STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225330	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons	390 Orleans Road North Chatham, MA 02650

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interviews, and document review, the facility failed to ensure that residents were fully aware of the grievance process. Specifically, for 11 of 11 residents attending the resident group meeting during the survey, the facility failed to ensure their grievance policy included the right to file grievances anonymously and failed to ensure residents were aware of and had access to grievance forms, and were aware they could formulate grievances anonymously, should they choose not to alert a staff member of their concern(s).Findings include:Review of the facility's policy titled Grievances & Resolution of Other Issues, undated, failed to indicate residents and/or their representatives had the right to file grievances anonymously.On 1/7/26 at 9:58 A.M., the surveyor toured all three units in the facility. A document titled Grievances was posted on a bulletin board on each unit. The document indicated, but was not limited to:-You have a right to file a grievance in writing or orally and may do so anonymously.The posting failed to indicate availability and location of grievance forms as well as instructions on where or how to submit the forms to file anonymously.On 1/7/26 at 1:00 P.M., the surveyor held a resident group meeting with 11 residents in attendance. Eleven of 11 residents said that they were not aware of their right to file a grievance anonymously. They said if they have an issue, they must tell a staff member about it. The residents said they have not seen any grievance forms anywhere, and even if they had them, there is nowhere to file them to remain anonymous.During an interview on 1/7/26 at 2:21 P.M., the Administrator identified himself as the Grievance Officer. He reviewed the grievance policy and said it does not include the residents or their representatives right to file grievances anonymously. He said the process to file grievances is that a resident or their representative can tell a staff member their concern and if it can't be addressed right away, the staff person obtains a grievance form from the social worker and completes it on the resident's behalf. He said they do not have a process in which a resident or their representative has access to grievance forms to complete on their own and submit them anonymously. He said they need to speak to staff and they will complete the form.

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of Resident Council Minutes, a resident group meeting, interviews, and record reviews, the facility failed to ensure grievances brought forward from the Resident Council were addressed and promptly resolved to ensure the residents felt their concerns were acted upon timely and included the facility response to the group.Findings include:Review of the facility's policy titled Resident Council, undated, indicated but was not limited to the following:-The purpose of the Resident Council is to provide a forum for: a. Residents to have input in the operation of the facility; b. Discussion of concerns; c. Consensus building and communication between residents and facility staff; and d. Staff to disseminate information and gather feedback from interested residents.Review of the facility's Grievance & Resolution of Other Issues policy, undated, included but was not limited to:-It is the policy of the organization to afford all persons served with known mechanisms by which requests for review and resolution of issues can be raised without discrimination or reprisal, including but not limited to those about treatment which has been furnished; those about treatment that has not been furnished; and those about behavior of other residents/patients.-We seek resolution expediently, and keep the applicable parties informed within established and appropriate timeframes. Those timeframes generally include prompt investigation which begins within two business days of receipt of the complaint, with all participants in the investigatory process reported to the administrator or designee withing the following three business days and in response to the aggrieved within a week.-Persons-served have reasonable expectation of care and services, and that the facility addresses those expectations in a timely, reasonable, and consistent manner.-Communication back to the party with the concern is coordinated by one of the senior staff members.Review of Resident Council Minutes, dated 8/28/25, indicated residents voiced concerns about the Certified Nursing Assistants (CNA) rushing and would like them to slow down.Review of the Grievance book failed to indicate the residents' grievance voiced during the 8/28/25 meeting was addressed, acted upon or any follow-up was conducted.Review of Resident Council Minutes, dated 9/30/25 and 10/30/25, failed to indicate the residents' care concern brought forward during the 8/28/25 Resident Council meeting was addressed or had any follow-up.Review of Resident Council Minutes, dated 11/20/25, indicated residents voiced concerns about the CNAs using ear buds while providing care and staff talking in the middle of the night outside of their rooms and waking them up.Review of the Grievance book failed to indicate that any of the residents' grievances voiced during the 11/20/25 Resident Council meeting was addressed or acted upon or any follow-up was conducted.Review of Resident Council Minutes, dated 12/30/25, failed to indicate the residents' care concerns brought forward during the 11/20/25 Resident Council meeting were addressed or had any follow-up.On 1/7/26 at 1:00 P.M., the surveyor held a group meeting with 11 residents in attendance. The residents said there has been no follow-up to any of their concerns voiced during the 8/28/25 and 11/20/25 Resident Council meetings. They said their concern about CNA staff rushing while providing care continues to be a problem, staff continue to speak loudly outside of their room at night and early in the morning and it wakes them up. They said although staff wearing ear buds while providing care has improved, it continues to be a problem.During an interview on 1/7/26 at 2:21 P.M., the Administrator and surveyor reviewed the concerns brought forward by residents during the Resident Council meetings held on 8/28/25 and 11/20/25. He said the concerns were not brought forward through the grievance process and he was not aware the concerns were still a problem. He said they need to make sure concerns brought up during Resident Council are documented and brought through the grievance process to ensure they are addressed, and the problem is resolved.