observed providing supervision or assistance, and the resident was not visible from the hallway. Record review of Resident #56's ADL care plan on 8/6/25 at 7:00A.M., indicated the following: Eating: I require supervision or touching assistance to use suitable utensils to bring food and or liquid to my mouth and swallow food and or liquid once the meal is placed before me. Last revised 03/18/2025. Review of the Occupational Therapy Discharge summary dated [DATE] indicated Resident #56 requires contact guard assistance for self-feeding Review of the Speech Language Pathology Discharge summary dated [DATE] indicated the following: Min/close supervision. Swallow strategies/Position: To facilitate safety and efficiency. It is recommended the patient use the following strategies and/or maneuvers during oral intake, general swallowing techniques/precautions and alternation of liquid/solids upright posture during meals and upright posture for greater than 30 minutes after meals. (continued on next page)

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	225300	A. Building B. Wing	08/07/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/6/25 at 1:58 P.M., Nurse #1 said we setup Resident #56's meal and he/she likes to feed him/herself and does not require assistance. During an interview on 8/625 at 3:00 P.M., the Director of Nursing said she would expect Resident #56 would be provided with the level of assistance and supervision indicated on his/her care plan for self-feeding. Review of the medical record failed to indicate Resident #56 refused assistance with self-feeding. 2. Resident #28 was admitted to the facility in August 2024 with diagnoses including epileptic seizures, autistic disorder and dysphagia. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #28 is severely cognitively impaired as evidenced by a score of five out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). The MDS also indicated Resident #28 required supervision or touching assistance with eating. On 8/5/2025 at 8:08 A.M., the surveyor observed Resident #28 in his/her room eating breakfast. The door was closed and no staff were in the room to provide supervision or assistance. Resident #28 used both hands to pick up a glass of juice. Resident #28's hands were shaking and he/she struggled to drink without spilling. Resident #28 said his/her breakfast was good but did not engage in further conversation. Review of Resident #28's care plans indicated: Resident has an ADL (activities of daily living) and physical mobility deficit RT (related to) activity intolerance, weakness depression and epilepsy, 2/14/25. Interventions: Eating, I require set up/supervision for eating. Review of Resident #28's ADL Guide/Kardex dated 9/11/24 indicated Resident #28 required supervision/assistance with eating. The word occasional was hand written next to the word assistance. On 8/5/2025 at 11:58 A.M., the surveyor observed Resident #28 drinking coffee with both hands, sitting in bed with his/her lunch tray in front of him/her. The door was closed, and no staff were present in the room. Resident #28 said his/her meal was good. During an interview on 8/5/2025 at 12:02 P.M., Certified Nursing Assistant (CNA) #5 said Resident #28 eats his/her meals in his/her room with the door shut. CNA #5 then entered Resident #28's room and asked if he/she had finished eating his/her meal. On 8/6/2025 at 7:58 A.M., the surveyor observed CNA #9 deliver Resident #28's meal and leave the room. No staff remained to provide supervision per his/her plan of care. On 8/6/2025 at 11:58 A.M., the surveyor observed staff attempt to deliver Resident #28's lunch meal, but he/she declined. On 8/7/2025 at 7:57 A.M., the surveyor observed CNA #8 enter Resident #28's room, deliver his/her breakfast meal, and then leave closing the door behind her. CNA #8 then told the surveyor that Resident #28 is set up only for meals. The surveyor then observed Resident #28 in his/her room, sitting up in bed, eating his/her meal. (continued on next page)

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	225300	A. Building B. Wing	08/07/2025

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Rehabilitation & Nursing Center at Everett (the)	289 Elm Street Everett, MA 02149

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/7/2025 at 7:59 A.M., CNA #9 said she is assigned to Resident #28 and he/she does not require supervision or assistance with eating. During an interview on 8/7/2025 at 8:02 A.M., Unit Manager #1 said that residents who are care planned for supervision and assistance should not be eating alone in their rooms with the door closed. During an interview on 8/7/2025 at 8:19 A.M., the Director of Nursing (DON) said that Residents who are care planned for supervision and assistance should not be eating alone in their rooms with the door shut. The DON was not aware that Resident #28 was not receiving supervision or assistance per his/her care plan.

