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	12/18/2025

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

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure four Residents (#5, #62, #98 and #9), out of a total sample of 27 residents, received the necessary care and treatment, consistent with professional standards of practice, to prevent the development of pressure ulcers. Specifically: 1. For Resident #5 who had a stage 4 pressure ulcer (full Thickness and tissue loss appears as full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) the facility failed to consistently implement a physician's ordered air mattress.2. For Resident #62, who had a stage 3 pressure ulcer, the facility failed to ensure that the wound doctor's treatment orders were being followed as recommended.3. For Resident #98, the facility failed to ensure that the air mattress was set to 100 pounds as per the physician's order.4. For Resident #9, who is assessed to be at high risk for developing pressure ulcer/injuries, the facility failed to ensure weekly skin evaluations were completed weekly and timely. Findings include: Review of the facility policy titled, Prevention and management of Pressure Ulcers/Injuries, dated as revised 11/2024, indicated the purpose of this policy is to ensure a resident receives care consistent with professional standards of practice to prevent pressure ulcers and/or residents with pressure ulcers receive necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. Risk Assessment: Develop the resident-centered care plan and interventions based on the risk factors identified, the condition of the skin, the resident's overall clinical condition. 6. Select appropriate support surfaces based on the resident's mobility, continence, body size, weight, and overall risk factors. 1. Resident #5 was admitted to the facility in October 2022 with diagnoses including hemiplegia and hemiparesis following cerebral infraction affecting the left non-dominant side, seizures, contracture of the left hand, and glaucoma. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/23/25, indicated that Resident #5 had a moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. This MDS indicated Resident #5 did not reject care and was dependent on staff for upper and lower body dressing. This MDS indicated Resident #5 was at risk for developing pressure ulcers and had one stage four pressure ulcer. On 12/15/25 at 7:30 A.M., the surveyor observed Resident #5 in a room that was not assigned to him/her. He/she was on a standard mattress, and his/her heels were directly on the mattress. Nurse #1 said that Resident #5 was moved on Thursday 12/11/25 so his/her room could be painted. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/15/25 at 8:33 A.M., the surveyor observed the Hospice Home Health Aide (HHA) providing care to Resident #5. The HHA said that Resident #5 did not have his/her air mattress. The surveyor observed a dressing on Resident #5's left foot. On 12/16/25 at 6:50 A.M., 12/16/25 at 8:51 A.M., and 12/16/25 at 3:42 P.M., the surveyor observed Resident #5 on his/her air mattress. The air mattress was not plugged in and was not functioning, the power cord was observed to be disconnected from the device resting on the floor. Resident #5's air mattress was not inflated. Review of Resident #5's NSH Norton Scale for Predicting Risk for Pressure Ulcers - V2, dated 10/20/25, indicated Resident #5 scored an eight indicating that he/she was at high risk for skin breakdown. Review of Resident #5's physician's orders, dated 12/1/25, indicated: -Wound Care Stage IV (four) Left Medial Heel - wash with normal saline, pat dry, apply calcium alginate to wound bed and cover with abdominal pad, wrap with kerlix and secure with tape once daily and everyday shift, every other day. Review of Resident #5's physician's orders, dated 12/4/24, indicated: -Check air mattress setting every shift patient weights 107 pounds, setting #2. Review of Resident #5's plan of care related to pressure ulcer left heel related to immobility, dated as revised 10/10/25, indicated: -Special Mattress as ordered. Review of Resident #5's Treatment Administration Record (TAR), indicated that nursing documented Resident #5's air mattress was in place on: -Friday 12/12/25, all three shifts, -Saturday 12/13/25, evening and night shift, -Sunday 12/14/25, day and night shift, -Monday 1215/25, all three shifts, and on -Tuesday 12/16/25, all three shifts. Review of Resident #5's consultant wound note, dated 12/11/25, focused wound exam (site 5) stage 4 pressure wound of the left medical heel full thickness indicated: -2.2 x 2 x not measurable in depth due to presence of necrosis. Review of Resident #5's consultant wound note, dated 12/16/25, focused wound exam (site 5) stage 4 pressure wound of the left medical heel full thickness indicated: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-2 x 1.1 x 0.1 centimeter (cm). During an interview on 12/17/25 at 7:43 A.M., Nurse #1 said that he moved Resident #5's room on Thursday morning (12/11/25) because Resident #5's room needed to be painted and Nurse #1 said he thought it was only going to be a day job. Nurse #1 said that he did not move Resident #5's air mattress because he didn't think Resident #5 would have been in the room for that long. Nurse #1 said that the air mattress is provided to Resident #5 because he/she has a pressure ulcer on his/her foot and that he is supposed to check for functioning and placement each shift. During an interview on 12/17/25 at 3:19 P.M., the Director of Nursing (DON) said nursing should have moved Resident #5's air mattress with the room move. The DON said that the air mattress is for pressure ulcer relief. 2. Resident #98 was admitted to the facility in September 2014 with diagnoses including type 1 and 2 diabetes mellitus, schizophrenia and age-related osteoporosis. Review of Resident #98's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Score of 10 out of 15 indicating moderate cognitive impairment. Further review of the MDS indicated that the Resident requires assistance from staff for Activities of Daily Living, has a current stage 3 unhealed pressure ulcer and is at risk of developing pressure ulcers/injuries. During an interview on 12/15/25 at 7:55 A.M., Resident #98 said he/she feels lousy and that his/her bottom hurts. The Resident said he/she has an open area on her buttocks. During a follow up interview on 12/16/25 at 8:26 A.M., Resident #98 said his/her backside hurts because of his/her open area on his/her skin. Review of Resident #98's Norton Scale for Predicting Pressure Ulcers evaluation (clinical tool used to assess a patient's risk of developing pressure ulcers) dated 11/24/25 indicated that the Resident scored a 6 indicating that he/she is at a high risk for developing pressure ulcers. Review of Resident #98's weekly skin evaluation dated 12/9/25 indicated the following: Left Ischium Wound, treatment order in place Review of Resident #98's physician's order dated 11/24/25 indicated the following: - Left ischium wound (the lower, back part of your left hip bone) – NS (normal saline) wash, apply hydrogel and xeroform gauze to wound, apply skin prep to surrounding intact skin, cover with foam dressing, every day shift Review of Resident #98's Wound Evaluation and Management Summary conducted by the wound physician on 11/19/25, 11/25/25, 12/2/25 and 12/11/25 indicated the following: - Summarized Wound Care Assessment and Individualized Treatment Plan: Stage 3 Pressure Wound of the Left Ischium. - Dressing Treatment Plan: Primary Dressing: Hydrogel w/ (with) silver apply once daily and as (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed: if saturated, soiled, or dislodged. Xeroform gauze apply once daily and as needed: if saturated, soiled or dislodged. Review of Resident #98's physician's order dated 12/16/25 at 10:48 A.M., transcribed into medical record by Corporate Nurse #1, indicated the following: - Left ischium wound – NS wash, apply silvasorb gel and xeroform gauze to wound, apply skin prep to surrounding intact skin, cover with foam dressing. On 12/16/25 at 11:09 A.M., the surveyor observed a wound treatment on Resident #98's left ischium performed by Nurse #10, Corporate Nurser #1 was also observing the treatment. The 12/16/25 physician's order was used for the wound treatment – silvasorb gel and xeroform gauze. During an interview on 12/16/25 at 11:28 A.M., the surveyor asked Corporate Nurse #1 why the wound order was changed from hydrogel to silvasorb 21 minutes before the wound treatment observation, Corporate Nurse #1 said the facility ran out of hydrogel so she switched it to silvasorb. Corporate Nurse #1 said Resident #98 normally gets hydrogel for his/her stage 3 left ischium wound. The surveyor and Corporate Nurse #1 reviewed the Wound Doctor's recommendations indicated that Resident #98 should be getting hydrogel with silver. The surveyor and Corporate Nurse #1 then reviewed the Treatment Administration Record for December 2025 which indicated that staff have been applying hydrogel, not hydrogel with silver every day. Corporate Nurse #1 said she did not realize that Resident #98 was supposed to be getting hydrogel with silver and staff have been using the wrong treatment medication as recommended by the Wound Doctor. Corporate Nurse #1 said the silver decreases the chance of getting bacteria in the wound and not using hydrogel with silver can increase the chance of bacteria getting in the wound. Corporate Nurse #1 said the Wound Doctor comes in weekly and assesses Resident #98's wound and makes treatment recommendations which should then be applied to the Resident's orders. During an interview on 12/16/25 at 11:35 A.M., Nurse #10 said silver will improve the wound healing and it is different than just hydrogel. Nurse #10 said he follows the orders as written and he was unaware the written order was different than what the Wound Doctor recommended. During an interview on 12/16/25 at 11:53 A.M., the Physician Assistant (PA) said the facility should follow the Wound Doctor's recommendations, the PA then said the silver acts as an anti-bacterial. During an interview on 12/16/25 at 2:55 P.M., the Director of Nursing (DON) said the Wound Doctor comes in weekly and makes rounds and will make treatment recommendations which then get transcribed to himself. The DON then said he will confer with the Medical Director and then they will get entered as physician's orders for the Residents. The DON said Resident #98 should have been receiving hydrogel with silver, not just hydrogel. The DON continued to say that the silver acts as antibiotic and it helps with the bioburden of the wound and by not using silver could possibly cause the wound to not improve. 3. Resident #62 was admitted to the facility in September 2024 with diagnoses including dementia, adult failure to thrive and moderate protein-calorie malnutrition. Review of Resident #62's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that Resident #62 had a Brief Interview for Mental Status score of 0 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident was dependent on staff (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for activities of daily living and is at risk of developing pressure ulcers and at the time had one stage 3 pressure ulcer. The surveyor made the following observations: On 12/15/25 at 7:05 A.M. and 2:48 P.M., 12/16/25 at 6:50 A.M. and 12/17/25 at 7:17 A.M., Resident #62 was sleeping in his/her bed, Resident #62 was using an air mattress, and the air mattress pump was set to 250 pounds. Review of Resident #62's Weights and vital summary indicated that the Resident weighed 89.2 pounds on 12/9/25. Review of Resident #62's physician's order dated 9/25/25 indicated the following: Air Mattress: Set to 100 – Check and document setting every shift one time a day every 14 days for wound care Review of Resident #62's Norton Scale for Predicting Pressure Ulcers evaluation (clinical tool used to assess a patient's risk of developing pressure ulcers) dated 12/8/25 indicated that the Resident scored a 6 which indicated that the Resident is at a high risk for developing pressure ulcers. Review of Resident #62's weekly skin evaluation dated 12/14/25 indicated the following: coccyx area/groin area fragile, barrier cream applied. Review of Resident #62's skin breakdown care plan, dated and revised 9/23/25, indicated the following interventions: administer treatments as ordered and monitor effectiveness, Air mattress on bed. Review of Resident #62's Kardex (a form indicating the type of care a resident needs) indicated the following under the Resident Care section: administer treatments as ordered and monitor effectiveness, Air mattress on bed. During an interview on 12/18/25 at 9:04 A.M., Nurse #7 said air mattresses should be set to the weight of the resident or by physician's order. Nurse #7 said Resident #62's skin is fragile and he/she has had open areas in the past so we use the air mattress as a preventative measure. Nurse #7 said Resident #62's air mattress should not have been set to 250 pounds as it would be too firm. During an interview on 12/18/25 at 9:04 A.M., Unit Manager #2 and Corporate Nurse #1 said air mattresses should be set by what the Resident's weight is. Unit Manager #2 said she noticed yesterday that Resident #62's air mattress was at the incorrect setting, so she switched it to 100 pounds. Unit Manager #2 said if the air mattress is set too high it will be too firm for Resident #62. During an interview on 12/18/25 at 9:40 A.M., the Director of Nursing (DON) said air mattress settings should be set to the physician's order and the purpose of them is for pressure relief and they can be used as a preventative measure for pressure ulcers. The DON said Resident #62's air mattress should have been set to 100 pounds. 