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure that each resident's drug regimen was free from unnecessary psychotropic medications to promote or maintain the residents' highest practicable mental, physical, and psychosocial well-being. Specifically, the facility failed to ensure for one Resident (#84), out of a total sample of 26 residents, that as needed (PRN) use of Ativan (treats anxiety) was limited to 14 days and the prescriber documented an evaluation of the Resident's current condition and the appropriateness for continued use prior to extending its duration.Findings include:Review of the facility's policy titled Psychotropic Medication Use, dated 2001, indicated the following:-Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record.-PRN orders for psychotropic medications are limited to 14 days.-For psychotropic medications that are not antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order.Review of the facility's policy titled 14-day PRN Psychotropic/Anti-Psychotic Medication Review Procedure, undated, indicated but was not limited to:-The purpose of this procedure is to ensure consistency in the communication process to assure compliance with Centers for Medicare and Medicaid Services (CMS) guidelines regarding PRN orders for psychotropics and anti-psychotics which states as follows: -PRN orders for psychotropic drugs are limited to 14 days. Except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's record and indicate the duration for the PRN order.Resident #84 was admitted to the facility in June 2023 and had diagnoses including anxiety disorder.Review of the Minimum Data Set (MDS) assessment, dated 1/6/26, indicated Resident #84 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15, and was administered psychotropic medication.Review of Resident #84's medical record indicated but was not limited to:-Ativan (Lorazepam) 0.5 milligrams (mg) every 6 hours as needed for anxiety for 14 days (4/19/25, discontinued 4/29/25)-Ativan 0.5 mg every 6 hours as needed for anxiety for 30 days (4/29/25)Review of the medical record failed to indicate the Physician or Physician extender documented a clinical rationale for the extension of the PRN Ativan order as required.-Ativan 0.5 mg every 6 hours as needed for anxiety/agitation for 30 days (8/29/25)Review of a Physician's progress note, dated 8/29/25, indicated to extend the PRN Ativan order for another 30 days for anxiety/agitation. However, there was no current PRN Ativan order in place. The last PRN Ativan order was initiated on 4/29/25 for 30 days.-Ativan 0.5 mg every 6 hours as needed for anxiety/agitation for 180 days (start date 10/2/25, d/c 11/26/25)Review of the medical record failed to indicate the Physician or Physician extender documented a clinical rationale for the extension of the PRN Ativan order as required.During an interview on 1/8/26 at 11:24 A.M., Unit Manager #3 reviewed Resident #84's medical record and said there was no documentation from the Physician or Physician extender to indicate an evaluation was conducted and a documented clinical rationale for continued use and extension of PRN Ativan.During an interview on 1/9/26 at 10:30 A.M., the Director of Nursing (DON) reviewed Resident #84's medical record and said neither the Physician nor Physician extender documented a clinical rationale for the continued use of PRN Ativan prior to extending the order.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards for three Residents (#109, #84, #138), out of a total sample of 26 residents. Specifically, the facility failed:1. For Resident #109, to complete weekly skin assessments as ordered by the physician;2. For Resident #84, to implement a physician's order for head-of-bed elevation positioning; and 3. For Resident #138, to obtain a physician's order for an Registered Nurse (RN) pronouncement of death.Findings include:Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following:-The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated:-Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error.-In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. 1. Review of the facility's policy titled Skin Care Program, revised 4/2023, indicated, but was not limited to, the following:-All residents have a full body skin assessment to address any skin issues on a weekly basis.-Skin check is to be performed by a licensed nurse on a weekly basis on a previously assigned day (recommended day is a shower day if applicable).-Weekly skin check must be completed even if a shower does not occur.