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	02/09/2026

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interviews, the facility failed to develop, maintain, and implement an active, interdisciplinary, personˆcentered care plan to address a known elopement risk for one Resident (#83), in a sample of 25, despite documented severe cognitive impairment (BIMS=3 on 11/24/25), exitˆseeking behavior, and a highˆrisk elopement score of 14 (11/18/25). The facility resolved the elopement/wandering care plan on 11/28/25 without IDT review or subsequent risk reassessment, and did not implement effective interventions (e.g., wander alert specifications, door/elevator supervision) consistent with assessed needs. On 1/17/26, Resident #83 eloped from the facility, was not identified as missing until approximately 5:00 PM, and was located by police at Boston's South Station, approximately 21 miles away from the facility, and transported to the hospital, placing the Resident at a likelihood of serious harm and death. Findings include:Review of the facility's policy titled Policy: Care Plans, comprehensive person-centered, revised 1/2024, indicated but was not limited to:-a comprehensive, person-centered care plan will be developed for each resident. The care plan will include objectives that meet the resident's physical, psychosocial, and functional needs is developed for each resident [sic];-the interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, may assist with the development of a comprehensive care plan for each resident;-the care plan interventions are derived from information gathered as part of the comprehensive assessment;-the IDT may include: the provider, the nurse responsible for the resident, the aide responsible for the resident, nutrition staff, the resident or the resident's legal representative, other appropriate staff as determined by the resident's needs or as requested by the resident;-evaluation of residents is ongoing and care plans are revised as information about the resident and the resident's conditions change;-the IDT team reviews and updates the care plan when there has been a significant change in the resident's conditions, when there is a change and at least quarterly, in conjunction with the required quarterly MDS assessment. Resident #83 was admitted to the facility in November 2025 with diagnoses including dementia, insulin dependent type two diabetes, restlessness, and agitation. Review of the Resident's Minimum Data Set (MDS) assessment, dated 11/24/25, indicated Resident #83 scored 3 out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment, displayed disorganized thinking, and required supervision while walking. Review of the Resident's hospital records, dated 11/13/25, indicated but were not limited to:-Son reported Resident wandering and entering closets during the night;-Son reported the Resident had increasing aggressive and wandering behaviors and only brief and intermittent moments of clarity;-Patient not safe to discharge home as family is unable to provide necessary support;-Patient cannot be left alone without supervision due to current cognitive function and imbalance;-Hospital case worker indicated the Resident would need a secure unit and he/she was independent with a cane and potential to wander. 11/18/25 admission Note:Resident admitted from hospital with diagnosis of agitation related to cognitive decline. Past medical history of dementia, wandering behaviors. Brought to hospital by son on 11/13 for worsening agitation and confusion and wandering, noticing progressive decline since June 2025. 11/18/25 Nursing Evaluation:Resident was oriented to person, exit seeking, oblivious to (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	needs or safety, watching others go out of doors, early dementia, elopement attempt in last 30 days. 11/18/25 Elopement Risk Assessment:Resident was oriented to person, was exit seeking, wanted to go home/leave, independently mobile with early dementia, and elopement attempt in the last 30 days; Resident is at risk for elopement. SCORE: 14 (High Risk). 11/20/25 Physician Evaluation:Resident claims he/she feels well, does not understand why he/she is here and wants to know when he/she can go home to live with his/her son. 11/24/25 Physician Evaluation:Resident wants to go home. 11/25/25 Psychiatric Evaluation:Resident said he/she liked the facility and enjoyed his/her roommate's company; however, he/she still wanted to go home. Attention: alert and oriented with confusion, impaired thought process, impaired judgement and memory. Review of Resident #83's active care plan did not indicate a care plan for wandering or elopement risk. Review of the resolved care plans indicated a care plan for wandering/elopement risk had been in place from 11/18/25 and resolved (discontinued) on 11/28/25. Review of the Resident's elopement risk and wandering care plan (active from 11/18/25 to 11/28/25) indicated, but was not limited to, the following:Focus:-Resident is an elopement risk/wanderer; Goal:-will not leave the facility unattended through review date;-safety will be maintained through the review date; Interventions:-distract wandering by offering pleasant diversions, structured activities, food, conversation, TV, book;-identify pattern of wandering and intervene as appropriate;-monitor triggers for wandering/eloping;-provide structured activities as needed;-Wander alert: (SPECIFY) Device # Model [sic] On 1/20/26 at 7:26 A.M., the Assistant Director of Nursing (ADON) said Resident #83 eloped over the weekend and could not be found until police located the Resident and took him/her to the hospital. Review of the elopement investigation documentation included, but was not limited to, the following:On 1/17/26, Resident #83:-asked for change for a $20 bill to give his/her son money for food and the bus that day;-was observed walking up and down the hallway as he/she usually does;-was observed wandering to and from the unit elevator for 20-30 minutes prior to eloping;-was heard asking another resident if their visitor had left yet;-was observed on surveillance cameras entering the elevator with an unknown person and exiting the front door;-around 5:00 P.M., staff could not locate Resident #83;-the facility notified police and the Resident's son (activated healthcare proxy);-the facility learned Resident #83 had a cell phone that was provided by his/her son;-police located Resident #83's cell phone signal and at 6:15 P.M. identified Resident #83 was on a train;-Officers were able to ping the Resident's phone approximately 10 miles southwest of the facility. Shortly after a ping was located east of the facility. The Resident was believed to be on the train with the next stop being in South Boston;-Officers made contact with Resident #83 at South Station and took him/her to the hospital for evaluation. During an interview on 1/20/26 at 11:18 A.M., MDS Nurse #1 said she completed Resident #83's admission MDS assessment, dated 11/24/25, which involved reviewing the Resident's entire medical record including progress notes, medication administration records, recorded behaviors, evaluations, social service documentation, and activities documentation; she said she looks everywhere. MDS Nurse #1 could not recall if she met with Resident #83 for this assessment. MDS Nurse #1 said she specifically reviewed information dated from 11/18/25 through 11/24/25 as this was the lookback period for Resident #83's admission MDS assessment. She said she did not see documentation that the Resident displayed wandering behavior, so she resolved the elopement risk/wanderer care plan. MDS Nurse #1 said she was aware that Resident #83 recently eloped on 1/17/26. She said she still agrees with her decision to resolve the Resident's elopement risk/wanderer care plan based on information gathered for the 11/24/25 MDS assessment. During an interview on 1/20/26 at 12:14 P.M., Nurse #2 said he completed Resident #83's elopement risk evaluation on 11/18/25 and determined him/her to be at high risk for elopement. Nurse #2 said because Resident #83 was assessed to be high risk for elopement on 11/18/25, the Resident should have an active elopement risk care plan in place. During an interview on 1/20/26 at 12:44 P.M., Consulting Staff #2 said the initial elopement evaluation indicated Resident #83 was at high risk for elopement and the Resident had a previous care plan for his/her wandering and elopement risk. She (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	said modifying the plan of care for elopement is an interdisciplinary decision and would not hinge on information gathered for an MDS assessment. Consulting Staff #2 said the elopement risk/wanderer care plan should have remained in place until a subsequent elopement risk assessment was performed and the Interdisciplinary Team (IDT) deemed Resident #83 was no longer an elopement risk. Consultant #2 said the facility had no policy regarding elopement risk or elopement prevention. During an interview on 2/2/26 at 2:36 P.M., the Director of Nursing (DON) said care plans were created during admission and updated on an ongoing basis. He said an elopement risk care plan should not be resolved by the MDS nurse based on MDS assessments. The IDT would discuss the need to keep a resident on elopement risk, and if needed, re-evaluate the resident's risk for elopement. Refer to F689