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	225300	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide adequate supervision during the 11:00 P.M. - 7:00 A.M. shift on two of five resident units. Specifically:1. The facility failed to ensure staff were awake and alert on the [NAME] Unit when staff were found asleep and three Residents (#3, #32 and #2) were observed wandering the unit.2. The facility failed to ensure that all assigned staff were consistently awake, alert, and were not simultaneously on their break during the night shift on the Main 1 unit.Findings include:Review of the Employee Handbook, dated 2018, failed to include expectations of staff sleeping while on duty. During the Resident Group Interview on 8/6/2025 at 10:35A.M., two of four participants reported staff sleep on the [NAME] and Main 1 Unit during the overnight shift. One Resident reported that staff hide in the TV room and another said that staff sleep at the nurses station. 1. During an early morning visit on 8/7/25 the following was observed on the [NAME] Unit, (a secured unit which houses residents with behavioral issues and dementia) while three Residents (#3, #2, and #32) were observed awake and wandering: On 8/7/25 at 3:23 A.M., the surveyor entered the [NAME] Unit. Certified Nursing Assistant (CNA) #1 was observed seated in a chair in the hallway with her head resting against the handrail which was padded with a cloth object. CNA #2 was observed asleep in a chair across from the nurses station. His mouth was open, and legs spread. Nurse #2 was observed asleep behind the nurses station with her shoes off and feet elevated. She was leaning back in her chair with her mouth open, and she could be heard snoring. At this time, Resident #3 was observed ambulating up and down the hallway of the unit and he/she greeted the surveyor. a. Resident #3 was admitted to the facility in February 2020 with diagnoses including vascular dementia, delusional disorder and generalized muscle weakness. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #3 is severely cognitively impaired evidenced by a score of five out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). The MDS also indicated Resident #3 has daily behaviors of wandering. Review of Resident #3's fall care plan dated 5/27/25 indicated: Focus: Resident #3 has had actual falls and is at risk for further falls due to his/her poor insight into safety, psychotropic drug use and unsteady gate. He/she does not call for assistance or recognize the call light. Actual fall 11/1/23; 5/23/25 actual fall sustained a minor abrasion on R (right) forehead. Interventions: Will be offered and assisted back to bed when observed to be ambulating late at night. Assist with ambulation (he/she often refuses hands on assist) provide cues for safety and offer (continued on next page)