-Refusal of skin assessment must be documented in EHR (electronic health record) including interventions and re-education of the resident. Resident #109 was admitted to the facility in November 2025 with diagnoses including pressure ulcer of the right buttock, sepsis, and severe protein-calorie malnutrition. Review of Resident #109's Minimum Data Set (MDS) assessment, dated 11/18/25, indicated Resident #109 was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Further review of the MDS assessment indicated Resident #109 had five unstageable pressure ulcers and a surgical wound present on admission to the facility and the Resident was receiving pressure ulcer care. Review of Resident #109's Care Plan indicated, but was not limited to, the following:Focus: The Resident has actual impairment to skin integrityRight gluteus unstageable pressure ulcer – present on admitInflammatory disorder of scrotumFirst degree burn of neck present on admitRight thigh three unstageable pressure area present on admitLeft plantar foot unstageable pressure area – present on admitOstomy scabbed from tape burns present on admitInterventions: Weekly skin assessment Review of Resident #109's Physician's Orders indicated, but was not limited to, the following:-Weekly Skin Assessment due. Document skin condition in a WEEKLY SKIN CHECK assessment every evening shift every 7 day(s) FRI 3-11 (order date: 11/12/25) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #109's medical record failed to include documentation of weekly skin check assessments completed after 12/12/25. Review of Resident #109's Progress Notes failed to indicate that Resident #109 had refused weekly skin checks after 12/12/25. During an interview on 1/6/26 at 9:58 A.M., Resident #109 said he/she has a wound on his/her buttocks and the nurses at the facility perform wound care for him/her. During an interview on 1/8/26 at 10:16 A.M., Unit Manager #1 said Resident #109 is followed by the consulting wound physician and was admitted to the facility with multiple wounds. During an interview on 1/8/26 at 2:30 P.M., Unit Manager #1 said Resident #109 should have weekly skin assessments documented in the electronic medical record and the last one she could see was documented on 12/12/25. Unit Manager #1 said the weekly skin assessments should have been completed every week. During an interview on 1/8/26 at 3:09 P.M., the Director of Nursing (DON) said Resident #109 should have had his/her weekly skin assessment completed and documented in the medical record. 2. Resident #84 was admitted to the facility in June 2024 and had diagnoses including dysphagia (difficulty swallowing) following cerebral infarction, gastroesophageal reflux disease and shortness of breath. Review of the MDS assessment, dated 1/6/26, indicated Resident #84 had severe cognitive impairment as evidenced by a BIMS score of 7 out of 15, and required substantial/maximal assistance with bed mobility. Review of the medical record indicated a Physician's Order including, but not limited to: -Keep HOB (Head of bed) at 30-45 degrees, no lying flat, every shift for productive cough, chest congestion (2/1/25) On 1/6/26 at 9:58 A.M., the surveyor observed Resident #84 lying in bed asleep. The HOB was flat and not at 30-45 degrees according to physician's orders. On 1/6/26 at 11:26 P.M., the surveyor observed Resident #84 lying in bed asleep. The HOB was flat and not at 30-45 degrees according to physician's orders. On 1/6/26 at 1:18 P.M., the surveyor observed Resident #84 lying in bed awake. The HOB was flat and not at 30-45 degrees according to physician's orders. On 1/7/26 at 9:43 A.M., the surveyor observed Resident #84 lying in bed asleep. The HOB was flat and not at 30-45 degrees according to physician's orders. Review of the January 2026 Medication/Treatment Administration Record (MAR/TAR) was signed off by nursing that the Resident's HOB was positioned between 30 – 45 degrees at the time of the surveyor's observations of the bed being flat. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/26 at 3:51 P.M., the surveyor and Nurse #2 observed Resident #84 lying in bed asleep. The HOB was flat. Nurse #2 said the head of the bed is supposed to be elevated to between 30 - 45 degrees but it is not. During an interview on 1/7/26 at 4:00 P.M., Unit Manager #3 said nursing staff need to ensure the head of Resident #84's bed is always elevated to between 30 – 45 degrees according to the physician's order. During an interview on 1/9/26 at 10:30 A.M., the DON said Resident #84's head of the bed should be elevated and accurately documented according to physician's orders. 3. Review of the facility's policy titled Death of a Resident, documenting, dated 2001, indicated but was not limited to: -Appropriate documentation shall be made in the clinical record concerning the death of a resident -A resident may be declared dead by a licensed physician or registered nurse with physician authorization in accordance with state law. Resident #138 was admitted to the facility in December 2025 and had diagnoses including a displaced fracture of medial condyle of the right tibia and a history of falls. Review of the medical record indicated a nursing progress note, dated 12/31/25. The note indicated Resident #138 was working with physical therapy and occupational therapy staff in his/her room and began to experience shortness of breath and chest pain. The Resident was assessed and found to have a non-palpable pulse and became apneic (transient cessation of respiration). The heart monitor showed no survivable heart rate/rhythm and was pronounced dead at 10:20 A.M. Further review of the medical record failed to indicate an order for RN pronouncement of death was obtained. During an interview on 1/9/26 at 10:30 A.M., the DON reviewed Resident #138's medical record and said a physician's order for an RN pronouncement was not obtained as required.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide residents with adequate supervision and effective interventions to prevent avoidable accidents for four Residents (#20, #24, #84, and #72), out of a total sample of 26 residents. Specifically, the facility failed:1. For Resident #20, to implement the Resident's seat/chair alarm as indicated in the Resident's care plan;2. For Resident #24, to implement the Resident's personal alarm as indicated in the Resident's care plan; 3. For Resident #84, to develop and consistently implement effective interventions to prevent four unwitnessed falls; and 4. For Resident #72, to implement the Resident's bed/chair alarm and fall mats as indicated in the Resident's care plan.Findings include:Review of the facility's policy titled Falls and Fall Risk, undated, indicated, but was not limited to, the following:-It is the policy of the organization to ensure the risk of harm to residents caused by falls is minimized.-Residents who do fall will be appropriately managed.-The Safety Care Plan will be updated accordingly.