4. For Resident #9 the facility failed to ensure weekly skin evaluations were completed weekly and timely. Review of the facility's policy titled, Prevention and management of Pressure Ulcers/Injuries, revised (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/2024 indicated, Risk Assessment, 4. License nurse conducts a weekly skin evaluation. Resident #9 was admitted to the facility in June 2016 and has diagnoses that include but are not limited to unspecified dementia, type 2 diabetes mellitus, and chronic kidney disease. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #9 scored a 3 out of 15 on the Brief Interview for Mental Status Exam, indicating severe cognitive impairment. Further, the MDS indicated Resident #9 is at risk of developing pressure ulcers/injuries. During an observation on 12/15/25 at 8:58 A.M., Resident #9 was observed in the dining room eating his/her breakfast. Resident #9 was observed to be a person who requires care. Resident #9 smiled but was unable to participate in an interview. Review of Resident #9's clinical record indicated the following: -NSH Norton Scale for Predicting Risk of Pressure Ulcers dated 9/7/25 and 10/20/25 categorized Resident #9 as high risk for developing pressure ulcers, with a score of 4. -A care plan indicating Resident #9 as incontinent and has potential complications associated with frequent urinary and bowel incontinence, diminished perception, history of dementia, dated as revised 11/15/23 with the goal, Resident will have intact skin through next review, revised 10/17/25. -A care plan indicating Resident has potential for skin breakdown d/t (due to) frequent incontinence, dx (diagnosis) diabetes and quarterly Norton Score, revision date 5/14/25, interventions included license nurse to monitor skin weekly for alteration in skin integrity, dated initiated 3/21/20. Review of the physician's orders failed to indicate an order for a weekly skin evaluation. Review of the documented Weekly Skin Evaluations dated November 2025, failed to indicate a Weekly Skin Evaluation, was completed on 11/10/25 or within the week. Further, the last documented Weekly Skin Evaluation was documented on 12/1/25. During an interview of 12/17/25 at 9:35 A.M., Nurse #9 said all residents are assessed for risk for developing skin issues and a plan of care is determined by the risk level. Nurse #9 said all residents have a weekly skin assessment completed. Nurse #9 said Resident #9 is at risk for developing pressure areas because he/she is in a wheelchair and is diabetic. Nurse #9 reviewed Resident #9's medical record and said the Resident's weekly skin evaluation was missed and now is overdue. During an interview on 12/18/25 at 10:00 A.M., Unit Manager #2 said Resident #9 is high risk for developing pressure areas, and a weekly skin check is required to be documented on skin evaluation in the medical record weekly.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to ensure dental services were provided for four Residents (#51, #81, #73, #72) out of a total sample of 27 Residents. Specifically, the facility failed to:1. Ensure Resident #51 was provided with consent to be seen by dental services resulting in the Resident not being seen by a dentist while residing in the facility for one year.2. Ensure Resident #81 was seen by dental services following a physician's order.3. Ensure Resident #73 had follow up as required following a dental visit.4. Ensure Resident #72 was seen by dental services following a physician's order. Findings include:Review of the facility policy titled Ancillary Physician Services, dated and revised March 2025, indicated the following: - Routine dental services are available to meet the resident's health needs. - Routine dental services are provided to our residents through: a contract agreement with a licensed Dentist that come to the facility routinely. - Social Services or nursing representatives will assist residents with appointments - Services are record in the resident's medical record. 1. Resident #51 was admitted to the facility in November 2024 with diagnoses including adjustment disorder and anxiety disorder. Review of Resident #51's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 13 out of 15 indicating intact cognition. Further review of the MDS indicated that the Resident has obvious or likely cavities or broken natural teeth and does not have dentures. During an interview on 12/15/25 at 7:43 A.M., Resident #51 was observed to have no bottom teeth and missing the majority of his/her teeth. Resident #51 told the surveyor that he/she has no teeth and has not seen the dentist since living in this facility but would like to. During a follow-up interview on 12/17/25 at 9:13 A.M., Resident #51 told the surveyor that he/she still would like to see a dentist because he/she has no teeth and that no one has ever approached him/her about it. The Resident continued to say he/she would like to get some information about dentures. Review of Resident #51's physician's orders indicated the following order: - Consults: Dental services as needed – Dated 11/18/24 Review of Resident #51's Care plan dated 12/1/25 indicated the following: - Focus: DENTAL: Resident #51 has no front teeth, he/she has rear teeth only - Interventions: Cut up meat as ordered, Refer to Dentist as needed Review of Resident #51's medical record indicated a Request for Service document indicating that the (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident consented to be seen by dental services. The form was signed on 12/16/25, one year after the Resident was admitted to the facility. Further review of the medical record failed to indicate that Resident #51 has ever been seen by the dentist or dental hygienist. The surveyor requested the most recent dental visitation logs dated for September 2025, and Resident #51 was not on the list. During an interview on 12/17/25 at 2:12 P.M., Nurse #7 said we obtain a consent form for dental services when a resident is admitted to the facility and then we fax it to the contracted dental services provided and then the Resident will be seen by the dentist. When asked why Resident #51's dental consent form was not obtained until a year after his/her admission Nurse #7 said she did not know about it and it should have been done when he/she was admitted to the facility so he/she could be seen by the dentist. Nurse #7 said she did not know Resident #51 wanted to see a dentist. During an interview on 12/18/25 at 9:03 A.M., Unit Manager #2 and Corporate Nurse #1 said consent to be seen by dental services is obtained upon admission to the facility and then it is faxed to the dental company. They then said if a resident expressed desire to be seen by a dentist we would arrange an appointment. Unit Manager #2 and Corporate Nurse #1 said they were not aware no dental consent was obtained until yesterday and Resident #51 should have been seen by the dentist by now. During an interview on 12/18/25 at 9:35 A.M., the Director of Nursing (DON) said consent for dental services is obtained on admission to the facility, the DON said he is still getting familiar with how the dental process works in the facility and they are trying to figure out a system. The DON then said Resident #51 should have been seen by the dentist by now. 2. Resident #81 was admitted to the facility in May 2025 with diagnoses including adult failure to thrive, major depression, and cognitive impairment. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/7/25, indicated that Resident #81 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of the MDS failed to indicate any dental issues. During an interview on 12/15/25 at 7:33 A.M., Resident #81 said he/she has a missing tooth and would like to see the dentist. During an interview on 12/17/25 at 9:00 A.M., Resident #81 said he/she does still have tooth pain and would like to be seen by the dentist. Review of Resident #81's physician's order, dated 8/2/25, indicated please put him/her on list for the dentist visit. Review of Resident #81's physician's progress note, dated 8/2/25, indicated resident is requesting dental visit, pain in tooth, missing tooth. Review of Resident #81's medical record indicated a Request for Service document indicating that the Resident consented to be seen by dental services. The form was signed on 8/6/25. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's dental visit list, dated 8/12/25, failed to include Resident # 81. Review of Resident #81's physician's order, dated 9/16/25, indicated left sided tooth pain, consult outpatient dentist for consult. Review of Resident #81's entire medical record failed to include any dental visits since admission. Review of Resident #81's care plan on 12/17/25 failed to include a plan of care related to dental. During an interview on 12/17/25 at 8:16 A.M. Unit Manager #2 said she was not aware that Resident #81 had an issue with his/her teeth or that there was an order to be seen by the dentist. She said the process for receiving ancillary services in the facility is to request consent when a resident is admitted and then fax to the ancillary service so the resident can be added to the next schedule. She said if there was an issue that needs attention prior to the next scheduled visit then the facility can contact a local provider for the resident to see. During an interview on 12/18/25 at 9:35 A.M., the Director of Nursing (DON) said that he has only been the DON since July and is currently trying to figure out a system for setting up ancillary services needed by the residents. He was unaware that Resident # 81 had dental issues or had an order to be seen by the dentist. He said that there had been some difficulty getting resident set up for ancillary services related to such things as insurance coverage, however, he would expect documentation of any attempts to set up these services. 3. Resident #73 was admitted to the facility in September 2024 with diagnoses including adult failure to thrive, cerebral infarct, and dysphagia. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/5/25, indicated that Resident # 73 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Further review of the MDS failed to indicate any dental issues. During an interview on 12/17/25 at 9:00 A.M., Resident #73 said that he/she had seen the dentist a few months ago and had been waiting to get dentures but had not heard anything. Review of Resident #73's plan of care related to dental, dated as revised 9/16/25, indicated is edentulous. He/she would like new upper and lower dentures. Review of Resident #73's physician's order, dated 9/4/24, indicated he/she has an order for a dental consult as needed. Review of Resident #73's dental group exam, dated 9/11/25, indicated patient has no teeth, patient would like full upper and lower dentures, full upper and lower dentures will aid in mastication. Nursing home staff were asked to have responsible party sign consent for denture form. During an interview on 12/18/25 at 9:18 A.M. Unit Manager #2 said that she was unaware of Resident #73's request for dentures or anything about the consent for denture form. Review of Resident #73's entire medical record failed to include a consent for denture form. During an interview on 12/18/25 at 9:35 A.M., the Director of Nursing (DON) said that he has only been the DON since July and is currently trying to figure out a system for setting up ancillary services needed by the residents. He was unaware about Resident #73 requesting dentures or where the (continued on next page)