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 interview, the facility failed to ensure adequate supervision and interventions were implemented to prevent accidents for one Resident (#83), out of a total sample of 25 residents. Specifically, the facility failed to ensure an elopement/wandering care plan and interventions for a resident assessed at high risk for elopement (score 14, 11/18/25) was maintained and implemented, failed to include the Resident in the elopement photo/binder alert system, and failed to prevent unsupervised exit through the main door, resulting in an elopement on 1/17/26. Resident #83 was not discovered missing from the facility until 5:00 P.M. and was located by the police at a South Boston train station, approximately 21 miles away, and hospitalized , placing the Resident at immediate risk of serious harm and death. Findings include:Review of the facility's policy titled Policy: Care Plans, comprehensive person-centered, revised 1/2024, indicated but was not limited to:-a comprehensive, person-centered care plan will be developed for each resident. The care plan will include objectives that meet the resident's physical, psychosocial, and functional needs is developed for each resident [sic];-the interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, may assist with the development of a comprehensive care plan for each resident;-the care plan interventions are derived from information gathered as part of the comprehensive assessment;-the IDT may include: the provider, the nurse responsible for the resident, the aide responsible for the resident, nutrition staff, the resident or the resident's legal representative, other appropriate staff as determined by the resident's needs or as requested by the resident;-the IDT team reviews and updates the care plan when there has been a significant change in the resident's conditions, when there is a change and at least quarterly, in conjunction with the required quarterly MDS assessment. Resident #83 was admitted to the facility in November 2025 with diagnoses including dementia, insulin dependent type two diabetes, restlessness, and agitation. Review of Resident #83's Minimum Data Set (MDS) assessment, dated 11/24/25, indicated the Resident:-scored 3 out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment;-displayed disorganized thinking;-required supervision while walking. Review of the Resident's hospital records, dated 11/13/25, indicated but were not limited to:-Son reported Resident wandering and entering closets during the night;-Son reported the Resident had increasing aggressive and wandering behaviors and only brief and intermittent moments of clarity;-Patient not safe to discharge home as family is unable to provide necessary support;-Patient cannot be left alone without supervision due to current cognitive function and imbalance;-Hospital case worker indicated the Resident would need a secure unit and he/she was independent with a cane and potential to wander. Further review of Resident #83's medical record included, but was not limited to, the following: -11/18/25 admission Note:Resident admitted from hospital with diagnoses of agitation related to cognitive decline. Past medical history of dementia, wandering behaviors. Brought to hospital by son on 11/13 for worsening agitation and confusion and wandering, noticing progressive decline since June 2025. -11/18/25 Nursing Evaluation:Resident was oriented to person, exit seeking, oblivious to needs or safety, watching others go out of doors, early dementia, elopement attempt in last 30 days. -11/18/25 Elopement Risk Assessment:Resident was oriented to person, was exit seeking, wanted to go home/leave, independently mobile with early dementia, and elopement attempt in the last 30 days; Resident is at risk for elopement. SCORE: 14 (High Risk). -11/19/25 Social Services Assessment:Resident had dementia with a BIMS score of 3; Resident wanders. -11/20/25 Physician Evaluation:Resident claims he/she feels well, does not understand why he/she is here and wants to know when he/she can go home to live with his/her son. -11/24/25 Physician Evaluation:Resident wants to go home. -11/25/25 Psychiatric Evaluation:Resident said he/she liked the facility and enjoyed his/her roommate's company; however, he/she still wanted to go home. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Attention: alert and oriented with confusion, impaired thought process, impaired judgement and memory. -12/9/25 and 1/9/26 Nursing Summary Notes indicated the Resident wandered. Review of Resident #83's active care plan did not indicate a current care plan for wandering or elopement risk. Review of the Resident's previous care plans indicated an elopement risk/wanderer plan active from 11/18/25 to 11/28/25 which indicated, but was not limited to, the following:Focus:-Resident is an elopement risk/wanderer; Goal:-will not leave the facility unattended through review date;-safety will be maintained through the review date; Intervention:-distract wandering by offering pleasant diversions, structured activities, food, conversation, TV, book;-identify pattern of wandering and intervene as appropriate;-monitor triggers for wandering/eloping;-provide structured activities as needed;-Wander alert: (SPECIFY) Device # Model [sic]. On 1/13/26 at 12:43 P.M. and on 1/14/26 at 2:00 P.M., the surveyor observed Resident #83 ambulating up and down the unit hallway with his/her cane. On 1/20/26 at 7:26 A.M., the Assistant Director of Nursing (ADON) said Resident #83 eloped over the weekend and could not be found until police located the Resident and took him/her to the hospital. During an interview on 1/20/26 at 8:11 A.M., the Director of Nursing (DON) said Resident #83 eloped over the weekend and was a known elopement risk. He said the elopement investigation was still open. Review of Resident #83's medical record indicated, but was not limited to, the following:-11/21/25, Humalog insulin, inject as per sliding scale at 0800, 1200, 1700;-11/18/25, Humalog insulin, inject as per sliding scale at 2100;-Insulin Glargine at bedtime. During an interview on 1/20/26 at 10:12 A.M., Nurse #3 said the Resident often walked the unit, but she never noticed him/her linger around exits. She said she worked the day and evening shifts on the day Resident #83 eloped. Nurse #3 said she had given the Resident his/her morning and afternoon medications and treatments and when she went back around 5:00 P.M. to get the Resident's blood sugar reading, she could not find the Resident. She said the facility was searched and the elopement protocol was initiated. On 1/20/26 at 10:39 A.M., Consulting Staff #2 and the Administrator provided the surveyor documentation of the ongoing elopement investigation. During an interview on 1/20/26 at 10:39 A.M., the Administrator said he was the manager on duty and worked the front desk the day of the elopement. The Administrator said he left the front desk for a brief period and arrived back around 2:40 P.M. at which point he observed a person (Resident #83) at the door trying to exit the building. The Resident stated to the Administrator he/she was a visitor and wanted to exit the building. The Administrator asked the person if they signed out and he/she said yes. The Administrator said Resident #83 was not in the elopement binder, and he did not recognize the person as Resident #83, therefore, he unlocked the door and Resident #83 exited the building. Consulting Staff #2 and the Administrator said Resident #83 had been identified as an elopement risk and resided on a unit with an elevator that required a numerical code to call the elevator and a second code to move the elevator, plus a third code was needed to exit the main door. Consultant Staff #2 said since Resident #83 resided on what she believed to be a secure unit, he/she was not required to wear a wander bracelet (an electronic bracelet alarm system used to prevent residents with a tendency to wander from leaving monitored areas) and Resident #83 had no plan in place for elopement risk because his/her elopement risk care plan was resolved (discontinued) on 11/28/25. She said there was no evidence in the medical record indicating why the elopement care plan was resolved and Resident #83 should have been included in the elopement binder. During an interview on 1/20/26 at 11:18 A.M., the MDS Nurse said she completed Resident #83's admission MDS assessment in November. She said she did not see