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	225300	A. Building B. Wing	08/07/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	periods of rest. The Resident will be offered a chair to sit on when he/she is observed ambulating excessively on the unit. Resident #32 was observed exiting his/her room wrapped in a blanket and paced. b. Resident #32 was admitted to the facility in August 2024 with diagnoses including unspecified dementia, and delusional cognitive communication deficit. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #32 is severely cognitively impaired evidenced by a score of three out of a possible 15 on the Brief Interview of Mental Status Exam (BIMS). The MDS also indicated that Resident #32 has behaviors of rejecting care. Review of Resident #32's fall care plan dated 2/17/25 indicated: Resident is at risk for falls r/t confusion, incontinence, psychoactive drug use, wandering. Resident #2 was observed exiting his/her room and stood in the hallway briefly, then returned to his/her room. c. Resident #2 was admitted to the facility in November 2019 with diagnoses including catatonic schizophrenia and generalized muscle weakness. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #2 is severely cognitively impaired evidenced by a score of seven out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). The MDS also indicated Resident #2 had behaviors of rejecting care. Review of Resident #2's Fall Risk care plan, dated 11/23/21 indicated: Resident #2 is at risk for falls r/t psychoactive drug use, decreased safety awareness, stands for long periods of time. At 3:24 A.M., CNA #1 said that there were three staff on the unit and that Nurse #2 and CNA #2 should not be sleeping. At 3:25 A.M., Resident #3 continued to pace up and down the hallways and CNA #2 and Nurse #2 woke up. Nurse #2 said she, CNA #1, and CNA #2 were the staff on the unit and that the unit consisted of Residents who have dementia and behavioral issues. Nurse #2 said that there are Residents on the unit who are awake and wander all night long. At 3:31 A.M., Resident #3 continued to walk up and down the unit. CNA #2 then got up from the chair he had been asleep on and entered a closet. Resident #3 then walked over and sat on the chair. During an interview at 3:34 A.M., CNA #2 said that he had been asleep when the surveyor arrived and he should not have been. CNA #2 said that there are Residents who wander the unit all night long. The surveyor then observed Resident #32 re-emerge from his/her room wrapped in a blanket and shuffle to the nurses station. At 3:43 A.M., Resident #3 and Resident #32 continued to wander and pace the unit. During an interview at 3:45 A.M., Nurse #2 said she normally works the night shift, and she is not supposed to be sleeping at the nurses station. Nurse #2 said her shoes were off and she was asleep (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225300	A. Building B. Wing	08/07/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at the nurses station when the surveyor arrived. Nurse #2 said if she feels tired, she will set an alarm and find a room to sleep in. When the surveyor inquired which room she would go to, Nurse #2 then said she would go down to the break room. Nurse #2 said that there are residents who are awake and roam the unit all night long. During an interview on 8/7/2025 at 5:28 A.M., Corporate Nurse #1 and the Director of Nursing (DON) said they were not aware that residents had reported concerns regarding staff sleeping at night. The DON said that one awake CNA cannot provide sufficient supervision to residents on the unit. The DON said that overnight staff should be taking breaks on the unit, but not at the nurses station and there should be more than one person awake and alert to supervise. 2. The following was observed on the Main 1 unit, (a long term care unit), during an early morning visit on 8/7/25: At 3:21 A.M., the surveyor exited the elevator on the Main 1 unit, the surveyor observed Nurse #3 sitting at the nursing station with her head resting on her left palm and her eyes were shut. The surveyor did not observe any other staff members on the Unit. The surveyor made additional rounds on the unit to locate staff. At 3:23 A.M., the surveyor observed CNA #3 down the long hall in a small day room on the Main 1 unit. She was observed laying across the love seat with her eyes shut. The surveyor continued to make rounds on the unit to locate additional staff. At 3:25 A.M., the surveyor again observed Nurse #3 sitting at the desk with her head resting on her left palm with her eyes closed and she appeared asleep. At 3:26 A.M., the surveyor observed CNA #4 sitting in a small day room with a TV set at a loud volume. CNA #4 introduced herself to the surveyor and she began to walk towards the Main 1 unit nursing station with the surveyor. At 3:27 A.M., the surveyor heard the Main 1 unit phone ring, and Nurse #3 appeared startled and opened her eyes, and she answered the phone. The surveyor asked Nurse #3 if there were any staff on break and Nurse #3 said no. The surveyor asked Nurse #3 the location of the any additional staff members on the unit, and she said CNA #3 was down the long hall providing care to a Resident. The surveyor and Nurse #3 walked down the long hall and observed CNA #3 in the long hall in a small day room with her eyes shut laying across the love seat. Nurse #3 then said that CNA #3 must have been on her break. During an interview at 4:26 AM CNA #3 said that she was taking a break and was sleeping in the day room for her break from 3:00 A.M. to 3:30 A.M. CNA #3 said that she is to let the Nurse know when she goes on break and where she will be. CNA #3 said that she made Nurse #3 aware that she was going on break. During an interview at 4:43 A.M., CNA #4 said that on 8/7/25 at 3:26 A.M., she was on her break that was scheduled from 3:00 A.M., to 3:30 A.M., and she was watching TV in the small day room. CNA #4 said that she let Nurse #3 know she was going on break. During an interview at 4:04 A.M., Nurse #3 said that she does not sleep during her shift because she is unable to get comfortable. Nurse #3 once again said that CNA #3 was on his/her break when CNA #3 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225300	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was observed sleeping. During a follow up interview at 4:49 A.M., Nurse #3 said that there are no assigned break times, and the CNAs are supposed to communicate with her when they are going on break. Nurse #3 said that she was aware CNA #3 was on break, however this contradicted her initial interview. Nurse #3 said that both the CNAs should not be on break at the same time. During an interview on 8/7/25 at 5:32 A.M., the Director of Nursing said that the CNAs should communicate with the Nurse and the CNAs should let the nurse know when they are taking their breaks and they should both not be on break at the same time.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide adaptative equipment during meals for two Residents (#28 and #119) out of a total of 34 sampled residents. Findings include: 1. Resident #28 was admitted to the facility in August 2024 with diagnoses including epileptic seizures, autistic disorder and dysphagia. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #28 is severely cognitively impaired evidenced by a score of five out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). The MDS also indicated Resident #28 required supervision or touching assistance with eating. Review of Resident #28's physicians orders indicated: Patient to be provided with weighted utensils and 2 handle overed (SIC) cup with meals, 4/30/25 On 8/5/2025 at 8:08 A.M., the surveyor observed Resident #28 in his/her room eating breakfast. Resident #28's tray included weighted utensils and regular drinking glasses and mugs. Resident #28 used both hands to pick up a glass of juice. Resident #28's hand were shaking and he/she struggled to drink without spilling. Resident #28 said his/her breakfast was good but did not engage in further conversation. On 8/6/2025 at 7:58 A.M., the surveyor observed Certified Nursing Assistant (CNA) deliver Resident #28's breakfast meal. The tray included a plastic fork instead of weighted utensils and did not include two handled cups with covers. Review of Resident #28's meal ticket indicated: weighted utensils, weighted two handle cup with lid. Eats in room. On 8/6/2025 at 11:58 A.M., the surveyor observed Resident #28's lunch tray. The tray included a plastic fork instead of weighted utensils and did not include two handled cups with covers. The surveyor observed staff attempt to deliver Resident #28's lunch tray, but he/she declined. During an interview on 8/7/2025 at 6:53 A.M., the Food Service Director (FSD) said that specialty utensils for residents are indicated on the tray ticket. The FSD said dietary staff are expected to follow the tray ticket and place the correct utensils, cups and plates on the trays. Review of the Adaptive Equipment Tally Report, dated as printed on 8/7/25, indicated Resident #28 requires weighted utensils and a weighted two handle cup with lid. On 8/7/2025 at 7:57 A.M., the surveyor observed CNA #8 deliver Resident #28's breakfast tray which included weighted utensils but did not include two handled cups with lids. During an interview on 8/7/2025 at 8:02 A.M., Unit Manager #1 said the kitchen staff should be following the meal ticket and placing specialty equipment on resident trays. Unit Manager #1 said the team had a meeting yesterday (8/6/25) and that Resident #28 requires weighted utensils and two handled cups with lids with his/her meals. Unit Manager #1 was not aware Resident #28 was not receiving the two handled cups, or that he/she had been served meals with plastic forks instead of (continued on next page)