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	225324	A. Building B. Wing	12/18/2025

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

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consent form would be. He said he would expect documentation in the Resident's medical record to indicate any communication regarding this. 4. Resident #72 was admitted to the facility in October 2022 with diagnoses including severe protein-calorie malnutrition, anxiety, and depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/17/25, indicated that Resident # 72 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Further review of the MDS failed to indicate any dental issues. During an interview on 12/15/25 at 7:33 A.M., Resident # 72 said he/she would like to see the dentist as he/she had broken teeth. During an interview on 12/17/25 at 9:25 A.M., Resident #72 said he/she would like to be seen by the dentist as he/she had difficulty managing his food sometimes. Review of Resident #72's physician's order, dated 11/7/25, indicated needs to follow up with dentist broken tooth making hard for him to swallow. Review of Resident #72's medical record on 12/17/25 indicated a blank Request for Service (to receive ancillary services) over three years after Resident had been admitted to the facility and over a month after Resident had a physician's order to follow up with a dentist. Review of Resident #72's plan of care related to the teeth, dated as revised 2/17/2022, indicated care deficit pertaining to the teeth or oral cavity characterized by: altered oral mucous membrane; problems with dentures/ teeth/ gums. Interventions include: Refer to dentist as needed. Review of Resident #72's entire medical record failed to indicate any assessment of his/her oral cavity or contact with dentist to follow up with his/her broken tooth, failed to indicate any consent to receive dental services in facility or that he/she had received dental visits since admission. During an interview on 12/17/25 at 8:16 A.M. Unit Manager #2 said she was not aware that Resident #72 had an issue with his/her teeth or that there was an order to be seen by the dentist. She said the process for receiving ancillary services in the facility is to request consent when a resident is admitted and then fax to the ancillary service so the resident can be added to the next schedule. She said if there was an issue that needs attention prior to the next scheduled visit then the facility can contact a local provider for the resident to see. During an interview on 12/18/25 at 9:35 A.M., the Director of Nursing (DON) said that he has only been the DON since July and is currently trying to figure out a system for setting up ancillary services needed by the residents. He was unaware that Resident # 72 had dental issues or had an order to be seen by the dentist. He said that there had been some difficulty getting resident set up for ancillary services related to such things as insurance coverage, however, he would expect documentation of any attempts to set up these services.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interviews, the facility failed to have an effective immunization program in place for 11 Residents out of a total sample of 27 residents. Specifically, the facility failed to ensure the influenza vaccine was administered as soon as in became available. Findings include:Review of the facility policy titled Influenza Vaccine, dated as revised 11/5/20, indicated all residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza.-Administration of the influenza vaccine will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of vaccination.-Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents unless the vaccine is medically contraindicated, or the resident has already been immunized.-Residents admitted to the facility between October 1st and March 31st shall be offered the vaccine.-Prior to the vaccination, the resident or resident's legal representative will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such educations shall be provided in the residents' medical record.- For the residents who receive the vaccine, the date of vaccination will be included in the resident's medical record.Review of the CDC guidelines titled Who Needs a Flu Vaccine, dated 9/18/25, indicated the following:-Everyone 6 months and older should get a flu vaccine every season with rare exceptions. Vaccination is particularly important for people who are at higher risk for serious complications from influenza.-Flu vaccination has important benefits. It can reduce flu illnesses, visits to doctor's office's .as well as make symptoms less severe and reduce flu-related hospitalizations and deaths in people who get vaccinated but still get sick.-Administration of the influenza vaccine when it becomes available rather than on a specific date.-vaccination is ideally recommended to occur in September or October to offer the best protection, before the season peaks.Review of the CDC guidelines titled People at Increased Risk for Flu Complications, dated 9/11/24, indicated some of the people at increased risk for complications of the flu are:-Adults aged 65 and older-People with Chronic lung disease-People with blood disorders-People with heart disease-People with a Body Mass Index (BMI) of 40 Kg (kilograms)/M (meters) or higher-People with a weakened immune system due to .chronic conditions requiring chronic corticosteroids or other drugs Review of 27 Resident medical records failed to indicate that 11 of the 27 Residents were offered/administered the influenza vaccination.During an interview on 12/18/25 at 9:45 A.M., the Director of Nursing (DON) said that the facility's influenza program includes everyone with consents will get immunized. An order must be obtained to administer the vaccine and then the order will be transcribed on the Medication Administration Record (MAR) and after the vaccine is administered it will also be recorded in the electronic record under the immunization tab.He said that in October the facility vaccinated the first wave of residents for everyone that had consents and wanted vaccines. He said that all new admits are offered the vaccine and medical record checked to see if they have already received. The DON said the influenza season starts in October and the facility did have the vaccine available at that time. He said there had been a lot of resistance from residents agreeing to receive the vaccine and from getting the consents returned from legal representatives.The DON said that there is no real excuse as to why some residents have not received the influenza vaccine despite having orders and consent since October.

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	225324	A. Building B. Wing	12/18/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, the facility failed to ensure that Residents on the third-floor unit were provided with a dignified existence. Specifically, the facility failed to ensure that staff members were not using their personal cellphones in the Resident Dining Room while Residents were occupying it. Findings include: Review of the facility policy titled Resident Rights, dated and revised January 2024 indicated the following:- Employees shall treat all residents with kindness, respect and dignity- Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence. During the survey period, the surveyor made the following observations:On 12/15/25 at 10:48 A.M., multiple Residents were observed sitting at the table in the dining room, a Certified Nursing Assistant (CNA) was standing, leaning against the counter with her cellphone in her hand not interacting with any Residents. On 12/16/25 at 10:30 A.M., multiple Residents were observed sitting at tables in the dining room, a Certified Nursing Assistant (CNA) was sitting in a chair documenting care on a tablet, while doing so she was texting on her personal cell phone in view of facility Residents.During an interview on 12/18/25 at 9:15 A.M., Unit Manager #2 and Corporate Nurse #2 said all residents are expected to have a dignified existence in the facility and staff members should not be on their phones in front of residents. During an interview on 12/18/25 at 9:46 A.M., the Director of Nursing said residents deserve a dignified existence in the facility and staff members should not be using their cell phones in front of residents in the dining room.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for one Resident (#2), out of 27 sampled residents. Specifically, for Resident #2 the facility failed to code a fall with major injury (subacute L1 fracture, a bone in the lumbar spine). Findings include: Resident #2 was admitted to the facility in January 2023 with diagnoses including traumatic brain injury, abnormal posture, and a history of falling. Review of the Minimum Data Set (MDS) assessment, dated 10/10/25, indicated that Resident #2 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. This MDS indicated Resident #2 had one fall with minor injury. Review of the RAI manual, dated October 2025, indicated a major injury is a fall including bone fractures. Review of Resident #2's incident report, dated 7/30/25 at 9:30 P.M., indicated:-he/she was found with half his/her face on the floor and lying on his/her left side by certified nursing assistant while going to do a brief change. Has knot to left forehead. Director of Nursing made aware. Review of Resident #2's nursing note, dated 7/30/25, indicated he/she was found with half his/her face on the floor and lying on his/her left side by certified nursing assistant while going to do a brief change. Has knot to left forehead. Director of Nursing made aware. Review of Resident #2's nursing note, dated 7/31/25, indicated Resident #2 came back to the facility after sustaining a head strike from a fall in his/her room at the facility. Scans of the head are normal with a subacute compression fracture for L1 vertebra. Review of Resident 32's hospital Discharge summary, dated [DATE], indicated: -Seen in the emergency department after a fall. They did find a subacute fracture of your L1 vertebra. During an interview on 12/16/25 at 10:33 A.M., the MDS Nurse said that she codes falls based on the RAI manual and she should have coded the L1 fracture as fall with major injury, but she did not. During an interview on 12/16/25 at 10:30 A.M., the Director of Clinical Operations said that falls should be coded according to the RAI manual.