documentation that the Resident displayed wandering behavior, so she resolved the elopement risk/wanderer care plan. The MDS Nurse said she was aware that Resident #83 recently eloped. The MDS Nurse said she still agrees with her decision to resolve the Resident's elopement risk/wanderer care plan based on the MDS assessment. During an interview on 1/20/26 at 12:14 P.M., Nurse #2 said he completed Resident #83's elopement evaluation and determined him/her to be at high risk for elopement. Nurse #2 said based on the evaluation he would have expected the Resident's photo to be in the elopement binder and an elopement and wandering care plan to be in (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	place. Review of the elopement investigation documentation included, but was not limited to, the following:On 1/17/26, Resident #83:-asked for change for a $20 bill to give his/her son money for food and the bus that day;-was observed walking up and down the hallway as he/she usually does;-was observed wandering to and from the unit elevator for 20-30 minutes prior to eloping;-was heard asking another resident if their visitor had left yet;-was observed on surveillance cameras entering the elevator with an unknown person and exiting the front door. Further review of the elopement investigation documentation indicated:-around 5:00 P.M., staff could not locate Resident #83;-the facility notified police and the Resident's son (activated healthcare proxy);-the facility learned Resident #83 had a cell phone that was provided by his/her son;-Consulting Staff #2 and the Administrator said they were unaware the Resident had a cell phone;-police located Resident #83's cell phone signal and at 6:15 P.M. identified Resident #83 was on a train. Review of the [NAME] Police Department Patrolman Narrative (Reference: 2 6NWD-52-OF), dated 1/17/26, indicated but was not limited to:-The reporting party was Resident #83's son;-Resident #83's son drove to the facility to try to help find the Resident at which point he then called the police;-Resident #83's son stated:Resident suffers from dementia and is a severe diabetic;Resident's blood sugars can be very volatile, and he/she needs to be monitored;Resident recently moved to the State, so he/she does not know the area much and due to dementia thinks at times he/she is in their home state.-There was a delay in reviewing video footage as the Administrator was waiting for the password to get into the system from someone that was not on site, then once in the system the Administrator did not know how to operate the system and requested the Officer do so. The Officer was only able to get glimpses of Resident #83 walking in the hallway around 8:00 A.M. that morning;-Officers were able to ping the Resident's phone approximately 10 miles southwest of the facility. Shortly after a ping was located east of the facility. The Resident was believed to be on the train with the next stop being in South Boston;-Officers made contact with Resident #83 at South Station and took him/her to the hospital for evaluation. Review of the Massachusetts Bay Transportation Authority commuter rail schedule as of 2/3/26 indicated a direct evening route from a [Town Name] train station to South Station (in South Boston) to be approximately 30 to 40 minutes in duration. South Station was indicated as being the last stop for that commuter line. Review of weather data obtained from the United States Department of Commerce indicated the temperatures on 1/17/26 in [town name], Massachusetts was a maximum of 40 degrees Fahrenheit and a minimum of 25 degrees Fahrenheit. Review of hospital records, dated 1/20/26, stated Resident #83 was alert and oriented x3; forgetful; intermittent confusion; reported the facility was giving him/her too many pills and he/she did not want to stay there. The Emergency Department (ED) team felt that patient did not have insight into his/her illness and need for medications; overall felt to lack capacity. In discussion with the patient's son, patient to return back to facility. However, patient then refused to leave ED despite use of olanzapine (an antipsychotic drug used to treat mental health conditions by stabilizing mood and reducing behavioral disturbances) 5 milligrams x1. Reattempted to discharge patient later in the evening but again patient refused. Given 250 milligrams of Depakote (an anti-epileptic drug commonly used as a mood stabilizer to manager specific, often severe, behavioral issues) to calm patient prior to discharge. During an interview on 1/20/26 at 12:44 P.M., Consulting Staff #2 said the initial elopement evaluation indicated Resident #83 was at high risk for elopement and the Resident had a care plan for his/her wandering and elopement risk. She said modifying the plan of care for elopement is an interdisciplinary decision and would not be based solely on information gathered for an MDS assessment. She said the elopement risk/wanderer care plan should have remained in place until a subsequent elopement risk assessment was performed and the IDT deemed Resident #83 was no longer an elopement risk. Consultant #2 said the facility had no policy regarding elopement risk or elopement prevention. On 2/2/26 at 3:16 P.M., the surveyor placed a call to Resident #83's son and left a message. The son called the surveyor back on 2/3/26. During a telephone interview on 2/3/26 at 12:09 P.M., Resident #83's son said the Resident moved to Massachusetts to live so he could take care of him/her. The (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	son said the Resident is smart enough to [NAME] his/her way out of things which is why he opted for a secure facility. He said Resident #83 told him soon after admitting into the facility that if he did not get him/her out of the facility, he/she would jump out the window and that he/she was going to escape. The son said he notified a staff member about these statements. He said he was shocked when the Resident eloped as he was told the facility was a secure place. The son also said Resident #83 had his/her cell phone during the time of admission to the facility and the facility should have known about it as the Resident always carries his/her two wallets and cell phone on his/her person. The son went on to say that the facility called him twice on 1/17/26. During the first call, the facility asked him if he'd taken the Resident out of the building to which he replied he was the only authorized person to sign the Resident out of the building and he had not done so. He said the facility did not indicate they were searching for the Resident. The son said the facility called him a second time, about 30-60 minutes later, and asked again if he had taken Resident #83 out of the building. He replied he had not. The facility then notified him the Resident could not be found. He then drove approximately 30-35 minutes to the facility. The son said he called the police and was surprised the facility had not already done so given Resident #83 had dementia.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) program with documentation of the development, implementation, and evaluation of corrective actions or performance improvement activities and failed to maintain a QAPI program which addressed the full range of care and services including clinical care. Findings include: Review of the facility's policy titled Quality Assurance Performance Improvement (QAPI), dated as last revised 6/2024, indicated but was not limited to the following:-The purpose of the committee is to review and analyze facility related data and direct appropriate actions for the facility response.-Our QAPI plan addresses: Clinical indicators, Environmental indicators, and Resident indicators.-We will identify areas of improvement and rank them by factors such as prevalence, risk, relevance, responsiveness, feasibility, and continuity. From this we will determine our Performance Improvement Projects (PIP).-The Administrator is responsible and accountable for developing, leading, and monitoring a QAPI program.-The committee maintains QAPI minutes, project, PIPs, Plan-Do-Study-Act (PDSA) reviews, data, data analysis and sample performance improvement support tools.-The QAPI Committee will complete an annual self-assessment / review of the QAPI program.-PIPs are reported by the project lead to the QAPI Committee verbally and documented in the meeting minutes.-The PDSA process and Root Cause Analysis (RCA) are used to identify improvement opportunities and understand how to improve them.-The QAPI Committee monitors the process according to pre-determined time frames, observing if the changes in the process resulted in the desired outcome. If the changes to the process have not resulted in the goal of the PIP, further changes are made and monitoring of the process takes place again.-The QAPI program will be evaluated annually. The key elements of the program will be reviewed to assure that they are occurring and that the program is efficient.