-Examples of interventions may include but are not limited toa. Addressing medical issues with the physician such as hypotension and dizziness, and tapering, discontinuing, or changing problematic medicationsb. Use of low bed with matsc. Alarms to alert staff of attempts to self-transferd. Enabling devices i.e. Velcro alarmed seat belt, wedge cushionse. Perimeter mattressf. Non-skid strips-If interventions have been successful in preventing additional falls, the staff will continue with the current approach or reconsider whether these measures are still needed if the problem that required the intervention has resolved.-All care plans are reviewed and updated quarterly or with a significant change in condition when the MDS (Minimum Data Set) is completed. Review of the facility's policy titled Care Plans – Comprehensive, undated, indicated, but was not limited to, the following:-Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain.-Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. -Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 1. Resident #20 was admitted to the facility in December 2025 with diagnoses including altered mental status and mild cognitive impairment. Review of the Minimum Data Set (MDS) assessment, dated 12/13/25, indicated Resident #20 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15. Review of Resident #20's medical record indicated Resident #20 had fallen on 12/23/25 and 1/3/26. Review of Resident #26's Care Plans indicated, but was not limited to, the following:Focus: SAFETY PLAN: Patient has a potential for injury related to: weakness, admit fall score of 13Interventions:-seat/chair alarm when OOB (out of bed) in w/c (wheelchair) without direct supervision (12/24/25) Review of Resident #20's Kardex (Certified Nursing Assistant (CNA) Care Card) indicated, but was not limited to, the following:-Safety: seat/chair alarm when OOB in w/c without direct supervision (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #20's fall incident reports/investigations indicated, but was not limited to, the following:-On 12/23/25 at 1:30 P.M., the CNA observed the Resident stand up from his/her wheelchair and begin to walk. The CNA asked the Resident if he/she was supposed to be walking and held on to the Resident's waist. Before the CNA had a chance to put the gait belt on, the Resident fell to the floor. At the time of the fall, no alarms were in place. -On 1/3/26 at approximately 8:10 P.M., the CNA assigned to the Resident's care informed the nurse he had heard the Resident calling out and observed him/her on the floor in his/her room. The Resident stated he/she was trying to lose the blinds and fell on his/her buttocks. The Resident's chair alarm was not in place at the time of the fall. Review of Resident #20's Progress Notes indicated that on 1/3/26, the Resident had an unwitnessed fall, his/her seat alarm was not on, and the CNA was educated on ensuring the Resident's safety alarm was on at night. During an interview on 1/7/26 at 1:37 P.M., Nurse #6 said after Resident #20's first fall on 12/23/25, the Resident had asked to use a chair alarm so he/she could remember to sit down when it went off and Nurse #6 implemented the alarm. During an interview on 1/8/26 at 2:42 P.M., Nurse #5 said she was working when Resident #20 fell on 1/3/26. Nurse #5 said she was not in the room at the time of the fall, but she did not hear a chair alarm sounding when the Resident fell and she would have heard it if it had been in place. During an interview on 1/8/26 at 3:09 P.M., the Director of Nursing (DON) said Resident #20 had been cleared by therapy to transfer independently in his/her room during the day when he/she fell on 1/3/26, but the Resident's chair alarm had not been removed from his/her care plan and should have been in place at the time of the fall. 2. Resident #24 was admitted to the facility in October 2025 with diagnoses including Alzheimer's disease and history of falling. Review of Resident #24's MDS assessment, dated 12/22/25, indicated Resident #24 was severely cognitively impaired, as evidenced by a BIMS score of 3 out of 15. Further review of the MDS assessment indicated the Resident had had one fall with no injury since the last MDS assessment 10/20/25. Review of Resident #24's medical record indicated Resident #24 had fallen on 11/29/25 and 1/2/26. Review of Resident #24's Care Plans indicated, but were not limited to, the following:Focus: SAFETY PLAN: Patient has a potential for injury related to: cognitive impairment, history of fall, cognitive impairment [sic]Interventions:-Personal Alarm without direct supervision Review of Resident #24's Fall incident Reports/Investigations indicated, but was not limited to, the following: -On 11/29/25, the Resident was in the Oyster Pond Unit dayroom seated in a recliner chair watching television. The Resident scooted toward the edge of the recliner and subsequently lost his/her balance, resulting in a fall onto the floor. There was no chair alarm in place and the fall was unwitnessed. Review of Resident #24's Rehabilitation Screen status post fall, dated 12/1/25, indicated the Resident was in the recliner at the time of the fall but his/her alarm was not placed on the recliner when the Resident was transferred out of his/her wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #24's Kardex indicated, but was not limited to, the following:-Personal Alarm without direct supervision Review of Resident #24's Progress Notes indicated that on 11/29/25, Resident #24 was in the Oyster Pond Unit dayroom in a recliner and scooted toward the edge of the recliner and had a fall. During an interview on 1/8/26 at 3:09 P.M., the DON said when Resident #24 had fallen on 11/29/25, his/her chair alarm was not in place. The DON said the alarm was not transferred with the Resident when he/she was transferred from the wheelchair to the recliner chair. The DON said the Resident should have been supervised in the dayroom and that was likely why the alarm was not moved. 