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	225324	A. Building B. Wing	12/18/2025

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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 observations, record review and interview, the facility failed to ensure that Activities of Daily Living were provided for dependent Residents for three Residents (#57, #88, #13) out of a total sample of 27 Residents. Specifically, the facility failed to:1. Ensure incontinent care was provided in a timely manner for Resident #57, who is assessed as incontinent of bladder and bowel, resulting in Resident #57 sitting in a soiled brief for an extended period. 2. Ensure that incontinent care was provided within a timely manner for Resident #88 who is assessed as incontinent of bowel and bladder resulting in Resident #88 sitting in a soiled brief for an extended period.3. Ensure that Resident #13 was supervised during mealtimes as indicated by the plan of care. Findings include: Review of the facility policy titled Activities of Daily Living (ADLS), Supporting, dated and revised November 2024, indicated the following: - Residents will be provided with care, treatment and services as appropriate to maintain or improve as able their ability to carry out activities of daily living (ADLs). - 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: Elimination (toileting), Dining (meals and snacks) 1) Resident #57 was admitted to the facility in July 2023 and has diagnoses that include but are not limited to muscle weakness, lupus (an autoimmune condition in which the body's immune system attacks its own tissues and organs and causes swelling and irritation, inflammation, that may affect joints, skin, kidneys, blood cells, brain, heart and lungs), spondylopathy cervical region (degenerative changes affecting the spinal column), and anxiety. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #57 scored 15 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as cognitively intact. Further, the MDS indicated Resident #57 did not display behaviors and is dependent on staff for daily care activities including toileting, is incontinent of bladder and bowel and is at risk for developing pressure ulcer/injuries. During an interview on 12/15/2025 at 4:48 P.M., Resident #57 was greeted by the surveyor in the dining/activity room. Resident #57 said he/she has been out of bed since around 10:00 A.M. and has been asking to go back to bed. Resident #57 said he/she has not been changed since he/she got up and is soaked. Resident #57 became weepy and said 7 hours is too long to be out of bed. During an interview on 12/16/25 at 9:01 A.M., Resident #57 said he/she gets up on Mondays, Wednesdays and Fridays and on the days he/she stays in bed, he/she can use the call bell to be changed. Resident #57 said on the days he/she is out of bed; I drink and need to be changed, I know I am wet or sometimes soiled. Resident #57 voice wavered, said he/she is upset with being out of bed for seven hours at a time. On 12/17/25 at 10:01 A.M., Resident i#57 was observed being provided with care and Certified Nursing Assistant (CNA) #1 said Resident #57 was getting up today. On 12/17/2025 at 10:23 A.M., Resident #57 was out of bed in his/her wheelchair in the dining/activity (continued on next page)

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	12/18/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. On 12/17/25 the following observations and interviews were conducted by the surveyor: -At 11:13 A.M., Resident #57 was participating in an activity. When the activity was over Resident #57 was moved to his/her spot in the room where he/she remained through his/her lunch meal. -At 1:07 P.M., Resident #57 said he/she had not been changed, that he/she remained in the corner, and they (staff) know I have a diaper on. Resident #57 filled up with tears as he/she spoke to the surveyor. -At 1:55 P.M., Resident #57 remained in the same area in the activity/dining room. Resident #57 said he/she is wet and has not been checked or offered to be changed. -At 2:15 P.M., Resident #57 was provided an oatmeal cookie by a staff Certified Nursing Assistant. -At 2:34 P.M., Resident #57 eyes were closed, and he/she was observed dozing in his/her wheelchair. -At 2:42 P.M., Resident #57 was drinking a beverage left in front of him/her. -At 2:55 P.M., Resident #57 said he/she is wet and he/she wants to get back to bed. Resident #57 said now I will need to wait for the 3-11 staff. -At 3:26 P.M, Resident #57 remained in the same area in the activity/dining room. Resident #57 said he/she is wet, that he/she has not been asked to be changed and that after five hours he/she is tired and uncomfortable. -At 4:31 P.M., Resident #57 observed dozing in chair. He/she woke up and said no one had approached him/her about being changed, He/she said he/she is tired and just stuck here. -At 5:10 P.M., the Resident #57 remained in his/her wheelchair in the activity/dining room. During an interview on 12/18/25 at 8:30 A.M., Resident #57 said he/she got back into bed around dinner time on 12/17/25. Review of Resident #57's medical record indicated the following: -CNA task documentation of behavior monitoring and interventions dated 12/13/25, 12/14/25, 12/15/25, 12/16/25 and 12/17/25 indicated 'no behaviors observed'. -A care plan for potential alteration in skin integrity, immobility obesity, lupus, cervical spondylosis, incontinence of bladder and bowel, revised 7/15/25 Interventions include but are not limited to protect skin with incontinent care. -A behavioral care plan, Resident #57 has a behavior problem. He/she is reported to being verbally abusive, resistive to care etc. dated revised 10/13/25. Interventions included anticipate care needs and provide before the resident becomes overly stressed date initiated 7/12/23. -An incontinence care plan, resident has the potential for complications associated with bowel and (continued on next page)

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	225324	A. Building B. Wing	12/18/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bladder incontinence, revision date 7/15/25, goal, Resident #57 will be kept clean and dry and comfortable daily through next review, target date 1/16/26, Interventions included Check and change resident every 2-3 hours and as needed for incontinent episodes, date initiated 7/19/24. -A Kardex (a breakdown of the care plan and care requirements for each resident, used by care staff) printed and dated 12/18/25, Bladder/Bowel, check and change resident every 2-3 hours and as needed for incontinent episodes. During an interview on 12/17/25 at 4:37 P.M., Certified Nursing Assistant (CNA) #2, said Resident #57 is up in his/her wheelchair a few days a week when she comes in on the 3:00 P.M.-11:00 P.M., shift. CNA #2 said she will change Resident #57 when he/she gets transferred into bed. CNA #2 said Resident #57's requires two staff to transfer back to bed using the mechanical lift. CNA #2 said Resident #57's brief will be soiled with feces sometimes and is always wet and often his/her clothing is wet through. CNA #2 said Resident #57 is incontinent and needs to be checked and changed every 2 to 3 hours. During an interview on 12/18/25 at 8:42 A.M., CNA #1 said residents who are incontinent are to be changed every 2-3 hours. CNA #1 said Resident #57 is incontinent, drinks a lot and needs to be changed and asked to be changed when she is in bed. CNA #1 said Resident #57 uses a large brief. CNA #1 said Resident #57 has a schedule to be out of bed a few days a week. CNA #1 said she cared for Resident #57 yesterday (12/17/25) and that she did not nor did any other staff change Resident #57 once he/she was up in his/her wheelchair. CNA #1 said the next shift should have got him/her into bed to be changed around 3:00 P.M, or after. CNA #1 said Resident #57 should not be up for over four hours. CNA #1 said Resident #57 told her that on Monday (12/15/25) that he/she was up until 7:00 P.M. CNA #1 said she cares for the Resident and does not want him/her to get skin wounds for being up too long. During an interview on 12/18/25 at 9:07 A.M., Unit Manager #2 said residents who have incontinence should be checked and changed, and given appropriate incontinence care every 2 to 3 hours. Unit Manager #2 said Resident #57 could be transferred into bed to be provided with incontinent care and can get back up if he/she chooses to. During an interview on 12/18/25 at 9:28 A.M., Nurse #6 said to prevent skin breakdown for residents who are incontinent they should be checked and changed every few hours. Nurse #6 said Resident #57 does not exhibit behaviors, is incontinent and should be provided with incontinent care every few hours whether he/she is in bed or up in his/her wheelchair. Nurse #6 said Resident #57 is alert and oriented and does not always ask for assistance and should not have to ask for care. 2. Resident #88 was admitted to the facility in April 2020 with diagnoses including Alzheimer's disease, dementia, chronic kidney disease stage 3b, anxiety disorder and heart failure. Review of Resident #88's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status score of 2 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident requires substantial/maximal assistance with toileting hygiene, substantial/maximal assistance with toilet transfer, and staff assistance with walking. Review of Resident #88's Kardex (a form indicating the level of care a resident needs) indicated the following under the Resident Care section: (continued on next page)