-The plan will be revised annually. Review of the 2025 QAPI binder with the Administrator indicated the following:-No documented projects/PIPs that had been worked on throughout the year.-Sign-in sheets for the quarterly meetings and the lab/pharmacy reports for each quarter, but no meeting minutes.-Kitchen audits from July through October but failed to indicate a project and goal they were related to. During an interview on 1/20/26 at 3:00 P.M., the Administrator said they had one clinical project for pressure ulcers that just got started and he did not have any details on the project. He said the Director of Nurses (DON) did not have any other QAPI information in his office either. The Administrator said he did not have any other information regarding any plans they may or may not have been working on in 2025. He said there should have been documented projects to review but he does not have anything. He said he must re-do everything. During an interview on 1/20/26 at 4:34 P.M., the Assistant Director of Nurses (ADON) said the only PIP she has is related to pressure ulcers and it's new. She said they don't have any other formal QAPIs or PIPs that she is aware of. She said they work on things but not in a QAPI format. During an interview on 1/20/26 at 4:45 P.M., the DON said they have been working on psych consents for a few months but there was not a PIP for it, they were just making sure the consents were complete and accurate. He said it had been about three months, and they were almost done with the audit. He said they did not have any projects in QAPI format they were working on or that he could review from last year.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) program with documentation of the development, implementation, and evaluation of corrective actions or performance improvement activities. Findings include: Review of the facility policy titled Quality Assurance Performance Improvement (QAPI) dated as last revised 6/2024 indicated but was not limited to the following:-The purpose of the committee is to review and analyze related data and direct appropriate actions for the facility.-It is the responsibility of the QAPI Committee to consider all data presented by the QAPI team and to direct the QAPI team to continue or conclude the assignment.-Our QAPI plan addresses Clinical Indicators, Environmental Indicators, and Resident Indicators.-We will identify areas of improvement and rank them by factors and determine our Performance Improvement Projects (PIP).-The Administrator is responsible and accountable for developing, leading, and monitoring the QAPI program.-The Committee maintains QAPI minutes, project, PIP, Plan-Study-Do-Act (PDSA) reviews, data analysis, and sample performance improvement support tools.-The QAPI Committee will complete an annual self-assessment / review of the QAPI program.-The QAPI team analyses data regularly as part of their project assignment.-The QAPI Committee monitors progress to ensure that interventions or actions are implemented and effective in making and sustaining improvements.-PIPs are reported to the project lead and documented in the meeting minutes. Review of the 2025 QAPI binder with the Administrator indicated the following:-No documented projects/PIPs that had been worked on throughout the year.-No evidence of data collection and analysis. During an interview on 1/20/26 at 3:00 P.M., the Administrator said he did not have any data on any projects to provide. He said there should be plans for each department to be working on something, but he did not have anything and therefore could not speak to what they had been doing or not doing last year or if the projects had to be revised or were effective. Additionally, he said the plan of correction from last year should be part of QAPI and he did not have anything related to that to be able to speak to it. He said Corporate has templates they have to fill in but they are not related to specific facility QAPI plans. He said the way they do QAPI has to change.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and document review, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) Committee which included the required members at their meetings. Specifically, the facility's Director of Nurses (DON) and Infection Preventionist (IP) failed to attend and participate in three of the last three quarterly QAPI meetings. Findings include: Review of the facility's policy titled Quality Assurance Performance Improvement, dated as last revised 6/2024, indicated but was not limited to the following:-The facility will form a QAPI that meets quarterly. The Committee must include the Medical Director, Administrator, Director of Nurses, Infection Preventionist, and two other staff members.-The purpose of the committee is to review and analyze related data and direct appropriate actions for the facility. Review of the quarterly sign-in-sheets for 2025 indicated the following:-April 2025: The DON was present. He also served as the IP at that time.-July 24, 2025: The DON and Assistant Director of Nurses (ADON)/IP were present.-October 2025: The DON and Assistant Director of Nurses (ADON)/IP were present. During an interview on 1/20/26 at 2:02 P.M., the ADON/IP said she has not attended a QAPI meeting since she was hired about six months ago. She said she thinks it is important for the IP to be part of the QAPI process, but she has not been. During an interview on 1/20/26 at 3:00 P.M., the Administrator said he could not speak to the meetings and/or attendance because he had no meeting minutes and could only refer to the sign-in sheets in the binder. He said he was not hired until November 2025. During an interview on 1/20/26 at 4:34 P.M., the ADON said she was not employed at the facility for the April meeting, and that was her signature on the July and October attendance sheets, but she said the previous Administrator would write up QAPI and just have her sign the attendance sheet. The ADON said they never had any meetings to discuss any QAPI plans/projects. During an interview on 1/20/26 at 4:45 P.M., the DON said he had attended and participated in QAPI meetings in the past as an ADON but in 2025 since taking over as DON he had never attended a QAPI meeting. He said the previous Administrator just had us sign the paper and we never had any meetings or discussions regarding projects to work on.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on document review and interview, the facility failed to provide training and education to all their staff to outline current elements, projects, goals, and revisions of the facility's Quality Assurance Performance Improvement (QAPI) program. Findings include: Review of the facility's policy titled Quality Assurance Performance Improvement (QAPI), dated as last revised 6/2024, indicated but was not limited to the following:-Communication about QAPI activities is shared via staff meetings and/or trainings.Review of the facility's education records on QAPI training indicated staff were trained on the general concept of QAPI but failed to indicate staff were educated on the facility's QAPI projects, plans, or goals as required.During an interview on 2/2/26 at 1:30 P.M., Consulting Staff #3 said she does not have any records related to any QAPI project and education/training from 2025. She said the online training record she provided was education on the general Policy and Procedure and was not specific to any projects the facility was working on.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Resident Council Minutes, interviews, and record reviews, the facility failed to ensure concerns 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, last revised on 2/24, indicated but was not limited to the following:-The facility will provide a designated staff person who is approved by the resident group and facility who is responsible for providing assistance and responding to written requests from group meetings.