STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225324	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Newton Healthcare	25 Armory Street West Newton, MA 02465

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 records reviewed, interviews, and observations, for one of three sampled residents (Resident #1), who was readmitted to the facility from the hospital with a new diagnosis of seizures, the facility failed to ensure they developed and implemented a comprehensive individualized care plan specific to his/her associated risk of seizure activity, that included interventions, goals and outcomes. Findings include:Review of the facility's policy, titled Care Plans, Comprehensive Person-Centered, with a revision date of 01/2024, indicated the following:-A comprehensive, person-centered care plan will be developed for each resident. The care plan will include objectives that meet the resident's physical, psychosocial and functional needs and is developed for each resident.-Evaluation of residents is ongoing and care plans are revised as information about the resident and the resident's conditions change.Resident #1 was admitted to the facility in April 2026 diagnoses included dementia and chronic kidney disease.Review of Resident #1's Nursing Progress Note, dated 04/19/26, indicated that he/she had one episode of vomiting followed by shaking, facial twitching, and uncontrollable movements. The Note indicated Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation and treatment.Review of Resident #1's medical record indicated he/she was readmitted to the facility on [DATE].Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated he/she had a primary discharge diagnosis of Seizures. The Summary indicated he/she sustained his/her first known seizure on 04/19/26 which lasted greater than 15 minutes in duration.Review of Resident #1's Comprehensive Care Plan indicated there was no documentation to support that he/she had an individualized care plan that included or addressed the following:-New diagnosis of seizures.-Monitoring and reporting seizure activity.-Interventions to maintain a safe environment during seizure activity.During an interview on 06/04/26 at 2:51 P.M., the Minimum Data Set (MDS) Coordinator said that she monitors resident care plans for completion and accuracy. The MDS Coordinator said she initiates a seizure precaution care plan for residents who have a diagnosis of a seizure disorder. The MDS Coordinator said the Unit Managers used to generate most of the resident care plans but two of them recently quit.During an interview on 06/04/26 at 3:00 P.M., the Director of Nurses (DON) said it was his expectation that nursing would have added or revised Resident #1's care plan following his/her hospitalization and new diagnosis of seizures.

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
	225324	A. Building B. Wing	06/04/2026

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on records reviewed and interviews, for one of three sampled Residents (Resident #1) who was experiencing an emergent change in condition, the facility failed to ensure quality of care was provided when multiple facility staff members did not know the access code to the elevator and Emergency Medical Services (EMS) were delayed in transporting him/her to the Hospital Emergency Department (ED) for evaluation and treatment. Findings include:Review of the Report submitted via the Health Care Facility Reporting System (HCFRS), dated 04/22/26, indicated that on 04/19/26 Resident #1 experienced a medical emergency and Emergency Medical Services (EMS) were unable to release the elevator in a timely manner due to code [series of numbers required to be enter into the keypad located inside the elevator] not being provided [by facility staff] in a timely manner. Resident #1 was admitted to the facility in April 2026, diagnosis included dementia. Review of Resident #1's Nursing Progress Note, dated 04/19/26, indicated he/she had an episode of vomiting, shaking, facial twitching and uncontrollable movements. The Note indicated a physician's order was obtained to transfer him/her to the Hospital ED for treatment and evaluation. During a telephone interview on 06/05/26 at 2:45 P.M., Nurse #1 said she was on duty on 04/19/26 when Resident #1 experienced a seizure. Nurse #1 said the keypad on the inside of the elevator was for the Wanderguard system (a system that alarms when a resident wearing a wanderguard bracelet is within the alarm's vicinity).Nurse #1 said the codes were supposed to be kept in the Resource Binder on the Unit, but when she and other staff members looked, the codes were not there. Nurse #1 said she called an off-duty employee to get the code. Nurse #1 said it took EMS about ten minutes to leave the facility. During an interview on 06/04/26 at 2:12 P.M., the Administrator said the codes should be in the Resource binder and he concluded that the problem was nursing staff didn't know where to look for the codes.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. Based on records reviewed and interviews for two of three sampled residents (Resident #2 and Resident #3), who were at risk for developing Diabetes-related foot complications, the Facility failed to ensure they received proper care and treatment to maintain good foot health.Findings include:During an interview on 06/04/26 at 1:20 P.M., the Director of Clinical Operations said the Facility did not have a policy related to the care and services for a resident with Diabetes or a policy for Diabetic foot care.1) Resident #2 was admitted to the facility in December 2025 diagnoses included Diabetes Mellitus with diabetic neuropathy (damage or dysfunction to the nerves). Review of Resident #2's medical record indicated there was no documentation to support that the nursing staff obtained a physician's order to administer diabetic foot care to him/her nightly.Review of Resident #2's Treatment Administration Records for the months of February 2026 through June 2026, indicated there was no documentation to support diabetic foot care was being provided. 2) Resident #3 was admitted to the facility in October 2022 diagnoses included Diabetes mellitus with neuropathy.Review of Resident #3's medical record indicated there was no documentation to support that nursing staff obtained a physician's order to administer diabetic foot care to him/her nightly.Review of Resident #3's Minimum Data Set (MDS) assessment, dated 05/09/26, indicated Resident #3 was alert and oriented and had a Brief Interview for Mental Status (BIMS) score of 15 (0-7 suggests severe cognitive impairment, 8-12 suggest moderate cognitive impairment, and 13-15 suggest no cognitive impairment).During an interview on 06/04/26 at 12:10 P.M., Resident #3 said nursing did not wash or apply lotion to his/her feet nightly.During an interview on 06/04/26 at 2:26 P.M., Nurse #3 said that she often works the evening shift (3:00 P.M. through 11:00 P.M.) and provides diabetic foot care for the residents that have a physician's order. Nurse #3 said that all residents who have a diagnosis of Diabetes should have an order for daily diabetic foot care.During a telephone interview on 06/05/26 at 8:09 A.M., Nurse #1 said she provides diabetic foot care when the resident has a physician's order to do so.During an interview on 06/04/26 at 3:00 P.M., the Director of Nurses (DON) said it was his expectation that diabetic foot care should be done at least weekly and it should include a foot soak. The DON said he was working on a facility policy for diabetic foot care.