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	12/18/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Bladder: incontinent, Bowel: incontinent - Toileting: assist to dependent Review of Resident #88's Activities of Daily Living (ADL) care plan, dated and revised 9/18/25, indicated the following: - Focus: Resident #88 has ADL self-care deficit as evidenced by incontinence of bladder and bowel -Interventions: Bladder: Incontinent, Bowel: Incontinent, Toileting: assist to dependent, Toileting – provide encouragement/supervision/assist/reminders. Provide incontinent care q (every) occurrence. Review of Resident #88's bowel and bladder care plan dated and revised 6/24/25 indicated the following: - Focus: Resident #88 is incontinent of bowel and bladder R/T (related to) decreased awareness of his/her needs d/t (due to) cognitive loss secondary to dementia, impaired mobility d/t muscle weakness and lack of coordination - Intervention: Assist with toileting and incontinence care, as needed Review of Resident #88's quarterly Nursing Evaluation, dated 12/1/25, indicated the following: Bladder: Continence/Incontinence – Incontinence is checked. Bowel: Continent of Stool? – No. Bowel Incontinence – frequently incontinent The surveyor made the following continuous observations of Resident #88 on 12/16/25: - At 10:10 A.M., Resident #88 was sitting in the corner of the dining room out of direct sight with his/her head down on a tray table. - At 11:07 A.M., Resident #88 was sitting in the corner of the dining room out of direct sight with his/her head down on a tray table. At no time during the observations did the surveyor observe staff check on or offer to change Resident #88. - At 12:40 P.M., Resident #88 was observed eating his/her lunch in the same spot in the dining room. - From 1:03 P.M. through 1:19 P.M., Resident #88 was still sitting in corner of the dining room out of direct sight. - At 2:08 P.M., just under four hours since the initial observation, the Occupational Therapist took Resident #88 to his/her room. The surveyor made the following continuous observations of Resident #88 on 12/17/25: - At 7:14 A.M., Resident #88 left his/her room using a rolling walker with a staff member and went into the corner of the dining room out of direct sight. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- From 8:01 A.M. through 8:21 A.M., Resident #88 ate his/her breakfast in the same spot in the dining room. - At 9:10 A.M., Resident #88 was sitting in the corner of the dining room out of direct sight. At no time during the observations did the surveyor observe staff check on or offer to change Resident #88. - From 9:30 A.M., through 11:00 A.M., Resident #88 was sitting in the corner of the dining room out of direct sight with his/her head down on a tray table. At no time during the observations did the surveyor observe staff check on or offer to change Resident #88. - At 11:16 A.M., just over four hours since the initial observation, Certified Nursing Assistant (CNA) #4 began walking Resident #88 to his/her room. CNA #4 told the surveyor he was going to toilet and put Resident #88 to bed. As CNA #4 began changing Resident #88's brief, Nurse #7 took over changing his/her brief. Nurse #7 showed the surveyor Resident #88's brief and it was soiled and swollen with bright yellow urine. During an interview on 12/17/25 at 11:23 A.M., CNA #4 said he knows the Resident's level of care by looking at the care plan and by what the nurses tell him. CNA #4 then said incontinent residents should be checked by staff every two hours to see if they urinated or had a bowel movement. CNA #4 said he was not sure the last time Resident #88 was toileted, the surveyor told him he/she has not been offered since 7:14 A.M. and CNA #4 said Resident #88 should have been offered to toilet before right now. During an interview on 12/17/25 at 11:25 A.M., Nurse #7 told the surveyor incontinent residents should be checked for an incontinence episode every two hours and Resident #88 should have been checked for an incontinence episode prior to when he/she just was checked. During an interview on 12/17/25 at 1:41 P.M., CNA #3 said Resident #88 is dependent on staff for toileting and he/she should be checked every two hours for incontinence. Nurse #7 then said Resident #88 has dementia and he/she cannot voice his/her needs all of the time. During an interview on 12/18/25 at 9:07 A.M., Unit Manager #2 and Corporate Nurse #1 said CNA's should be checking if incontinent residents are wet every 2-3 hours. When asked about Resident #88, Unit Manager #2 and Corporate Nurse #1 said Resident #88 is incontinent of bladder and bowel and needs to be checked every 2-3 hours and should have been checked sooner. During an interview on 12/18/25 at 9:26 A.M., the Director of Nursing (DON) said incontinent residents should be checked every 2-3 hours and Resident #88 should have been checked sooner. 3. Resident #13 was admitted to the facility in March 2018 with diagnoses including schizophrenia, dementia and muscle weakness. Review of Resident #13's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 14 out of 15 indicating intact cognition. Further review of the MDS indicated that the Resident required supervision or touching assistance with eating. The surveyor made the following observations: (continued on next page)

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	12/18/2025

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 12/15/25 at 7:14 A.M., Resident #13 was sitting in his/her wheelchair eating his/her breakfast in his/her room. No staff were present in the room supervising the Resident or supervising from the hallway. Resident #13's room is the last room at the end of the hallway. - On 12/16/25 at 12:26 P.M., Resident #13 was sitting in his/her wheelchair eating his/her breakfast in his/her room. No staff were present in the room supervising the Resident or supervising from the hallway. Resident #13's room is the last room at the end of the hallway. - On 12/17/25 from 8:16 A.M. through 8:29 A.M., Resident #13 was sitting in his/her wheelchair eating his/her lunch in his/her room. No staff were present in the room supervising the Resident or supervising from the hallway. Resident #13's room is the last room at the end of the hallway. - On 12/17/25 at 12:18 P.M., Resident #13 was sitting in his/her wheelchair eating his/her breakfast in his/her room. No staff were present in the room supervising the Resident or supervising from the hallway. Resident #13's room is the last room at the end of the hallway. Review of Resident #13's Kardex (a form indicating the level of care a resident needs) indicated the following under the Resident Care section: - EATING: Supervision with set up help Review of Resident #13's Activities of Daily Living (ADLs) care plan dated and revised 9/9/20, indicated the following: Focus: Resident has ADL Self-Care Deficit as evidenced by needs assistance with bathing, dressing, feeding. - Interventions: EATING: Supervision with set up help, Resident #13 prefers to eat in his/her room. Eats meals supervised in the main dining room as tolerated During an interview on 12/17/25 at 1:41 P.M., Certified Nursing Assistant (CNA) #3 said she thinks Resident #13 is independent with meals and does not need supervision. During an interview on 12/17/25 at 2:12 P.M., Nurse #7 said we look at a Resident's care plan and Kardex for ADL care. Nurse #7 said Resident #13 is independent with meals and does not need supervision. Nurse #7 said she was unaware that Resident #13's medical record indicated supervision with meals. During an interview on 12/18/25 at 8:56 A.M., Unit Manager #2 and Corporate Nurse #1 said staff should follow the care plan and Kardex for what level of ADL care they need. Unit Manager #2 said supervision means someone needs to be watching Resident #13 while he/she eats but that is difficult if he/she eats in his/her room. During an interview on 12/18/26 at 9:26 A.M., the Director of Nursing (DON) said his expectation is that staff follows each Resident's care plan for ADL care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to provide and implement an ongoing activities program for one Resident (#88) to meet his/her needs for engagement in meaningful activities, out of a total sample of 27 residents.Findings include:The surveyor requested a policy on Resident Activities, but the facility said they do not have a Resident Activities policy.Resident #88 was admitted to the facility in April 2020 with diagnoses including Alzheimer's disease, dementia, chronic kidney disease stage 3b, anxiety disorder and heart failure. Review of Resident #88's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicating that the Resident had a Brief Interview for Mental Status score of 2 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident requires substantial/maximal assistance with toileting hygiene, substantial/maximal assistance with toilet transfer, and staff assistance with walking. Review of Resident #88's most recent Annual MDS dated [DATE] indicated the Resident enjoys reading books, newspapers or magazines, listening to music, doing things with groups of people, participating in favorite activities and spending time outdoors.Review of Resident #88's Kardex (a form indicating the type of care a resident needs) indicated the following under the Activities section: Invite to scheduled activities.Review of Resident #88's Care plans indicated the following dated and revised 10/28/25:Focus: Resident has previous recreational interest/patterns: Daily contact with close friends and/or relatives. Resident #88 Enjoys watching TV and listening to music. He/she will often engage in activities such as art projects. Even with the language barrier he/she enjoys being included and easy to understand activities. Resident #88 is currently a long-term care resident. He/she is at risk for social isolation due to language barrier, some physical limitations, and some cognitive impairment. However, Resident #88 is able to communicate through gestures and some limited English vocabulary, Resident #88 loves music, dancing, watching TV and enjoys one to one attention.Interventions: Introduce to other residents with similar interests, disabilities and/or limitations, invite to scheduled activities, offer to assist/escort resident to activity functions, offer variety of activity types and locations.Review of the Certified Nursing Assistant (CNA) documentation for December 2025 indicated that CNA's only documented activity participation for Resident #88 on 12/2/25 and 12/4/25 through 12/17/25.Review of Resident #88's quarterly Recreation Assessment conducted by the Activities Director dated 7/3/25 indicated the following:- Primary Language: Cantonese- Summary/Notes: Resident #88 participates in all of the music programs and enjoys singing! He/she also loves when family comes to visit him/her. The recreation department will continue to encourage Resident #88's social and cognitive progress.Review of Resident #88's quarterly Recreation Assessment conducted by the Activities Director dated 9/4/25 indicated the following:- Primary Language: Cantonese- Summary/Notes: Resident #88 spends a lot of time with other residents in the activities room. He/she enjoys watching TV, coloring and is frequently visited by family. The recreation department will continue to encourage and monitor Resident #88 in his/her social progress, accommodating for his/her language barrier.Review of Resident #88's quarterly Recreation Assessment conducted by the Activities Director dated 12/5/25 indicated the following:- Primary Language: CantoneseSummary/Notes: Resident #88 does not like larger groups and does not like group activities due to language barrier, but loves one on one visits with staff, He/she enjoys coloring and having his/her nails painted. When doing independent activities, he/she likes to watch TV in the living room with other residents. The recreation department will continue to monitorThe surveyor made the following observations in the third-floor dining room:- On 12/15/25 at 7:49 A.M., Resident #88 was in the corner out of direct sight of staff members, he/she had his/her head resting face down on a bedside table.- On 12/15/25 at 12:13 P.M., Resident #88 was in the corner out of direct sight of staff members, he/she had his/her head resting face down on a bedside table.- On 12/16/25 at 10:10 A.M., Resident #88 was in the corner out of direct sight of staff members, he/she (continued on next page)