-Department heads must respond to grievances addressed in the minutes in writing before the next meeting.Review of Resident Council Minutes, dated 7/5/25, indicated the residents would like to get a video game, more hamburgers for evening meals, and evening activities once a month. The minutes also indicated that the residents would like to go outside more. The form indicated follow up was required but no follow-up was indicated as completed.Review of Resident Council Meeting Minutes, dated 8/7/25, indicated residents would like a Bingo evening activity with prizes; Kitchen director updated on residents getting more hamburgers. No follow up was reviewed, documented, or included from the meeting.Review of the Resident Council Meeting Minutes, dated 9/9/25, indicated No follow up was reviewed, documented, or included from the meeting.Review of the Resident Council Meeting Minutes, dated 10/9/25, indicated follow-up was needed, the residents said they would like to have a specific exercise activity called [NAME]-Boom more than one time a month, residents would like to get a video game. No follow up was reviewed, documented, or included. For the question asked if the facility addresses grievances, the answer was left blank, indicating it was not reviewed. Review of the Resident Council Meeting Minutes, dated 11/13/25, indicated no issues were discussed, no resident concerns were documented or reviewed, and no follow-up created. Review of the Resident Council Meeting Minutes, dated 12/9/25, indicated the residents would like more soup with meals, tomato and grilled cheese options, and would like to have a social event once a month with food. No follow up was reviewed, documented, or included.On 1/15/26 at 11:00 A.M., the surveyor held a Resident group meeting with 13 residents in attendance. The residents had the following concerns:7 out of 13 residents said they only discuss the activities department at Resident Council. 4 out of 13 residents said no one reviews the outcome of previously discussed concerns.5 out of 13 residents said they are unsure of the grievance process or the process for follow-up from requests made from Resident Council. During an interview on 1/14/26 at 4:10 P.M., the Activity Director said she verbally discusses any issue that arises at Resident Council with the appropriate department head. She said she doesn't have a way to track the follow-up from the department heads and bring it to the Resident Council Group meeting. She said she has never initiated a grievance form from a complaint at Resident Council. She said she does get complaints and issues, but she resolves the issues. She said for example there was a resident who was missing a shirt and she gave her one of hers. She said there is no way to track the completion and resolution of grievances or concerns. She said she verbally follows up with the residents if she receives an answer from the previous concerns at the following Resident Council Meeting. She said she was aware of the same topics being brought up multiple times with no follow-up indicated.During an interview on 1/15/26 at 2:15 P.M., the Director of Clinical Operations said she expects the staff responsible for facilitating Resident Council to address concerns across all departments and follow a process to initiate responses to provide the Resident Council Group. She said she would expect the Activity Director would be initiating grievances when residents voice a complaint or a group concern, she would expect there to be written follow-up from the department head. She said the Activity Director is responsible for this process and reporting back the responses.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and document review, the facility failed to ensure residents had the right to voice and formulate grievances, have those grievances responded to promptly, and be provided a resolution to their grievance. Specifically, the facility failed to:1. Ensure residents 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); and2. Maintain evidence demonstrating the results of all grievances for a period of no less than three years from the issuance of the grievance decision.Findings include: Review of the facility's policy titled Grievances, last revised 2/24, indicated but was not limited to the following:Guidelines:-The administrator is identified as the grievance official responsible for oversight of the grievance process in the facility. This includes responsibility for reviewing and tracking grievances, necessary investigating, ensuring that grievances are addressed and a response provided.-Any resident, and/or health care representative, family member, employee, or appointed advocate may file a grievance without fear of discrimination or reprisal in any form.Procedure:-If a resident, and or health care representative, or another interested family member of a resident has a complaint, a staff member will inform the person of the grievance process and assist the resident, or person acting on the resident's behalf, to file a written grievance with the facility using the grievance form as needed.-If the person filing the grievance is anonymous or wishes to remain anonymous confidentiality will be maintained, to the extent possible.-Upon receipt of a written grievance the Administrator will refer it to the appropriate department head for investigation. The department head will submit a response of the findings to the Administrator.-The Administrator will review the findings with the person investigating the grievance to determine what corrective actions need to be made.-Evidence of results of grievances will be maintained for three years.On 1/14/26 at 11:00 A.M., the surveyor held a Resident group meeting with 13 residents in attendance. The residents reported the following concerns:-11 out of 13 residents were not sure of the process for completing a grievance form, where they were located, or who the grievance officer was.-9 out of 13 residents were not sure what would be considered a grievance or how to formulate a grievance anonymously.On 1/15/26 at 12:30 P.M., the surveyor toured the building and failed to find information on the grievance process posted in the building.The surveyor observed an empty green folder in the lobby labeled grievances at the following times:-1/14/26 at 7:37 A.M.,-1/15/26 at 8:08 A.M-1/15/26 at 1:08 P.M.On 1/14/26 at 2:00 P.M., the surveyor toured the building and failed to find information on how to file a grievance, a way for residents to file a grievance anonymously, and the person responsible for the grievance process. During an interview on 1/14/26 at 4:51 P.M., Nurse #4 said the grievance forms are kept behind the enclosed nurses' station and she would give a resident a form if they asked for a grievance form. She said they are not accessible for the residents or visitors to obtain on their own. During an interview on 1/14/26 at 4:48 P.M., Nurse #1 said the grievance forms were behind the nurses' station on South 2 and were not accessible to residents without asking staff for assistance. She said residents have the ability to voice grievances verbally to staff and then the staff would interpret if they thought it is a complaint or a grievance and fill out a grievance form if warranted. She wasn't sure what the difference would be between a complaint or grievance, but she said not every complaint is a grievance but could not offer an example of what she meant. She said she was not sure who the grievance officer was in the building or the process. She said she would investigate to see if a grievance was valid and bring it to the social worker's attention or bring it up during the morning clinical meeting. She was unable to define or elaborate on what valid meant. During an interview on 1/14/26 at 4:10 P.M., the Activities Director said she was unsure of where to find a grievance form, and she believed they were obtained through the social worker. She said she was not sure of the grievance process. She said she was not sure how a resident would file a grievance anonymously if they have to ask for a grievance form from (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff. She said she was not sure who is responsible for ensuring grievance forms are available for residents and visitors. During an interview on 1/15/26 at 1:20 P.M., the Administrator said he is the grievance officer and expects staff are assisting residents with grievances. He said he expects there are grievance forms available for residents and visitors to easily access and they should be able to file a grievance anonymously. He said he wasn't aware there wasn't a process in place for grievances to be filed anonymously. During an interview on 1/15/26 at 2:00 P.M., the Director of Clinical Operations said grievance forms should be readily available for residents and visitors, and they should be able to file grievances anonymously if they want. She said there should be information on the grievance process available for visitors and residents. 2. Review of facility grievances failed to indicate there were three years of resolved grievances. The facility was unable to provide grievances before the date of 1/2025.Facility staff provided the surveyor with a grievance book dated 2025 which indicated grievances starting in May 2025 through December 2025. During an interview on 1/14/26 at 3:00 P.M., the Administrator said he would look for three years of resolved grievances. During an interview on 1/15/26 at 1:20 P.M., the Administrator said he was able to find a few more grievances, but they were from the previous year. He said he was unable to find any additional grievances. He said he expects all grievance records to be retained.During an interview on 1/15/26 at 2:15 P.M., the Director of Clinical Operations said she expects that grievances are retained for three years after the resolution date.

