STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225343	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwood Healthcare	460 Washington Street Norwood, MA 02062

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), who in the morning on 3/31/26 exhibited signs of acute pain in his/her right shoulder and arm, and had a new Physician's order for a STAT (without delay, immediately) x-ray, the Facility failed to ensure that he/she was provided with radiology services consistent with his/her Physician's Orders, when nursing did not follow up on the order and a STAT x-ray was not obtained, as a result he/she had to be transferred to the Hospital Emergency Department the following day to obtain an x-ray.Findings Include:Resident #1 was admitted to the Facility in March 2025, diagnoses included Alzheimer's, dementia, lack of coordination, difficulty walking, and history of falling.Review of Resident #1's Incident Report, dated 03/29/26, indicated that he/she had an unwitnessed fall, he/she was assessed and no injuries were noted.Review of Resident #1's Nurse Progress Note, dated 03/31/26 (written by Nurse #2), indicated Resident #1 was assessed that morning, he/she exhibited signs of acute pain in his/her right shoulder and arm and there was visible quarter size dark purple bruising to his/her right upper and lower arm. The Note indicated that Resident #1 showed facial grimacing, he/she said, ouch when his/her arm (right) was touched. The Note further indicated that Resident #1's Physician ordered a STAT x-ray of his/her right shoulder and upper and lower arm for acute pain due to trauma related to status post fall on 03/29/26.Review of Resident #1's Physician's Orders, dated 03/31/26, indicated an x-ray of his/her right shoulder and arm to rule out fracture was ordered. Review of Resident #1's Radiology Provider Confirmation Order, dated 03/31/26, indicated an x-ray was ordered at 11:52 A.M, priority STAT. During an in-person interview on 05/05/26 at 1:46 P.M. and a telephone interview on 05/07/26 at 10:55 A.M. Nurse #2 said she worked from 7:00 A.M. to 11:00 P.M. (double shift) on 03/31/26 and was assigned to care for Resident #1 (both shifts). Nurse #2 said during the morning she noticed that Resident #1 appeared to be in pain. Nurse #2 said she assessed Resident #1 and there were quarter size bruises on his/her right upper and lower arm and said when she touched his/her shoulder and arm, he/she said, Ow. Nurse #2 said she notified Resident #1's Physician and obtained an order for a STAT x-ray of his/her right shoulder and arm.Nurse #2 said she called the x-ray provider to inform them that Resident #1 had an order for a STAT x-ray of his/her right shoulder and arm (order confirmed by x-ray provider at 11:52 A.M., priority STAT). Nurse #2 said when there is an order for a STAT x-ray their x-ray provider usually comes to the facility within one to four hours.Nurse #2 said the x-ray provider had not come to the facility by the end of her second shift (11:00 P.M., more than 11 hours after she had placed the order for the STAT x-ray) and that she had not called the x-ray provider back at any time during her double shift that day to see when and what time they would be coming to do Resident #1's STAT x-ray. Nurse #2 said she informed the 11:00 P.M. to 7:00 A.M. shift nurse (identified as Nurse #5) that the x-ray provider had not come to do Resident #1's x-ray and to follow up with them.During an interview on 05/07/26 at 1:17 P.M., Nurse #5 said she worked the 11:00 P.M. to 7:00 A.M. (night shift) on 03/31/26 into 04/01/26 on Resident #1's unit. Nurse #5 said during change of shift report the 3:00 P.M. to 11:00 P.M. nurse (Nurse #2) informed her Resident #1 was supposed to have a STAT x-ray of his/her arm and that the x-ray provider had not come to do the x-ray. Nurse #5 said she did not call the x-ray provider to see when they would be (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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coming to the facility.During an interview on 05/05/26 at 2:16 P.M., Nurse #3 said on the morning of 04/01/26 she informed the ADON that the x-ray provider had not come to do Resident #1's STAT x-ray. Nurse #3 said she called Resident #1's Physician and obtained an order to send him/her to the Hospital Emergency Department (ED) to have an x-ray done.Review of Resident #1's medical record indicated that there was no documentation to support that Nurse #2 followed up on the STAT x-ray before the end of her double shift on 3/31/26 at 11:00 P.M. (more than 11 hours after she obtained and placed the order) or that Nurse #5 followed up on the x-ray after being made aware during change of shift report that a STAT x-ray was still pending.During an in-person interview on 05/05/26 at 12:37 P.M. and a telephone interview on 05/07/26 at 1:53 P.M., the Assistant Director of Nursing (ADON) said on the morning of 04/01/26 she reviewed the 24-hour report and saw that Resident #1 was supposed to have a STAT x-ray of his/her right arm on 03/31/26. The ADON said she asked Nurse #3 if the x-ray provider had come to do Resident #1's x-ray and said Nurse #3 told her, they had not. The ADON said Nurse #3 notified Resident #1's Physician and an order was obtained to send him/her to the Hospital ED for an x-ray.The ADON said that the turnaround time for a STAT x-ray order to be done by the x-ray provider was four hours. The ADON said there was no documentation in Resident #1's medical record to support that nursing followed up with the x-ray provider as to why they had not come to do his/her x-ray.Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated that his/her x-ray results revealed a closed fracture of his/her right distal radius (broken wrist).During an in-person interview on 05/05/26 at 4:06 P.M and a telephone interview on 05/07/26 at 11:32 A.M., the Director of Nursing (DON) said on 03/31/26 Resident #1 was noted to be guarding his/her right arm, the Physician was notified and a STAT x-ray was ordered. The DON said the x-ray provider had not come to the facility to do Resident #1's x-ray on 03/31/26.The DON said that when there is an order for a STAT x-ray it is done within one to four hours by the x-ray provider. The DON said Nurse #2 did not follow up with the x-ray provider after four hours to see when they would be coming and that Nurse #2 should have notified Resident #1's Physician for further orders.The DON said that it was his expectation that nurses would follow up with the x-ray provider and that STAT orders are obtained.