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	225324	A. Building B. Wing	12/18/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had his/her head resting face down on a bedside table. Three Certified Nursing Assistants (CNAs) were in the dining room, one was documenting on an iPad and the other was on their personal cell phone not engaging with Resident #88.- On 12/16/25 at 11:07 A.M. and 1:03 P.M., Resident #88 was in the corner out of direct sight of staff members, he/she had his/her head resting face down on a bedside table., staff were not engaging with Resident #88.- On 12/16/25 at 1:19 P.M., the Activities Director came to the dining room to invite residents to live music on the second-floor dining room. The Activities Director did not attempt to speak to Resident #88 who was in the corner of the dining room.- On 12/17/25 at 7:14 A.M., staff were observed assisting Resident #88 out of his/her bedroom into the dining room where he/she was brought to the same corner seat in the dining room. At 9:10 A.M., Resident #88 was observed sitting in the same spot, on the bedside table was the daily activities calendar that was printed in English.- On 12/17/25 at 9:51 A.M., Resident #88 was in the corner out of direct sight of staff members, he/she had his/her head resting face down on a bedside table, the TV was on playing a show in English. Staff were not engaging with Resident #88. At 10:10 A.M., Resident #88 still had his/her head resting face down on a bedside table with no activities in front of him/her. From 10:10 A.M., through 11:16 A.M., CNAs and nurses entered the dining room but did not engage with Resident #88 nor provide him/her with any activities.During the surveyor's observations, none of the activities mentioned in his/her care plan and Recreation Assessment including art projects, music, TV in his/her language, coloring and nail painting were offered to Resident #88.Review of the facility's December activity calander indicated that Resident #88 did not participate in any of the scheduled activities from 12/15/25 through 12/17/25 from 9:00 A.M. through 2:00 P.M.During an interview on 12/17/25 at 1:41 P.M., CNA #3 said Resident #88 does not like to do anything, but staff should be offering him/her things to do.During an interview on 12/18/25 at 10:13 A.M., the Activities Director said she is in charge of the activities department, makes the facility's activity calendar, does individualized activities and completes each Resident's activities care plan. The Activities Director said we will talk to Residents who cannot read or comprehend a calendar, and we know the residents so we will know what activities each resident enjoys. The Activities Director said the facility has a lot of activity material for individual activities including puzzles, sorting materials and coloring supplies and she would expect staff to pass out activities to residents not involved in group activities. The Activities Director said Resident #88's cognition and communication is low and he/she has never been able to communicate in English to me. The Activities Director said Resident #88 loves to be greeted, likes to observe things, likes to interact with others, likes to color and likes to have his/her nails painted. The Activities Director said she would expect staff to offer Resident #88 activities and interact with him/her and hopes staff would be providing him/her material.During an interview on 12/18/25 at 12:41 P.M., Corporate Nurse #1 said Resident #88's Activities Assessment should be followed and staff should be engaging with him/her.

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	225324	A. Building B. Wing	12/18/2025

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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 observation, record review and interview, the facility failed to ensure professional standards in quality of care for one Resident (#87), out of a total sample of 27 residents. Specifically, for Resident #87, the facility failed to identify skin injuries on the soles of Resident #87's feet. Findings include: Resident #87 was admitted to the facility in March 2023 and has diagnoses that include but are not limited to iron deficiency anemia, furuncle unspecified (a pus-filled skin abscess of a hair follicle caused by a bacterial infection), an open abdominal wound, malignant neoplasm of the liver and bile duct, impulsiveness, adult failure to thrive, and dementia.Review of the most recent Minimum Data Set assessment dated as submitted 10/16/25 indicated Resident #87 scored a 7 out of 15 on the Brief Interview for Mental Status exam indicating he/she has severe cognitive impairment. Further the MDS indicated Resident #87 required partial/moderate assistance for lower body dressing, including footwear and displayed other behaviors 4-6 days in the look back period and rejection of care in 1-3 days of the look back period. The MDS did not code Resident #87 as having other wounds or skin problems. On 12/15/25 at 7:59 A.M., Resident #87 was observed lying in bed with both feet exposed and within view. Resident #87's left great toe was observed with small dark red areas on top of the toe and multiple scattered dark red areas were located on the sole of his/her left foot. Resident #87's right foot was observed with a few dark red areas. Resident #87 said there was no problem with his/her feet, and that they do not use any cream or treatment. Resident #87 said he/she just wanted food. During an observation on 12/15/25 at 11:27 A.M., the surveyors observed Resident #87, who was lying in bed with his/her feet exposed and visible. Resident #87's left great toe had dark red discoloration consistent with scabs and the sole of his/her left foot had a red open area with exposed layer of skin and other reddened scab like areas. The sole of his/her right foot had a few dark red scab-like areas. Resident #87 had an intact abdominal dressing dated 12/15/25. On 12/15/25 at 4:08 P.M., Resident #87 was observed walking in croc like shoes without socks. On 12/16/25 at 9:28 A.M., Resident #87 was resting in bed with his/her feet exposed and visible. Resident #87 was observed to have multiple red scab-like and open area on his/her left sole of his/her foot and great toe. Resident #87's right sole of foot had a few dark red scab-like areas. On 12/17/25 at 8:25 A.M., the surveyors observed Resident #87 lying on his/her back in bed. Resident #87 abdominal dressing was off, and his/her hands were stained blood colored. Resident #87 feet were exposed and visible. Resident #87's left foot had open areas and multiple dark red scab-like areas on the sole and dark red areas on the left great toe. Resident #87's right foot had red scab-like areas on the sole of his/her foot. Resident #87 asked what was wrong with his/her feet. Review of the progress notes dated from 12/1/25 through 12/16/25 in Resident #87's clinical record failed to indicate any documentation on the areas on Resident #87's left and right feet. Review of the weekly skin evaluations documented in the clinical record indicated on 12/12/25 Resident #87 refused the weekly skin evaluation. Prior to 12/12/25 the last documented weekly skin evaluation was dated 10/29/25. Review of the Norton Scale for predicting Risk of Pressure Ulcers dated 9/23/25 indicated Resident #87 as low risk with a score of 16. Review of Resident #87's physician's orders included the following:-Apply criticaid clear moisture barrier to heels and buttocks three times per day/PRN (as needed) for prevention, order date 5/12/25. -weekly skin check every evening shift every Tue. (Tuesday) Order dated 5/13/25 -wound prevention skin prep to bilateral heels every shift for skin prevention, order date 8/19/25. Review of the physician's orders failed to indicate an order to monitor or treat the open and red scab areas on the bottom of Resident #87's left and right feet. Review of the December 2025 Treatment Administration Record indicated the following: -Apply criticaid clear moisture barrier to heels and buttocks three times a day/PRN (and as needed) was signed off as administered 12/1/25 through 12/16/25 three times a day, thus indicating licensed nursing staff were in contact with Resident #87's feet three times a day and failed to note or identify the areas observed on Resident #87's feet. -Wound prevention: skin prep to bilateral heels every shift for prevention was (continued on next page)