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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. Based on observations, interviews, and record review, the facility failed to ensure one Resident (#8), out of a total sample of 23 residents, received care and treatment in accordance with professional standards. Specifically, the facility failed to ensure a physician's order to increase Trazodone (antidepressant/used for behavior management) was transcribed into the electronic medical record and implemented. Findings include: Review of the Lippincott Manual of Nursing Practice, 11th Edition (2019) indicated: Scope of Practice, Licensure, and Certification: The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. The National Council of State Boards of Nursing and the National League of Nursing have developed standards that guide each State Board in the development of their licensure requirements and scope of practice rules. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice dated as revised April 11, 2018, indicated but was not limited to the following: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. Resident #8 was admitted to the facility in June 2025 with diagnoses which included depression, vascular dementia with or without behavioral disturbances, and Alzheimer's dementia. Review of the Minimum Data Set (MDS) Assessment, dated 12/19/25, indicated Resident #8 scored 3 out of 15 on the Brief Interview for Mental Status (BIMS) Assessment indicating he/she had severe cognitive impairment, was feeling down and depressed, and was administered antidepressant and antipsychotic medications. Review of the Active Physician's Orders in the electronic medical record indicated but were not limited to the following:-Trazodone 50 milligrams (mg) give 0.5 tablet by mouth two times daily (10/31/25) Review of the handwritten Physician's Orders in the paper medical record indicated but were not limited to the following:-11/18/25: Discontinue Trazodone 25mg twice daily (BID) and start Trazodone 50mg BID.-The order was written and signed by the Nurse Practitioner (NP). Review of the Medication Administration Records (MAR) from 11/18/25 through review on this day (1/16/26) indicated Resident #8 received Trazodone 25mg BID daily and not Trazodone 50mg BID as ordered on 11/18/25. Review of the psychiatric progress note, dated 11/25/25, indicated the reason for the visit was for a follow up after a Trazodone dose increase. The assessment indicated Resident #8 recently had a recommendation for an increase in Trazodone, which was not initiated because they were waiting for approval from the spouse. Additionally, he/she had been compliant with medication but sometimes was resistant to care. Review of the medical record indicated his/her Health Care Proxy (HCP) had been activated on admission and his/her spouse was not the activated Health Care Proxy (HCP) on file. Review of the progress notes failed to indicate why the order was not transcribed and implemented as ordered. During an interview on 1/15/26 at 10:15 A.M., Nurse #2 said handwritten orders are usually flagged if they need to be entered into the computer and he was not sure why this was never done. During an interview on 1/16/26 at 12:55 P.M., the Director of Nurses (DON) and Consulting Staff #2 said all orders written in the paper chart should be taken off and transcribed into the electronic medical record. They said they did not know why this order had not been taken off for almost three months. The DON said he thought the night shift was checking for missed orders, but there was not an actual process in place, and they don't document chart checks anymore. He said there is not a good system in place to make sure orders are not missed, because some orders go directly into the computer and others get written down and flagged for the nurses to take off and enter into the computer. During an interview on 1/16/26 at 2:35 P.M., Nurse #1 said the physician's orders in the paper chart are usually flagged and then the nurse on duty that shift takes the order off and enters it into the computer. She said she was not sure why this was never done.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. Based on record review and interview, the facility failed to ensure that the necessary vision services were provided for one Resident (#1), out of a total sample of 23 residents. Findings include: The facility indicated they did not have a policy for Consultant Providers. Resident #1 was admitted to the facility in August 2025 with diagnoses which included diabetes mellitus with neuropathy, ketoacidosis, foot ulcer, and hyperglycemia. Review of the Minimum Data Set (MDS) Assessment, dated 11/21/25, indicated Resident #1 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) Assessment indicating he/she was cognitively intact. During an interview on 1/13/26 at 10:15 A.M., the surveyor observed Resident #1 wearing glasses. Resident #1 said he/she signed the consent for vision services and was told the eye doctor would see him/her at the facility. The Resident said his/her vision is so bad and it keeps getting worse. The Resident said he/she keeps asking about the eye doctor but has gotten nothing but the run around for months, no one will tell him/her when the eye doctor is coming. The Resident said their vision is so blurry, the left eye is worse than the right, and he/she has the highest cheaters he/she can get at the local pharmacy. The Resident said he/she often takes pictures of things with their phone to enlarge it so they can try and read it with their glasses on otherwise they cannot read anything. Review of the medical record indicated Resident #1 signed a consent / Request for Eye Health Services dated 8/15/25. Review of the Physician's Orders indicated but were not limited to the following:-Consults: Audiology, Dental, Optometry or Ophthalmology, Podiatry, Psych services as needed. (8/15/25) Review of the Social Service progress note, dated 9/10/25, indicated Resident #1 requested to be seen by the eye doctor through the vision services provider and nursing was made aware of the request. Further review of the progress notes failed to indicate why Resident #1 had not been seen since August 2025 (five months), when they were going to be seen, or anything else related to a pending eye appointment. During an interview on 1/15/26 at 10:15 A.M., Nurse #2 said the Director of Nurses (DON) organizes communication with the vision services provider. He said he thought the eye doctor came every couple of months and was not sure when he was coming again. He said if a resident wants to be seen they just tell the DON and he ensures they are on the list. During an interview on 1/15/26 at 12:44 P.M., the DON said he coordinates eye doctor visits with the vision services provider. He said he gets an email about a week before they come with a list of who will be seen. He said he was not sure when the last visit was or when the next visit was. He was unable to retrieve any emails from his computer regarding the eye doctor. He said if a consent is signed it is faxed over to the vision services provider and they add them to the list. He said he just started to keep copies of the consents but did not have Resident #1's in his office. He called the vision services provider and requested the visit summary log from August 2025 through January 2026. Review of the Visit Summary Log from the vision services provider for the Optometrist failed to indicate Resident #1 had been seen between August 2025 and January 2026. Additionally, the visit log indicated the eye doctor had been to the facility nine times in the last five months. During an interview on 1/15/26 at 2:40 P.M., Consulting Staff #2 said she was not sure of the process at this facility as far as who oversaw coordinating services. She said he/she has signed consent, should have been seen, and was not seen. During an interview on 1/15/26 at 2:42 P.M., the DON said Resident #1 had not been seen by the vision services provider and he did not know why. He called the vision services provider and confirmed he/she had never been seen and said they were going to email him a form to fill out so they could be seen. During an interview on 1/15/26 at 2:50 P.M., Nurse #1 said she had an email with a list of residents who had not been seen by an optometrist and why. She said Resident #1 was not seen because of insurance. She provided the surveyor with a list of patients with a Do Not Treat (DNT) Status. The full report was 10 pages long. Resident #1 was on page 8, and it indicated he/she had a DNT status date of 9/12/25 for insurance reasons. She said she had not done anything to get him/her seen and had not followed up with the vision services provider. Review of the DNT list provided indicated if the resident should be seen, (continued on next page)

