STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225309	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ledgewood Rehabilitation and Nursing Center	87 Herrick Street Beverly, MA 01915

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on record reviews and interviews, for one of three sampled residents (Resident #1), who was totally dependent on staff for his/her Activities of Daily Living (ADL) care needs, the Facility failed to ensure staff consistently provided necessary services to meet his/her ADL care needs, when on 5/16/25 Resident #1's request to nursing for care during the evening shift were not met and he/she was not provide care until the next morning. Findings include: Review of the Facility's Care and Treatment for ADL Care Policy, dated September 2024, indicated ADLs are provided in accordance with resident preference and needs. The Policy indicated that appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, oral care), mobility, and toileting. Review of Resident #1's clinical record indicated diagnoses included morbid obesity, Type 2 Diabetes with Polyneuropathy, and Acquired Absence of Right Leg Below Knee. Review of Resident #1's Care Plan Report, updated on 04/15/25, indicated he/she had self care and mobility deficits related to muscle weakness and activity intolerance. The Care Plan Report indicated he/she was nonambulatory, required a two person assist with a mechanical lift for transfers, was dependent for bathing needs, required an assist of two for repositioning in bed, dependent for use of bedpan and incontinent care, and to provide a sponge bath when full bath not tolerated. Review of Resident #1's Resident Profile (CNA care plan), dated 04/22/25, indicated Resident #1 did not ambulate, required a mechanical lift with two or more staff for transfers, was incontinent of bladder and bowel, and was totally dependent with a two person assist for bathing, grooming, positioning and toileting. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 04/24/25, indicated he/she was dependent on staff for personal hygiene, toilet hygiene, bathing, upper body dressing, and lower body dressing. The MDS indicated he/she had intact cognitive functioning and was frequently incontinent of bladder and bowel. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/17/25 at 11:45 A.M., Resident #1 said there was a day recently (exact date unknown) that around 11:00 P.M., he/she had been incontinent and requested staff to provide care. Resident #1 said CNA #1 told him/her that there was no other staff member there to assist him (CNA #1) to provide his/her care, and that he (CNA #1) needed to wait for the other CNA to come on the unit. Resident #1 said he/she had been incontinent of bowel and remained in bed without incontinence care for a total of nine hours until the 7:00 A.M. shift CNA arrived. During a telephone interview on 06/23/25 at 12:50 P.M., Nurse #1 said around 9:00 P.M. on 05/16/25, Resident #1, who was lying in bed, asked for assistance. Nurse #1 said Resident #1 did not specifically request incontinent care, but asked for assistance to get ready for bed for the night. Nurse #1 said she reminded Resident #1 that his/her assigned CNA had offered to provide care before she left at 9:00 P.M. Nurse #1 said she told Resident #1 that she would try to find assistance for Resident #1 from another CNA, and if they were unable, he/she would receive care from the CNAs that arrive at 11:00 P.M. for the evening (11:00 P.M. to 7:00 A.M.) shift. Nurse #1 said at the time of Resident #1's request, the CNA on the side of the unit she had been working on was assisting another resident, and that she did not know what the other CNA on the unit was doing. Nurse #1 said Resident #1 did not receive care prior to the end of her shift (11:00 P.M.) that night. Nurse #1 said when Nurse #2 arrived for the start of his shift (at 11:00 P.M.), she told Nurse #2 that they had not been able to provide care to Resident #1 on the last part of their shift (from 9:00 P.M. to 11:00 P.M.) and that he/she needed care. Nurse #1 said Resident #1 should not have had to wait until the next shift for care. Nurse #1 said she should have ensured Resident #1 received care after his/her request by either assisting an available CNA herself or asking the other Nurse working on the unit to help her. During a telephone interview on 06/23/25 at 9:10 A.M., Nurse #2 said he told CNA #1 that based on the change of shift report he received, Resident #1 had not received care as requested on the preceding shift and that they needed to provide it. Nurse #2 said since Resident #1 was incontinent of bowel, he assumed the care he/she had requested after 9:00 P.M. was for bowel incontinence. Nurse #2 said Resident #1 required a two person assist with care in bed. Nurse #2 said two CNAs were scheduled for the night shift (on 5/16/25 from 11:00 P.M. into 5/17/25 until 7 :00 A.M.) that night, however one CNA did not report to work as scheduled. Nurse #2 said at no time during the shift did CNA #1 indicate that he/she needed assistance to care for Resident #1. Nurse #2 said he assumed CNA #1 went to another unit to obtained assistance from a CNA for Resident #1 and that Resident #1 had received care. Nurse #2 said a CNA from another unit was sent to his unit to assist with care around 5:00 A.M. that day. Nurse #2 said he had provided Resident #1 with drinks during the shift and administered him/her medication at 6:00 A.M., and that Resident #1 never said he/she was still waiting for staff to provide care. During a telephone interview on 06/23/25 at 12:00 P.M., CNA #1 said upon his arrival to the unit at 11:00 P. M. on 05/16/25, Nurse #2 told him Resident #1 had not received care during the preceding shift. CNA #1 said at the start of the shift Resident #1 rang his/her call light, and asked him for incontinent care. CNA #1 said he told Resident #1 that he was waiting for the other CNA to arrive to provide assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 said he told Nurse #2 around 11:15 P.M. and again at 12:00 A.M. that the other CNA scheduled had not come to work on the unit, and that Nurse #2 told him to wait until someone arrived. CNA #1 said at around 5:00 A.M. a CNA from another unit came to provide assistance with resident care on the unit. CNA #1 said Resident #1's care needs were not provided before the 7:00 A.M. shift arrived. During a telephone interview on 06/17/25 at 3:05 P.M., Nurse #3 said she was scheduled for the day shift (7:00 A.M. to 3:00 P.M.) on 05/17/25. Nurse #3 said at around 8:00 A.M. she responded to Resident #1's call bell light, and Resident #1 stated he/she had been waiting since 11:00 P.M. to be changed but no one came to his/her room. Nurse #3 said with Resident #1's bed sheet pulled down, she could see that he/she had a bowel movement. Nurse #3 said she immediately coordinated care for Resident #1. During a telephone interview on 06/11/25 at 2:50 P.M., CNA #2 said at around 8:00 A.M. on 05/17/25 Resident #1 told her that he/she had a bowel movement, the previous night, had been waiting to be changed and asked her to provide care. CNA #2 said Nurse #3 was made aware and care was immediately provided. CNA #2 said the stool on Resident #1 was dry in appearance, like it had been there for many hours. During an interview on 06/11/25 at 2:00 P.M., the Director of Nurses (DON) said staff should ask a resident specifically what care is needed to determine if additional assistance is needed. The DON said Resident #1 should have received the care he/she requested in a timely manner in accordance with his/her plan of care with the assistance of nurse(s) and/or CNA(s). The DON said communication between staff needed to be clearer, that assistance with care was needed to provided at that time, so the resident(s) were not left to wait.