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	225324	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signed off as administered all three shifts from 12/1/25 through day shift on 12/17/25, thus indicating licensed nursing staff were in contact with Resident #87's feet to provide the prevention treatment and failed to identify the areas on Resident #87's left and right feet. Review of Resident #87's care plans include the following:Behavior, Resident has a behavior problem. He/she is reported to neglect self-care, refuse care, scratch self, picking at self, spitting etc. contributing factors may include: Dx (diagnosis) of dementia, DX of other specified depressive episode, Dx of dysthymic (depression) DO (disorder), revised 9/25/25. Goal Resident #87 will not harm him/herself or others secondary to his/her behavior through next review, revision on 12/12/25 Interventions included but not limited to encourage resident to stop picking at abdominal wound. Review of the care plan failed to have interventions related to Resident #86 picking or causing injury to other areas of his/her body including his/her feet. During an interview on 12/17/25 at 1:34 P.M., Nurse #5 said Resident #87 has a wound and treatment on his/her stomach and has a prevention treatment to his/her heels. Nurse #5 said she was not aware of any other areas on his/her feet and that she did not receive report from staff that Resident #87 had areas on the soles of his/her feet. Nurse #5 said the Resident does walk around with no shoes on at times and is low risk for developing pressure ulcers and has weekly skin checks. Nurse #5 said if changes in a resident's skin are identified an incident report is completed, the Nurse Practitioner/Doctor are called to obtain orders to monitor or provide treatment as indicated. Nurse #5 said Resident #87 has a history of removing his/her abdominal dressing and picking at scabs and could reach his/her feet. Nurse #5 and the surveyor went to observe Resident #87, but he/she was unavailable and in the dining activity room. During an interview on 12/17/25 at 2:19 P.M., Certified Nursing Assistant (CNA) #1 said Resident #87 has behaviors of picking his/her skin including his/her feet. CNA #1 said the Resident refuses to let the nurses put cream on his/her feet. CNA #1 said the nurses know the Resident has areas on the bottom (sole) of his/her feet. CNA #1 said the areas on the bottom of the Resident's feet look worse right now.During an interview on 12/18/25 at 10:03 A.M., Unit Manager #2 said Resident #87 can be very non-complaint, but staff can create a rapport with him/her, especially if you provide a snack. Unit Manager #2 said if new areas are identified the doctor is notified to see if they want treatment for the area. Unit Manager #2 said nursing should be aware of new areas to monitor, put in interventions and that should be done to prevent the wounds from worsening or leading to possible infection.During an interview on 12/18/25 at10:08 A.M., the Director of Nursing said the nursing staff should be aware of new skin areas on a resident, even if they have known behaviors, to monitor provide treatment as indicated and prevent infection or worsening of the wounds.

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	225324	A. Building B. Wing	12/18/2025

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one Resident (#43), out of a total sample of 27 residents, received proper treatment to maintain vision ability. Specifically, the facility failed to implement Resident #43's ophthalmologist's recommendations for a prednisolone eye drop taper (medication used to treat non-infectious eye inflammations, including those caused by surgery) and to discontinue Cosopt (eye drop used to lower raised pressure in the eye and treat glaucoma, a disease that is caused by increased pressure inside the eye, resulting in vision loss if untreated) after eye surgery. Findings include: Review of the facility policy titled, Ancillary Physician's Services, dated 3/2025, indicated routine optometry, podiatry, dental and audiology services are available to meet the resident's health needs. 2. Residents have the right to select an optometrist of their choice when services are needed. 3. Selected optometrists will be available to provide follow up care per resident's request. Resident #43 was admitted to the facility in January 2024 with diagnoses including right eye cataract (clouding of the eye's lens, causing blurry, dim or faded vision) glaucoma, and lack of coordination. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/10/25, indicated that Resident #43 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #43 had adequate vision. Review of Resident #43's plan of care related to vision, dated as revised 7/16/25, indicated: - Arrange consultation with eye care practitioner as required. Review of Resident #43's physician's order, dated 11/23/25 and discontinued on 12/5/25, indicated prednisolone 1%, instill one drop right eye four times a day for glaucoma and post op (operation) right eye, unsupervised self-administration. Review of Resident #43's nursing note, dated 11/25/25, indicated:-Resident was seen for follow up for right eye. No new concerns in the post visit summary, resident to continue with original post op instructions and daily schedule prednisone 4x/daily and latanoprost to both eyes nightly. Ofloxacin should be continue 4x daily to right eye and discontinue on 12/7/25. During an interview on 12/15/25 at 8:44 A.M., Resident #43 said he/she was concerned about his/her follow up appointments for eye care. Resident #43 showed the surveyor eye care recommendations that were dated 12/2/25. Review of Resident #43's postoperative care for cataract hospital paperwork, dated 12/2/25, indicated: -STOP Cospt (eye drop, used to treat glaucoma)-Prednisolone eye drops 4x/day both eyes for one week, then 3x/day for one week, then 2x/day for one week, then 1x/day for one week. -Follow up on 12/23/25 at 1:15 P.M. Review of Resident #43's physician's orders, dated 12/2/25, indicated: -Appointment on 12/23/25 at 1:15 P.M., Ophthalmology. During an interview on 12/18/25 at 9:55 A.M., Nurse #4 said that on 12/2/25 Resident #43 had a follow up appointment for his/her eye, Nurse #4 said that Resident #43 returned from the appointment on 12/2/25 with paperwork, Nurse #4 said she reviewed the paperwork and she obtained an order for the next appointment on 12/23/25 and she said she put a copy of the paperwork in the medical record in the paper chart and she gave the paperwork back to the Resident. Nurse #4 said she did not notice any recommendations for eye drops. Review of Resident #43's Physician Assistant (PA) note, dated 12/4/25, indicated: -Continue Prednisone right eye four times daily. Review of Resident #43's Medication Administration Record (MAR) indicated that the prednisone eye drops were no longer ordered to be administered after 12/5/25 at 9:00 A.M., despite the recommendation for the taper on 12/2/25. Further review of Resident #43's postoperative care for cataract hospital paperwork, dated 12/2/25, indicated that the prednisolone eye drop should have been continued beyond 12/5/25. Review of Resident #43's nursing note, dated 12/4/24, indicated: -Resident complained about dizziness with bradycardia. Physician Assistant (PA) notified and wanted to notify ophthalmology regarding low heart rate and dizziness while on Cosopt due to concern for beta-blocker effect. Further Review of Resident #43's postoperative care for cataract hospital paperwork, dated 12/2/25, indicated that the Cosopt should have been discontinued. During an interview on 12/16/25 at 9:10 A.M., Unit Manager #1 said that Resident #43 recently had a vitrectomy (continued on next page)

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	225324	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(removal of gel in the back of the eyes) and he/she wears an eye patch. Unit Manager #1 said that when a resident goes out for an appointment, the resident is provided with paperwork for the consultant to write recommendations. Unit Manager #1 said that when the resident returns from outside appointments the nurse on duty is responsible to review the paperwork and to notify the provider of recommendations and obtain orders. During an interview on 12/16/25 at 10:19 A.M., the Physician Assistant said that Resident #43 recently had eye surgery. He said that all recommendations from the ophthalmologist should be implemented by nursing. During a follow up interview on 12/16/25 at 10:25 A.M., Unit Manager #1 said that there were no further orders for the prednisolone eye drops after 12/5/25, but there should have been. During an interview on 12/17/25 at 3:23 P.M., the Director of Nursing said that Resident #43 is very controlling with his/her paperwork, and he/she didn't turn over to the paperwork to the desk from the hospital on [DATE]. The DON said that follow up recommendations from the hospital should be reviewed by nursing and implemented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Newton Healthcare	25 Armory Street West Newton, MA 02465