3. Resident #84 was admitted to the facility in June 2023 and has hemiplegia (paralysis on one side of the body) and hemiparesis (one-sided muscle weakness) affecting the right dominant side following a stroke and a history of falls. Review of the MDS assessment, dated 1/6/26, indicated Resident #84 had severe cognitive impairment as evidenced by a BIMS score of 7 out of 15, and had history of falls. Review of Resident #84's Interdisciplinary Care Plans included but was not limited to: -Focus: Safety Plan: Resident has a potential for injury related to: confusion with decreased safety awareness; right hemiparesis and weakness (9/28/23) -Interventions: Assist Resident back to bed after breakfast, lunch and dinner (12/11/23); Keep personal items within reach (12/6/23); Non-skid strips on floor on window side of the bed leading into the bed (1/30/24); Wedge cushion to reduce chance of sliding in wheelchair (12/29/23); Motion sensor when in bed without direct supervision to alert staff of attempts to exit bed unassisted (12/8/23); Lock rear wheelchair brakes when out of bed in wheelchair (2/16/24); Encourage resident to stay in common areas to promote more supervision (3/3/24) -Goal: I want to reduce my risk for injury (9/28/23) Review of the safety Kardex indicated the following interventions were in place as of 4/12/25: -Assist resident back to bed after breakfast, lunch and dinner -Encourage resident to stay in common areas to promote more supervision -Fabric covered cushion to reduce chance of sliding in wheelchair -Motion sensor when in bed without direct supervision to alert staff of attempts to exit bed unassisted (set to chime) -Personal alarm without direct supervision -Provide staff escorts to activities, needs staff assistance with transfer, has poor safety awareness -Rear lock wheelchair brakes when out of bed in wheelchair (continued on next page)

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Liberty Commons	390 Orleans Road North Chatham, MA 02650

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Slipper socks used at night while in bed -STOP sign on closet and on wall behind the bed to remind resident to call for assistance for transfers and ambulation Review of the medical record and fall investigations indicated Resident #84 had five falls from April 2025 to January 2026. Review of the falls indicated: -4/13/25 at 10:00 A.M., Resident #84 had an unwitnessed fall and was found lying on the floor on his/her back in front of a wheelchair in his/her room. The investigation revealed that after breakfast, Resident #84 was brought to his/her room by a student CNA who was unaware that the Resident should not be alone in his/her room. There were no injuries as a result of the fall. The following interventions were not in place at the time of the fall: assist Resident back to bed after breakfast, personal alarm without direct supervision. New interventions added to the care plan/safety Kardex: staff education on safety care plan and not leaving resident in wheelchair alone in room. -8/20/25 at approximately 11:45 A.M., Resident #84 had an unwitnessed fall and was found on the floor of his/her room next to the bed. The Resident's legs were on the side of the bed, and his/her head was in between the nightstand and tray table. The Resident sustained an abrasion to his/her left knee and left ear. The investigation revealed the Resident was last toileted after breakfast and put to bed. The following interventions were not in place at the time of the fall: Motion sensor when in bed without direct supervision to alert staff of attempts to exit bed unassisted. New interventions added to the care plan/safety Kardex: staff education on new intervention added to the care plan/safety Kardex: low bed with mats. -10/31/25 at 5:30 P.M., Resident #84 was in the dining room and was found on the floor by his/her wheelchair. The investigation revealed the Resident may have reached over the side of the wheelchair and it tipped and the Resident fell. Staff were in the room at the time of the fall but did not witness the fall. The Resident sustained an abrasion to the top of his/her scalp and right knee. Physical therapy evaluated and adjusted the wheelchair to lower the Resident's gravity to the floor. -11/21/25 at 6:30 P.M., Resident #84 was transported from the main dining room to the unit dayroom after dinner by a CNA to sit along with other residents. The Resident was later found on the floor in front of his/her wheelchair. There were no injuries as a result of the fall. The following interventions were not in place at the time of the fall: assist resident back to bed after breakfast, lunch and dinner and personal alarm without direct supervision in wheelchair. Staff were educated on the Resident's safety plan of care and getting the Resident to bed after dinner. -1/2/26 at 11:30 A.M., Resident #84 was brought to the nurse's station for supervision because he/she was anxious and having delusions. The nurse providing supervision left the nurse's station to respond to another resident's sounding safety alarm. When the nurse returned to the nurse's station, she found Resident #84 on the floor on his/her right side. The resident sustained an abrasion to the right side of his/her head. On 1/6/26 at 9:58 A.M. and 11:26 A.M., the surveyor observed Resident #84 lying in bed asleep. A mat was observed on the left side of the bed between halfway underneath his/her roommate's bed. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was no mat on the right side of the bed. On 1/6/26 at 1:18 P.M., the surveyor observed Resident #84 lying in bed awake visiting with his/her family member. A mat was observed on the left side of the bed between halfway underneath his/her roommate's bed. The Family Member said Resident #84 has had a few falls, and staff are supposed to put mats on the floor on either side of the bed, but there is only one mat in place. During an interview on 1/9/26 at 10:30 A.M., the surveyor and DON reviewed Resident #84's falls. The DON said that the safety team had reviewed each fall and found that for three of the five falls, staff did not implement interventions in place for the Resident's risk of falls. She said all fall interventions should be in place according to the safety care plan and CNA Kardex. 