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	please submit a new Request for Services form or [Vision Services Provider Name] Attending Physician Request for Services and a face sheet. For questions to call and/or email the scheduling team. During an interview with Consulting Staff #2 and the DON on 1/15/26 at 2:50 P.M., Consulting Staff #2 said Resident #1 should have been seen but wasn't. She said regardless of insurance we as the facility need to provide the services required and that did not happen. She said the facility must authorize the visit. She said she was not sure who had been getting the communication from the vision services provider or the DNT list, but they need a better process as no one had attempted to resolve this for months.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to implement an antibiotic stewardship program which included antibiotic use protocols and monitoring of antibiotic use in accordance with the facility's antibiotic stewardship program. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidance titled The Core Elements of Antibiotic Stewardship for Nursing Homes, undated, indicated but was not limited to the following: - The purpose of an antibiotic stewardship program is to improve the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance.- Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.- The CDC recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use.- Any action taken to improve antibiotic use is expected to reduce adverse events, prevent emergence of resistance, and lead to better outcomes for residents in this setting. Review of the facility's policy titled Antibiotic Stewardship Program, dated as revised 1/2024, indicated but was not limited to the following:-The antibiotic Stewardship Program establishes antibiotic treatment recommendations to optimize antibiotic prescribing, monitoring, and communication of resident changes in condition(s) to improve resident outcomes related to antibiotic usage.-The antibiotic stewardship program purpose is to monitor the use of antibiotics in residents.-When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the provider as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.-The Infection Preventionist (IP), or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics.-The IP will monitor overtime and report to the Director of Nursing (DON) as warranted: Measures antibiotic use and tracks antibiotic starts through use of the line listing and pharmacy reports; antibiotic susceptibility patterns (annual antibiogram data); negative outcomes or events related to antibiotic use During an interview on 1/14/26 at 7:59 A.M., the Infection Preventionist (IP) said the facility utilizes McGeer Criteria for infection (standardized, evidence-based definitions) to determine if an illness meets the criteria for antibiotic use. Review of the facility's Surveillance Sheets for December 2025 indicated but were not limited to the following: Resident #58 had a concern for a urinary tract infection (UTI) with an onset date of 12/16/25 and was placed on Vantin (antibiotic).Resident #58 had a concern for a UTI with an onset date of 12/31/25 and was placed on a Macrobid (antibiotic).Review of Resident #58's McGeer Criteria for Infection, dated 12/17/25, indicated the Resident had Suprapubic pain (discomfort in lower abdomen), new or marked increase in urgency and frequency. The McGeer Criteria did not include the microbiologic criteria (urine culture results) to determine if the concern met criteria for infection.Further review of the medical record failed to include any further McGeer Criteria for Infection.Review of Resident #58's progress notes indicated an antibiotic was initiated on 12/16/25 after a recent hospitalization with no urine culture documented. A nursing note for 12/18/25 was written after the concern for antibiotic usage was brought to the facility's attention by the hospital and indicated the antibiotic should be changed to Macrobid 100 milligrams (mg) by mouth twice a day for seven days.Further review of the December 2025 Surveillance Sheets failed to indicate Resident #58 was placed on an antibiotic on 12/18/25.Review of the nursing and physician progress notes from 12/19/25 through 12/27/25 failed to indicate a reasoning for continued antibiotic usage.Review of the nursing progress note, dated 12/29/25, indicated Resident #58 returned to the facility after a recent hospitalization and was placed on Macrobid 100 mg by mouth two times a day for a UTI for 7 days.Further review of the physician and nurse practitioner progress notes failed to indicate any reasoning for continued antibiotic usage.During an interview on 1/20/26 at 12:38 P.M., the IP said when a resident is prescribed an antibiotic, the McGeer Criteria for Infection is completed in the medical record. She said any nurse can complete the form. The IP said the McGeer criteria should (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have been completed for each antibiotic Resident #58 was started on and it was not done. The IP said she does not maintain the Antibiotic Stewardship Program. The IP said she does not follow up with the providers or physicians when antibiotics are prescribed. The IP said she assumes she should be maintaining the program, however, was not instructed to do so. The IP said she only documents antibiotic information on her surveillance sheets.During an interview on 1/20/26 at 3:12 P.M., the Director of Nursing (DON) said the Antibiotic Stewardship Program is maintained by the IP. He said his expectations are for her to inform the prescribers and document in the medical record when a resident does not meet antibiotic usage criteria. The DON said he was not aware the Antibiotic Stewardship Program was not being implemented.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on record review and interview, the facility failed to ensure one Resident (#24), out of a total sample of 23 residents, was invited to his/her care planning meetings to participate in their plan of care.Findings include:Review of facility's policy titled Care Plans, Comprehensive Person-Centered, last revised on 1/24, indicated but was not limited to the following:-The resident will be informed of his or her right to participate in his or her treatment.-The interdisciplinary team (IDT) may include: the provider, the nurse responsible for the resident, the aide responsible for the resident, nutrition staff, the resident and the resident's legal representative, and other appropriate staff as determined by the resident's needs or as requested by the resident. Resident #24 was admitted to the facility in November 2025 with diagnoses including chronic obstructive pulmonary disease and emphysema.Review of the Minimum Data Set (MDS) assessment, dated 10/24/25, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating that the Resident is cognitively intact.During an interview on 1/13/26 at 11:21 A.M., Resident #24 said he/she has not been invited to their care conference or any meetings with the interdisciplinary team to discuss their plan of care. Review of Resident #24's Care Plan Meeting Notes, dated 11/12/25 and 8/19/25, included no information relative to:-Whether the Resident and/or his/her Representative were invited to attend the meetings.-Whether the Resident and/or his/her Representative attended or did not attend the meetings.-Which members of the facility staff attended the meetings.During an interview on 1/14/26 at 4:10 P.M., the Activities Director said she used to attend care plan meetings prior to the previous social worker leaving in November. She said she isn't sure who coordinates the meetings now. She said she has not attended a care plan meeting since the new social workers started. During an interview on 1/15/26 at 12:11 P.M., Social Worker #2 said she expects residents and their representatives to participate in their care plan meetings. She said she thinks they are invited but is not sure of the process. She said Social Worker #1 is responsible for the care plan process.During an interview on 1/15/26 at 12:26 P.M., Social Worker #1 said she mails out invitations to the resident's responsible parties. She said she assumes the receptionist delivers the invitations to residents who are their own responsible person. She expects that Resident #24 would have received an invitation.During an interview on 1/15/26 at 10:27 A.M., the MDS Coordinator said she is not sure the process for inviting residents to their care plan meetings. She said she provides a list to each department for when the meeting should be scheduled but is unsure of the process for inviting residents who are their own responsible person.During an interview on 1/15/26 at 10:27 A.M., the Receptionist said the social workers are responsible for inviting residents who are their own responsible person. She said she isn't sure of which residents should receive an invitation. She said she hands the envelopes to mail to the postal worker to invite the resident representatives. During an interview on 1/15/26 at 2:15 P.M., the Director of Clinical Operations said she expects residents to be invited to participate in their care plan meetings and there needs to be a process in place for ensuring residents and their representatives are invited. She said she would expect Resident #24 to have been able to participate in their care plan meetings.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews and interviews, the facility failed to ensure one Resident (#8), out of a total sample of 23 residents, was free from unnecessary psychotropic medications by ensuring an as needed (PRN) dose of Zyprexa (antipsychotic) was limited to 14 days. Findings include: Review of the facility's policy titled Psychotropic Medication, dated as last revised July 2023, indicated but was not limited to the following:-Psychotropic medications will be prescribed at the lowest possible dosage and are subject to gradual dose reductions and re-review as needed.-The need to continue PRN orders for psychotropic medications beyond 14 days require that the practitioner document the rationale for the extended orders, the duration of the PRN order will be indicated in the order.-PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the health care practitioner has evaluated the resident for appropriateness of that medication. Resident #8 was admitted to the facility in June 2025 with diagnoses which included depression, vascular dementia with or without behavioral disturbances, and Alzheimer's dementia. Review of the Minimum Data Set (MDS) Assessment, dated 12/19/25, indicated he/she scored 3 out of 15 on the Brief Interview for Mental Status (BIMS) Assessment, indicating he/she had severe cognitive impairment, was feeling down and depressed, and was administered antidepressant and antipsychotic medications. Review of the Physician's Orders indicated but were not limited to the following:-Olanzapine (Zyprexa) Oral Tablet Disintegrating 5 milligrams (mg) give one tablet by mouth every 12 hours as needed for agitation or hallucinations (start date 6/18/25 and discontinue date 8/13/25). Review of the Medication Administration Records (MAR) from June through August 2025 indicated the following:-The order for Olanzapine did not have a 14-day stop date as required.