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	225300	A. Building B. Wing	08/07/2025

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weighted utensils. During an interview on 8/7/2025 at 8:19 A.M., the Director of Nursing (DON) said Residents with orders for weighted utensils and handled cups should receive them at meals. The DON was not aware Resident #28 was not receiving the two handled cups, or that he/she had been served meals with plastic forks instead of weighted utensils. 2. Resident #119 was admitted to the facility in March 2009 with diagnoses that include dysphagia and muscle weakness. Review of Resident #119's most recent Minimum Data Set (MDS) Assessment, dated 7/11/25, indicated that the Resident could not participate in the Brief Interview for Mental Status (BIMS) exam and is assessed by staff to have modified independence with cognitive skills for daily decision making. The MDS further indicates that Resident #119 requires supervision/ touching assistance with eating. On 8/5/25 at 9:08 A.M., the surveyor observed Resident #119 alone in his/her room eating breakfast in bed. The Resident had a built- up spoon utensil on his/her tray but did not have a blue mug or divided plate as indicated on his/her meal ticket. On 8/6/25 at 9:00 A.M., the surveyor observed a staff member set up the Resident's tray and exit the room. The Resident was in bed with the meal tray in front of him/her. There was no blue mug or divided plate on the tray. The Resident's coffee was in a regular coffee mug and the meal was served on a lip plate, but not a divided plate. On 8/6/25 at 12:24 P.M. the surveyor observed Resident #119 eating lunch in the dining room. His/her lunch was served on a lip plate, but not a divided plate. Resident #119 did not have a blue mug and his/her beverages were served in a Styrofoam cup with a straw. On 8/7/25 at 9:02 A.M., the surveyor observed Resident #119 eating breakfast in his/her room. The Resident's meal was not served on a divided plate. Review of Resident #119's meal ticket indicated the following: Adapt Equip (Adaptive Equipment): divided plate, built up utensil (spoon) Alerts: allergic to fish, blue mug, finger food Review of Resident #119's active activities of daily living (ADL) care plan indicated the following: EATING: [Resident] requires close supervision/ assist during meals, may have divided plate and built- up spoon for all meals. Review of Nutritional Comprehensive Assessment, dated 1/8/25, indicated the following: Diet order and rational: Reg, fort (fortified) foods, finger foods, PB&J @ L+D (peanut butter and jelly at lunch and dinner). 2 handled cup w/ lid, built up spoon, divided plate. Review of Adaptive Equipment Tally Report dated 8/7/25 provided from the kitchen indicated that Resident #119 requires the following: Built up utensil- spoon, divided plate. During an interview on 8/7/25 at 6:53 A.M., the Food Services Director said that specialty utensils are indicated on the tray ticket and staff are expected to follow the tray ticket and place the correct utensils, plates and other equipment on the trays. He said there is a report they can run and it's on the (continued on next page)