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain acceptable parameters of nutritional status for one Resident (#11) out of a total sample of 27 Residents. Specifically, the facility failed to obtain a re-weigh in a reasonable amount of time after a significant weight loss was identified.Findings include:Review of the facility policy titled Weight Measurement, dated and revised April 2019 indicated the following:- All Residents with significant weight changes will have verification of weight measurement for accuracy and documentation purposed. If verification of weight indicates significant weight change (suggested parameters for evaluation significance of unplanned and undesired weight loss are: 5% in 30 days, 7.5% in 90 days and 10% in 180 days) the resident and/or family representative and IDT will be notified and plan of care will be revised as appropriate.Resident #11 was admitted to the facility in July 2025 with diagnoses including adult failure to thrive, dementia and type 2 diabetes mellitus.Review of Resident #11's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated a Brief interview for Mental Status score of 2 out of 15 indicating severe cognitive impairment. Further review of the MDs indicated that the Resident is fully dependent on staff for all activities of daily living. Review of Resident #11's weights summary indicated the following:9/2/25: 121.8 lbs. (pounds)9/4/25: 121.7 lbs.10/7/25: 122 lbs.11/6/25: 112.2 lbs.11/26/25: 113 lbs.12/1/25: 111 lbs.From 10/7/25 to 11/6/25, Resident #11 lost 9.8 pounds, indicating a 8.03% weight loss. The next documented weight was not obtained until 11/26/25, 20 days after the documented significant weight loss.Review of Resident #11's weight change progress note written by the Registered Dietitian dated 11/6/25 indicated the following:- question accuracy of 11/6 weight (112#(pounds)) of 10# wt loss x 1 month. Recommend reweigh to confirm. Diuretic noted.Review of Resident #11's physician's orders does not indicate an order for Resident #11 to be weighed.Review of Resident #11's care plan dated 12/2/25 indicated the following:- Focus: State of nourishment, potential for less than body requirement due to poor Po (by mouth) intake r/t (related to) refusal of meals, decreased appetiteGoal: Resident #11 will maintain or increase his/her weight through next reviewReview of Resident #11's Medical Nutrition Therapy assessment dated [DATE], documented by the Registered Dietitian, indicated that the Resident's last documented weight is 122 pounds and his/her weight has decreased within the past six months.Review of Resident #11's medical record failed to indicate that the Resident was re-weighed prior to 11/26/25 to confirm the 8.03% weight loss identified on 11/6/25.During an interview on 12/17/25 at 1:41 P.M., Certified Nursing Assistant (CNA) #2 said CNA's will weigh the residents when we are told to and we give the weight report to the nurses, and they input them into the medical system.During an interview on 12/17/25 at 12:32 P.M., the Registered Dietitian said if a significant weight loss is triggered then the best practice is to obtain a reweigh within 48 hours and if the weight loss is confirmed the resident should be assessed. The RD said reweighs should be obtained regardless of if a resident is on a diuretic medication or not. The surveyor reviewed Resident #11's weight change with the RD and she said that the Resident should have been reweighed a day or two after 11/6/25.During an interview on 12/18/25 at 8:59 A.M., Unit Manager #2 and Corporate Nurse #1 said CNAs will weigh residents and nurses will input the weights. They then said the RD will inform staff that a reweigh is needed and Resident #11's reweigh should have been done sooner than 11/26/25.During an interview on 12/18/25 at 9:31 A.M., the Director of Nursing (DON) said the facility will talk about significant weight changes in risk meeting and we will do a reweigh to confirm the weight change. The DON then said reweighs should be obtained within 24-48 hours of the identified significant weight change. Unit Manager #2 and Corporate Nurse #1 said Resident #11 should have been weighed sooner after the 11/6/25 weight change.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review, and interviews, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for one Resident (#56) out of sample of 27 residents. Specifically, for Resident #56, the facility failed to obtain physician's orders for oxygen use. Findings include: Review of the facility policy titled, Oxygen Administration, dated as revised 1/2024, indicated the purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation1. Verify there is a physician's order in place. Review the physician's order or facility protocol for oxygen administration. Resident #56 admitted to the facility in December 2025 with diagnoses including anoxic brain injury, tracheostomy (surgically created airway opening) status, and pressure ulcer of the sacral region. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/9/25, indicated that Resident #56 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15. This MDS indicated Resident #56 was dependent on staff for activities of daily living and Resident #56 received oxygen therapy and tracheostomy care. Review of Resident #56's plan of care related to altered respiratory status and need for 6 liters of continuous oxygen via trach mask secondary to diagnosis of anoxic brain injury, dated as revised 12/11/25, indicated: - Oxygen settings as ordered. - Consult Respiratory Therapist as needed. Review of Resident #56's plan of care related to tracheostomy, Shiley size 6 cuffed (type of tracheostomy), dated as revised 12/11/25, indicated: - Oxygen setting: oxygen via trach mask at 6 liters per minute. Review of Resident #56's Respiratory Therapist (RT) note, dated 12/3/25, indicated that this writer has the following recommendation for the Resident: - Humidified oxygen at 6 liters per minute via trach mask, every shift. On 12/15/25 at 7:20 A.M., 12/15/25 at 8:36 A.M., 12/15/25 at 10:17 A.M., 12/15/25 at 12:21 P.M., 12/15/25 at 4:19 P.M., 12/16/25 at 6:49 A.M., 12/16/25 at 8:51 A.M., 12/16/25 at 12:27 P.M., 12/16/25 at 3:37 P.M., and on 12/17/25 at 6:50 A.M., the surveyor observed Resident #56 in his/her bed receiving oxygen at 5 liters per minute (LPM). On 12/16/25 at 12:32 P.M., the surveyor and Nurse #3 receiving oxygen at 5 LPM and he said that oxygen administration is based on the physician's orders. Nurse #3 said that the oxygen concentrator Resident #56 has cannot go above 5 LPM. Review of Resident #56's physician's orders on 12/17/25, failed to include an order for oxygen administration. During an interview on 12/17/25 at 7:45 A.M., Nurse #1 said that Resident #56 receives oxygen at 5 LPM and he said that oxygen use requires a physician's order. Nurse #1 reviewed Resident #56's physician's orders and he said that there was no order. During an interview on 12/17/25 at 3:08 P.M., the Director of Nursing said that Resident #5 receives oxygen therapy there should be a physician's order for oxygen use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one Resident #85 out of a total sample of 27 residents. For Resident #85, when the facility staff failed to wear the appropriate Personal Protective Equipment (PPE) while providing direct care for the Resident on enhanced barrier precautions due to a suprapubic catheter (a flexible tube that drains urine directly from the bladder through a small opening in the lower abdomen). Findings include: Review of the facility policy titled, Infection Control Guidelines for Nursing Procedures, dated as revised 7/2024, indicated to provide guidelines for general infection control while care for residents.-Enhanced Barrier PrecautionsEnhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs).>EBP is indicated for nursing home residents with any of the following:-Infection or colonization with an MDRO when Contact Precautions don't otherwise apply.-Chronic wounds.-Indwelling medical devices, including but not limited to i.e. IV, feeding tubes, trach, drains/pleurex, urinary catheters.>PPE-Use of gown and gloves during high-contact resident care activities that may provide opportunities for transmission of MDROs via staff hands and clothing examples of high contact resident activities: are dressing, bathing, shower, transferring, changing linen, personal hygiene, toileting/ brief change, device care, PICC, Central line.-While caring for a resident, change gloves after having contact with infective material (for example, fecal material and wound drainage). Resident #85 was admitted to the facility in April 2025 with diagnosis including diabetes, dementia, and urine retention. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/3/25, indicated that Resident #85 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. This MDS indicated Resident #85 required an indwelling catheter. Review of Resident #85's plan of care related to enhanced barrier precautions: suprapubic catheter, dated as revised 9/23/25, indicated: -18 French with 10 milliliter (mL) [NAME]. -Follow precautions as ordered. Monitor for changes and update provider as needed. Review of Resident #85's physician's order, dated 11/6/25, indicated:-Suprapubic catheter 16 French with 10 mL balloon continuous to catheter drainage bag while in bed. Review of the Resident #85 Physician Assistant note, dated 12/9/25, indicated:-Status post Levaquin (antibiotic medication) course for Proteus Mirabilis (gram negative bacteria) UTI (urinary tract infection), urine studies also grew vancomycin-resistant enterococcus faecalis (bacteria that is normally found in the intestines, that has become resistant to the antibiotic vancomycin) sensitive to Macrobid (antibiotic medication), Resident to start Macrobid twice daily. On 12/15/25 at 11:41 A.M., the surveyor observed Resident #85 in bed, his/her pants were pulled down below his/her knees, and the surveyor observed a 16 French 30 mL balloon catheter attached to a leg bag with yellow urine. Resident #85 said he/she was not sure why his/her pants were down. On 12/15/25 at 12:22 P.M., the surveyor observed Resident #85 in bed, his/her pants were pulled down below his/her knees, and the surveyor observed a 16 French 30 mL balloon catheter attached to a leg bag with yellow urine. Nurse #2 was bent down near Resident #85's catheter drainage bag, and she was not wearing PPE. Nurse #2 was observed obtaining Resident #85's vital signs with a multi-use blood pressure cuff. Nurse #2 said she was obtaining Resident #85's routine vital signs. While Nurse #2 was obtaining Resident #85's vital signs, Resident #85 requested to use the bathroom. The surveyor observed Nurse #2 transfer Resident from bed, she pulled up his/her pants, and she walked Resident #85 to the bathroom. The surveyor observed Nurse #2 lower Resident #85's pants and then assisted sitting him/her on the toilet. During an interview on 12/15/25 at 12:41 P.M., Nurse #2 said she should have worn PPE while providing care to Resident #85, but she did not. During an interview on 12/16/25 at 9:16 A.M., Unit Manager #1 said that she observed Nurse #2 providing care to Resident #85 without PPE, but she (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have. During an interview on 12/17/25 at 3:15 P.M., the Director of Nursing said that Nurse #2 should have worn PPE while providing care to Resident #85.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation and interviews, the facility failed to post nursing staff data daily, at the start of each shift, as required. Specifically, the facility failed to ensure they consistently posted the staffing as required. Findings include: On 12/15/25 at 6:42 A.M., the surveyors observed the daily staffing posted as Friday 12/12/25 at 1:55 P.M., there were no additional staffing sheets under this one sheet. During an interview on 12/16/25 at 1:29 P.M., the Scheduler said that after last recertification survey she is supposed to update that daily staffing sheets Monday through Friday and post the sheets at the entrance of the facility. She said that during the weekends it is the responsibility of the person in charge to print the staffing sheets, and she does not print them on Friday because she does not know the facility census. The Scheduler said that she noticed on 12/15/25 the staffing sheet was still dated 12/12/25. During an interview on 12/16/25 at 2:29 P.M., the Administrator said that he is aware of the requirement to post the daily staffing sheets. The Administrator said that after the last recertification survey the plan was for the Scheduler to post the daily staffing sheets during the week and on the weekends manager on duty is supposed to post the daily staffing on the weekends. The Administrator said that the Scheduler should print the schedules for the weekend on Friday and she should leave them for the manager on duty to post during the weekend. The Administrator said that the manager on duty this past weekend was the Food Service Director (FSD) and the Housekeeping Supervisor. The Administrator said that the manager on duty roles and responsibilities is a work in progress. During an interview on 12/17/25 at 7:18 A.M., the FSD said he was the manager on duty on Saturday 12/13/25 and he said he was not aware he is supposed to hang up signs with the daily staffing information. During an interview on 12/18/25 at 8:52 A.M., the Housekeeping Supervisor said she was the manager on duty on Sunday 12/14/25 and she said she was not aware she was supposed to hang the schedule for the weekend.