4. Resident #72 was admitted to the facility in December 2023 and has diagnoses including weakness and a history of falls. Review of the MDS assessment, dated 12/2/25, indicated Resident #72 had moderate cognitive impairment as evidenced by a BIMS score of 12 out of 15, requires substantial to maximum assistance for activities of daily living and utilized a bed alarm daily. Review of Resident #72's medical record indicated but was not limited to the following comprehensive care plan for the Resident's fall risk: Focus: Safety Plan: Resident has a potential for injury related to: Fall history prior to admission [DATE]) Interventions: Bed alarm to alert staff when resident is exiting the bed unassisted (8/20/25); Low bed with mats (1/21/25); seat/chair alarm when out of bed in wheelchair (4/4/24) Goal: I want to reduce my risk for injury (1/4/24, target date: 5/5/25) On 1/6/26 at 10:04 A.M., the surveyor observed Resident #72 lying in bed awake. No mats were noted on the floor next to the Resident's bed. A bed alarm box was attached to the Resident's bed frame at the head of the bed. However, the alarm cord that was connected to a pressure pad on the Resident's bed was not connected to the box and was lying on the floor. On 1/7/26 at 9:40 A.M., the surveyor observed Resident #72 lying in bed awake. No mats were noted on the floor next to the Resident's bed. A bed alarm box was attached to the Resident's bed frame at the head of the bed. However, the alarm cord that was connected to a pressure pad on the Resident's bed was not connected to the box and was lying on the floor. On 1/7/26 at 12:18 P.M., the surveyor observed Resident #72 seated in a positioning chair in the unit dining room. No seat alarm was in place. During an observation with interview on 1/7/26 at 4:00 P.M., Unit Manager #3 and the surveyor observed Resident #72 lying in bed asleep. No mats were noted on the floor next to the Resident's bed. A bed alarm box was attached to the Resident's bed frame at the head of the bed. However, the alarm cord that was connected to a pressure pad on the Resident's bed was not connected to the box and was lying on the floor. She said it is the responsibility of all staff to ensure the fall mats are in place and the bed alarm is connected and functioning. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/26 at 10:30 A.M., the DON said staff should implement fall care plan interventions at all times.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on interviews and record review, the facility failed to monitor the nutritional status of one Resident (#1) with an unplanned significant weight loss, out of a total sample of 26 residents. Specifically, the facility failed to identify and address a 5.27% significant weight loss in one month for Resident #1. Findings include:Review of the facility's policy titled Weight and Measuring the Resident, undated, indicated but was not limited to the following:- Report significant weight loss/weight gain to the nurse supervisor. Ensure physician and health care proxy notified.- 1 month - 5% weight loss is significant: greater than 5% is severe.- When recommended by the nurse or dietitian, weight monitoring can be done more frequently & recorded in the electronic record. The dietitian will review the results, making recommendations as necessary.- The dietitian will also review the unit Weight Record (weekly and/or monthly) to follow individual weight trends over time. Negative trends will be assessed and addressed by the dietitian whether the definition of Significant Weight Change is met.- If the weight change is desirable, this will be documented and no change in the care plan will be necessary.- If a weight loss meets the definition of Significant, the dietitian should discuss with the interdisciplinary team if a Significant Change MDS (Minimum Data Set) is necessary. Resident #1 was admitted to the facility in January 2023 with diagnoses including cerebral infarction, moderate protein-calorie malnutrition, and abnormal weight loss. Review of Resident #1's most recent Minimum Data Set (MDS) assessment indicated he/she was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Furthermore, the MDS assessment indicated he/she had a mechanically altered (change in food texture or liquids) diet as well as needing supervision from staff while eating. Review of Resident #1's Physician's Orders indicated but was not limited to the following:- 1/6/26: House Diet - moist ground texture, thin consistency- 11/25/25: Mighty Shake with meals for dietary supplement; document with % intake on MAR/TAR (Medication/Treatment Administration Record) appropriately- 11/25/25: Ensure Oral Liquid (Nutritional Supplements) - give 240 mL (milliliters) by mouth two times a day for supplement- 11/25/25: Weight weekly on Monday; every day shift every Monday Review of Resident #1's November 2025 Medication Administration Record (MAR) indicated but was not limited to the following:- 50% or less intake of Mighty Shake Dietary Supplement: 16 out of 16 administrations Review of Resident #1's December 2025 MAR indicated but was not limited to the following:- Ensure Oral Liquid Nutritional Supplement: refused three times (12/19/25, 12/22/25 and 12/29/25)- 50% or less intake of Mighty Shake Dietary Supplement: 84 of 93 administrations Review of Resident #1's January 2026 MAR indicated but was not limited to the following:- 50% or less intake of Mighty Shake Dietary Supplement: 14 of 22 administrations Review of Resident #1's weights in the medical record indicated but were not limited to the following:- 11/28/25: 239.0 pounds (lbs.)- 12/5/25: 237.8 lbs.- 12/8/25: 235.8 lbs.- 12/15/25: 234.0 lbs.- 12/22/25: 226.4 lbs.- 12/29/25: 226.0 lbs.