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	225300	A. Building B. Wing	08/07/2025

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meal ticket as well. During an interview on 8/7/25 at 9:07 A.M., Unit Manager #3 said that the kitchen should be putting all necessary adaptive equipment on the meal trays. She said that for Resident #119 the divided plate and blue mug should be provided for all meals. Unit Manager #3 said that when nursing staff are passing out meal trays, they should be ensuring that all necessary adaptive equipment is on the tray. During a follow up interview on 8/7/25 at 11:18 A.M., the Food Service Director said that he wasn't sure if they had divided plates in house but would order some if they didn't. He then came back to the surveyor and said they did have some and would ensure that the Resident was receiving it on his/her tray. The Food Service Director further said that the reason the blue mug is not on the adaptive equipment report is because it is written under alerts on the meal ticket but still should be on the Resident's tray. During an interview on 8/7/25 at 11:20 A.M., the Assistant Director of Nurses and Corporate Nurse said that the kitchen should ensure that all adaptive equipment listed as needed for a resident is on their trays, and that they receive it for all meals. They further said that nursing staff should be checking the trays during the meal pass and ensure that all necessary equipment is on the trays.

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	225300	A. Building B. Wing	08/07/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to maintain complete and accurate medical records for three Residents (#25, #78 and #15) out of a total sample of 34 residents. Specifically,1. For Resident #25, the facility failed to accurately document treatment administrations. 2. For Resident #78, the facility failed to accurately document the completion of a physician's order.3. For Resident #15, the facility failed to accurately document the route of medication administration. Findings include:1. Resident #25 was admitted to the facility in October 2013 with diagnoses including peripheral vascular disease and [NAME] insufficiency. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #25 was moderately cognitively impaired evidenced by a score of 11 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). The MDS also indicated Resident #25 had behaviors of refusing care. During an interview on 8/5/2025 at 9:57 A.M., the surveyor observed Resident #25's right leg was wrapped and dated 7/24/25. Resident #25 said he/she has edema and staff wrap his/her leg every three days. Review of Resident #25's physician's orders indicated: Wash RLE (right lower extremity) with warm soapy water, rinse and pat dry, wrap legs with unna boot from toes up to top of shin, change every three days, every day shift. On 8/5/2025 at 2:03 P.M., and 8/6/25 at 8:02 A.M. the surveyor observed Resident #25's leg wrap dated 7/24/25. Review of Resident #25's Treatment Administration Records, dated July 2025 and August 2025, indicated Resident #25's leg wrap was changed as ordered. During an interview on 8/6/2025 at 8:14 A.M., Unit Manager #1 said that Resident #25 always refuses treatments, and the staff should be documenting his/her refusals. Unit Manager #1 said staff should not document the treatments to Resident #25's right leg were completed because he/she had refused. 2. Resident #78 was admitted to the facility in September 2020 with diagnoses including schizophrenia, bipolar disorder and anxiety. Review of Resident #78's most recent Minimum Data Set (MDS) dated [DATE] had a Brief Interview for Mental Status score of 6 out of a possible 15, which indicated he/she has severe cognitive impairment. The MDS also indicated Resident #78 requires supervision for feeding tasks. Review of Resident #78's physician orders indicated the following orders: May use real utensils while in supervised area at lunch and plastic utensils at breakfast and dinner, every shift for Suicidal ideation with no plan, initiated on 6/30/24. On 8/5/2025 at 8:28 A.M., and 12:10 P.M., Resident #78 was observed eating meals in his/her room with no staff present in the room or in the hallways to supervise. The Resident was provided with regular utensils, including a knife. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225300	A. Building B. Wing	08/07/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/25 at 8:23 A.M. and at 12:20 P.M., Resident #78 was observed eating meals in his/her room with no staff present in the room or in the hallways to supervise. The Resident was provided with regular utensils, including a knife. Review of the Treatment Administrative Record for August 2025, indicated the nursing staff had marked the physician's order as complete indicating Resident #78 did not receive knives at the breakfast and lunch meals on 8/5/25 and 8/6/25. During an interview on 8/6/2025 at 12:22 P.M., Certified Nursing Assistant (CNA) #6 said Resident #78 is independent with meals and can use regular utensils, including a knife. During an interview on 8/6/2025 at 12:36 P.M., Nurse #5 said orders should not be signed off as completed if the order was not followed. During an interview on 8/6/2025 at 2:22 P.M., the Assistant Director of Nursing said Resident #78 should not have knives at meals and this order should not have been documented as completed if the Resident did receive knives at the four meals observed. During an interview on 8/7/25 at 7:50 A.M., the Director of Nursing said Resident #78 should not have knives at meals and this order should not have been documented as completed if the Resident did receive knives at the four meals observed. 3. Resident #15 was admitted to the facility in September 2023 with diagnoses that included cerebral infarction and dysphagia. Review of Resident #15's most recent Minimum Data Set (MDS) Assessment, dated 6/13/25, indicated that the Resident was unable to participate in a Brief Interview for Mental Status (BIMS) exam, and was assessed by staff as having severe impairment in cognitive skills and daily decision making. The MDS further indicated the use of a feeding tube. Review of Resident #15's active Physician's orders as of 8/6/25 indicated the following: -NPO (nothing by mouth) diet, NPO texture, NPO consistency, dated 3/25/24. -Aspiration precautions- elevate the head of the bed as tolerated to prevent aspiration, dated 7/8/24. -levETIRAcetam Oral Solution (a seizure medication) 100 mg/ml (milligrams per milliliter) (Levetiracetam), give 7.5 ml by mouth two times a day related to unspecified convulsions; other seizures, dated 9/18/23. -Senna Liquid (a medication to treat/prevent constipation) 8.8 mg/5 ml, give 5 ml by mouth two times daily for constipation, dated 9/8/23. Review of the August 2025 Medication Administration Record indicated that Levetiracetam and Senna were signed off as administered by mouth on 12 out of 12 opportunities. During an interview on 8/6/25 at 8:26 A.M., the surveyor inquired about observing Resident #15 receive medications. Nurse #6 said that she had just finished administering medications to Resident #15. She said that all medications were administered via G-tube (gastrostomy tube) and he/she does (continued on next page)

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	225300	A. Building B. Wing	08/07/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not take anything by mouth. Resident #15 was unable to participate in an interview. During an interview on 8/7/25 at 7:01 A.M., Nurse #3 said that Resident #15 has a feeding tube and receives nutrition through bolus feedings. She further said that all medications are administered through the feeding tube, and Resident #15 does not take anything by mouth. During an interview on 8/7/25 at 7:07 A.M., Unit Manager #3 said Resident #15 takes nothing by mouth, including medications. Unit Manager #3 said that medications signed off as being administered by mouth would be inaccurate. During an interview on 8/7/25 8:02 A.M., the Director of Nurses said that for Resident #15, medications signed off as being administered by mouth would be inaccurate. She said nurses should not sign off that medications are being administered by mouth because the Resident is NPO (cannot take anything by mouth). The Director of Nurses said the medications should be ordered to be administered via the Resident's feeding tube.