- 1/5/26: 221.6 lbs. Review of Resident #1's weights indicated he/she had a 5.27% weight loss in one month (11/28/25 to 12/22/25). Furthermore, review of Resident #1's weights indicated he/she continued to lose weight following the significant weight loss that was triggered on 12/22/25. Review of Resident #1's Nutrition Assessment, dated 12/1/25, indicated he/she was re-admitted to the facility following a hospitalization. The assessment indicated Resident #1's weight had risen in comparison to prior to the hospitalization but was within the usual fluctuation of his/her weight history. Furthermore, the assessment indicated Resident #1 was at a high risk for weight loss and there was a concern related to poor intake of meals and supplements. Further review of Resident #1's medical record failed to indicate any additional Nutrition Assessments were completed after 12/1/25. Review of Resident #1's Dietitian progress note, dated 11/26/25, indicated he/she was re-admitted to the facility following a hospitalization. The progress note indicated Mighty Shakes and Ensure nutritional supplements were offered daily, and they were required to prevent weight loss. The progress note further indicated Resident #1's weight had been relatively stable in the previous 90-days but does fluctuate due to fluid status and intake at meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #1's medical record failed to indicate any additional dietitian progress notes were completed after 11/26/25. Additionally, review of the medical record failed to indicate dietitian documentation identifying the significant weight loss of 5.27% in one month from 11/28/25 to 12/22/25 or identify the continued weight loss after 12/22/25. Review of Resident #1's nursing progress notes failed to indicate documentation related to Resident #1's significant weight loss. Review of Resident #1's physician (MD) and nurse practitioner (NP) progress notes failed to indicate documentation related to his/her significant weight loss. During an interview on 1/8/26 at 10:57 A.M., Nurse #3 said when a resident's weight is placed in the medical record it triggers if a weight loss is identified. Nurse #3 said staff would likely re-weigh the resident and alert the unit manager to the weight loss. Nurse #3 said the dietitian and or the unit manager would follow up with any documentation regarding the weight loss. During an interview on 1/8/26 at 11:28 A.M., the Dietitian said she reviews weights weekly on Tuesdays for the facility as most weekly weights are obtained on Monday. The Dietitian said she also receives messages from the unit managers at the facility when a weight loss is identified. The Dietitian said the interdisciplinary team meets weekly to discuss any residents with weight loss and document in progress notes the goals for each resident. The Dietitian and the surveyor reviewed the weights of Resident #1 from 11/28/25 to current. The Dietitian said she was unaware of a significant weight loss for Resident #1 on 12/22/25 and it did not trigger for her. The Dietitian said she was notified of a significant weight loss for Resident #1 on 1/5/26 and was waiting on a re-weight to confirm. The Dietitian said Resident #1's weight does fluctuate after hospitalizations due to an increase in fluid. The Dietitian said she had not completed any documentation since the Resident's re-admission. During an interview on 1/8/26 at 11:44 A.M., the Director of Nursing (DON) said weights are reviewed weekly by the dietitian and are discussed in weekly interdisciplinary team meetings. The DON said the Resident typically has an increase in fluid when they return from the hospital. The DON said the medical record should reflect documentation of the Resident's weight loss.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure all drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. Specifically, the facility failed to:1. Ensure medication carts were locked when not in direct supervision of the licensed nurse; and2. Ensure topical treatments were securely stored and not left at the bedside on one of three units in the facility.Findings include: Review of the facility's policy titled Storage of Medications, last revised 2024, indicated but was not limited to:-Medications and biologicals are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.-Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. 1. On 1/8/26 at 8:30 A.M., the surveyor observed an unlocked, unattended medication cart positioned outside the main dining room on the Oyster Pond unit (memory impaired residents on this unit). Nurse #1 was supervising residents in the dining room, and the unlocked medication cart was not in her line of sight. No other staff were in the vicinity of the medication cart. From 8:30 A.M. to 8:45 A.M., a visitor, maintenance staff, housekeeping staff, and activity staff were noted to walk by the unlocked medication cart. During an interview on 1/8/26 at 8:45 A.M., Nurse #1 said that she was responsible for the medication cart and forgot to lock it before she went into the dining room and left the cart unattended.During an interview on 1/9/26 at 10:30 A.M., the Director of Nursing said that medication carts should always be locked when unattended.2. On 1/6/26 at 9:00 A.M., the surveyor observed multiple topical treatments at the bedside in 9 of 16 resident rooms on the Oyster Pond North unit (memory impaired residents). On 1/8/26 at 11:42 A.M., Unit Manager #3 and the surveyor toured the Oyster Pond North unit. The following items were observed in multiple resident rooms, unsecured, and easily accessible to any residents on the unit:-room [ROOM NUMBER]: one tube Desitin cream (topical zinc oxide), two tubes of PeriShield with zinc oxide-room [ROOM NUMBER]: two cans of shaving cream, two tubes of PeriShield with zinc oxide-room [ROOM NUMBER]: two tubes of PeriShield with zinc oxide-room [ROOM NUMBER]: one tube of Desitin, one tube of PeriShield-room [ROOM NUMBER]: one tube of PeriShield with zinc oxide-room [ROOM NUMBER]: two tubes of PeriShield with zinc oxide, one can of shaving cream-room [ROOM NUMBER]: three tubes of PeriShield, one tube of Biofreeze (topical analgesic)-room [ROOM NUMBER]: one tube of PeriShield with zinc oxide-room [ROOM NUMBER]: one tube of PeriShield with zinc oxideDuring an interview on 1/8/26 at 12:00 P.M., Unit Manager #3 said the topical treatments found in the residents' rooms should be secured and not left at the bedside.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interviews and record reviews, the facility failed to notify the physician of a change in condition in order to reevaluate the potential need to alter the treatment plan for one Resident (#1), out of 26 residents sampled. Specifically, the facility failed to notify Resident #1's physician regarding a 5.27% significant weight loss over one month. Findings include:Review of the facility's policy titled Change in Resident's Condition or Status, undated, indicated but was not limited to the following:- The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: (d) a significant change in the resident's physical/emotional/mental condition.- A significant change in condition is a decline or improvement in the resident's status that: (a) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); (b) impacts more than one area of the resident's health status; (c) requires interdisciplinary review and/or revision to the care plan; and (d) ultimately is based on the judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument and 42 CFR 483.20(b)(ii). Review of the facility's policy titled Weight and Measuring the Resident, undated, indicated but was not limited to the following:- Report significant weight loss/weight gain to the nurse supervisor. Ensure physician and health care proxy notified.- 1 month - 5% weight loss is significant: greater than 5% is severe. Resident #1 was admitted to the facility in January 2023 with diagnoses including cerebral infarction, moderate protein-calorie malnutrition, and abnormal weight loss. Review of Resident #1's weights in the medical record indicated a weight of 239.0 pounds (lbs.) on 11/28/25 after returning from a hospitalization. Review of Resident #1's weights indicated he/she weighed 226.4 lbs. on 12/22/25, triggering a 5.27% significant weight loss in one month. Further review of Resident #1's weights in the medical record indicated he/she continued to lose weight after 12/22/25:- 12/29/25: 226.0 lbs.- 5.44% weight loss from 11/28/25- 1/5/26: 221.6 lbs. - 7.28% weight loss from 11/28/25 Review of Resident #1's medical record failed to indicate notification of the physician (MD) and/or nurse practitioner (NP) of a significant weight loss. Review of Resident #1's MD/NP progress notes failed to indicate documentation related to his/her significant weight loss. During an interview on 1/8/26 at 10:57 A.M., Nurse #3 said all residents on the unit are either weighed weekly or monthly and their weights are inputted into the medical record. Nurse #3 said staff will get notification after putting the weight in the medical record if the resident has had any type of weight loss. Nurse #3 said staff would then alert the unit manager of the weight loss and they would follow up and address with the interdisciplinary team. Nurse #3 said normally the unit manager or dietitian would follow up with the weight loss. During an interview on 1/8/26 at 11:20 A.M., Nurse #4 said when a resident's weight is out of range it will be highlighted in red in the medical record. Nurse #4 said generally a re-weight is obtained if a resident's weight is out of range to confirm. Nurse #4 said staff would then notify the physician and/or the dietitian and document the notification in their progress notes. During an interview on 1/8/26 at 11:28 A.M., the Dietitian said she reviews weights weekly on Tuesdays for the facility as most weekly weights are obtained on Monday. The Dietitian said she also receives messages from the unit managers at the facility when a weight loss is identified. The Dietitian said once the weight loss is confirmed she will notify the physician via email. The Dietitian said she was not aware of Resident #1's significant weight loss on 12/22/25 until 1/6/26 when she reviewed the weights. The Dietitian said she had not notified the physician of a weight loss for Resident #1 as she was waiting for a reweight. During an interview on 1/8/26 at 11:44 A.M., the Director of Nursing (DON) said weights are reviewed weekly by the dietitian. The DON said the interdisciplinary team discusses residents who have had or was at risk for weight loss in their weekly team meetings. The DON said notification to the physician of the weight loss should be indicated in the medical record.

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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. Based on observations, document review, and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment for one Resident (#12), of 26 sampled residents. Specifically, the facility failed to ensure Resident #12's continuous positive airway pressure (CPAP - used to treat sleep apnea) mask and tubing was maintained in a sanitary manner. Findings include: Resident #12 was admitted to the facility in August 2025 with diagnoses including but not limited to dementia. Review of Resident #12's Physician's Orders indicated but were not limited to the following:- 8/12/25: CPAP applied at night, fill water chamber with distilled water to fill line prior to use; store parts and tubing in plastic beg (sic - bag) when not in use; one time a day. On the following dates/times, the surveyor observed Resident #12's CPAP mask and tubing left on his/her bedside nightstand resting on a telephone and left open to air:- 1/6/26 at 9:26 A.M. and 12:51 P.M.,- 1/7/26 at 8:41 A.M. and 12:16 P.M., and- 1/8/26 at 8:04 A.M. During an interview on 1/8/26 at 10:56 A.M., Nurse #3 said any resident utilizing CPAP equipment should have it stored in a dated plastic bag when it is not in use. During an interview on 1/8/26 at 11:20 A.M., Nurse #4 said any resident who utilizes CPAP equipment should have it stored in a bag when it is not in use. Nurse #4 said after the parts are cleaned, they should be stored away appropriately. During an interview on 1/8/26 at 11:43 A.M., the Director of Nursing (DON) said all CPAP equipment should be stored in a plastic bag when not in use.