-The order for Olanzapine was active for 57 days.-Resident #8 received the medication 4 times after the initial 14 days. Review of the medical record, including progress notes, failed to indicate the provider evaluated and extended the PRN order for an additional 14 days at each 14-day interval. The order remained active with an indefinite end date for 57 days. During an interview on 1/15/26 at 10:15 A.M., Nurse #2 said PRN psychotropic orders should be limited to 14 days and then reviewed by the physician, and he was unsure why this order was active for so long. During an interview on 1/16/26 at 12:55 P.M., the Director of Nurses (DON) and Consulting Staff #2 said all PRN orders for antipsychotics should be limited to 14 days and this one was not. Additionally, Consulting Staff #2 said the dashboard should be reviewed daily to ensure accuracy of orders and there needs to be a better system in place. During an interview on 1/16/26 at 2:35 P.M., Nurse #1 said PRN psychotropic orders should be limited to 14 days. She said she did not know why this order was active for so long.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on document review and interview, the facility failed to ensure that monthly Medication Regimen Reviews (MRR) were addressed and implemented in a timely manner for one Resident (#6), out of a total sample of 23 residents. Specifically, the facility failed to ensure a recommendation by the pharmacy consultant to obtain a Vitamin D level to consider tapering down the Vitamin D dose and signed by the physician was reviewed by nursing, transcribed, and implemented per the provider's order. Findings include: Review of the facility's policy titled Medication Regimen Review, dated 8/2020, indicated but was not limited to the following:-The consultant pharmacist identifies irregularities.-Resident specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the resident's active record and reported to the Director of Nurses (DON), Medical Director, and/or prescriber as appropriate.-Recommendations are acted upon and documented by the facility staff and/or the prescriber.-The DON or designated licensed nurse address and document recommendations. Resident #6 was admitted to the facility in October 2021 with diagnoses which include osteoporosis, nutritional deficiency, and disorder of bone density. Review of the Consultant Pharmacist Recommendation to Prescriber, dated 7/17/25, indicated the following:-The Resident has been receiving Vitamin D 50,000 units once weekly since 2023. This is typically a loading dose that can be tapered down. Please consider evaluating a Vitamin D level to see if the frequency can be reduced to once or twice monthly.-The physician signed and dated the report on 7/25/25 and indicated they agreed with the recommendation and ordered a Vitamin D level. Review of the medical record, including notes, orders, and labs, failed to indicate nursing had transcribed the order and scheduled the lab draw. Review of the Consultant Pharmacist Recommendation to Prescriber, dated 8/19/25, indicated the following:-The Resident has been receiving Vitamin D 50,000 units once weekly since 2023. This is typically a loading dose that can be tapered down. Please consider evaluating a Vitamin D level to see if the frequency can be reduced to once or twice monthly.-Reissued-Unable to locate response.- Done in July was handwritten above the provider response section of the form.-The form was unsigned by the physician. Review of the medical record, including notes, orders, and labs, failed to indicate nursing had transcribed the order and scheduled the lab draw prior to the recommendation being reissued. Review of the Lab order, dated 8/28/25, indicated check a Vitamin D level. Review of the Lab result, dated 8/29/25, indicated the lab was drawn at 11:42 A.M. and resulted at 3:25 P.M. Review of the Physician's Orders indicated on 9/1/25 the physician changed the Vitamin D order. During an interview on 1/16/26 at 1:28 P.M., the DON said he prints the recommendations and the nursing supervisor completes them. He said after the physician reviews and signs them nursing writes the orders. He said he does not oversee the process to ensure they are completed and was not sure why the order for the lab was not transcribed in July as it should have been and the lab not booked until after it was repeated. Additionally, he said the August recommendation was blank when he pulled it out and he just wrote Done in July on the blank recommendation when he provided the copy to the surveyor yesterday afternoon. He said he did not check to ensure it was done in July, he just assumed it was because the July recommendation was signed. He said he does not have a process to ensure the recommendations are followed up on, he just assumes they are taken care of. During an interview on 1/16/26 at 1:28 P.M., Consulting Staff #2 said the order for the 8/29/25 Lab was written on 8/28/25 after the recommendation was repeated. She said she was not sure why it was not done when the provider signed the first recommendation on 7/25/25 as it should have been. Additionally, she said there is not a process in place to ensure completion and there should be. During an interview on 1/16/26 at 2:35 P.M., Nurse #1 said she prints the recommendations, sorts them by doctor, gives them to the doctors, and then writes the orders, but does not have a system to make sure every single one is addressed. She said she was not here in July and was not sure why this order was never written.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to ensure four of four kitchenettes were maintained in a clean, sanitary condition. Findings include: Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 3-305.11 (A) Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food (1) in a clean, dry location. 4-602.13 Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 6-101.11 Surface Characteristics. (A) Except as specified in (B) of this section, materials for indoor floor, wall, and ceiling surfaces under conditions of normal use shall be: (1) SMOOTH, durable, and EASILY CLEANABLE for areas where FOOD ESTABLISHMENT operations are conducted. On 1/14/26, the surveyor made the following observations in the unit kitchenettes: 7:30 A.M. North 2 Unit-corner floor area with TV mount, box, and bag of clothes with a sizeable amount of mouse droppings underneath-one package peanut butter crackers, condiment packets between refrigerator and wall 7:40 A.M. South 2 Unit-missing floor tile in one corner at the floor/wall junction containing buildup of crumbs and debris 11:17 A.M. North 1 Unit-grout at floor/wall junction receded and collecting debris, crumbs, and buildup-missing floor tile-water bottle, condiment packets on floor between refrigerator and wall-paper towels and cups behind refrigerator 11:26 A.M. South 1 Unit-one package peanut butter crackers, condiment packets, broken tile pieces, and debris behind the refrigerator-broken tile in areas around perimeter of floor/wall junction-receding grout at floor/wall junction with debris buildup including mouse droppings During an interview on 1/14/26 at 2:00 P.M., the Corporate Food Service Director (FSD) said the expectation was for kitchenette floors to be kept clean and sanitary. During an interview on 1/20/26 at 2:00 P.M., the surveyor reviewed with the Director of Clinical Operations (DCO) photos of unit kitchenettes which included missing floor tile, receding grout, mouse droppings, buildup and debris (including cups, napkins, condiment packets, packages of peanut butter crackers). The DCO said she expected kitchenettes floors to be maintained in a clean and sanitary condition with no missing tiles or receding grout that harbors debris. During an interview on 01/20/26 at 2:49 P.M., the Housekeeping Manager (HM) said housekeeping staff checked kitchenettes on a daily basis, two to three times per day, and performed tasks such as taking out the trash, cleaning surfaces, and sweeping and mopping the floor. The HM said kitchenette floors should be kept clean and sanitary and should not have a buildup of debris or mouse droppings.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to provide written documentation related to transfer discharge notices and bed hold policy to the responsible person/invoked Health Care Proxy (HCP) upon five hospitalizations for one Resident (#8), out of a total of 23 sampled residents. Findings include: Review of the facility's policy titled Transfer and Discharge Documentation, dated as last revised 7/2024, indicated if a resident was being transferred or discharged because his/her needs cannot be met at the facility, documentation will include: The specific resident needs that cannot be met and that appropriate notice was provided to the resident and/or legal guardian. Resident #8 was admitted to the facility in June 2025 with diagnoses which include depression, vascular dementia with or without behavioral disturbances, and Alzheimer's dementia. Review of the Minimum Data Set (MDS) Assessment, dated 12/19/25, indicated Resident #8 scored 3 out of 15 on the Brief Interview for Mental Status (BIMS) Assessment, indicating he/she had severe cognitive impairment. Review of the Physician's Orders indicated Resident #8's HCP had been invoked on 6/17/25. Review of medical record census report indicated Resident #8 was transferred to the hospital five times between June and October 2025 (once each in June, July, and October, and twice in August). Review of the Discharge/Transfer Evaluations indicated but were not limited to the following:-June 2025: failed to indicate the HCP was provided a copy of the Bed Hold Policy and Notice of Transfer/Discharge.-July 2025: failed to indicate the HCP was provided a copy of the Bed Hold Policy and Notice of Transfer/Discharge.-August 2025 Transfer 1: failed to indicate the HCP was provided a copy of the Bed Hold Policy and Notice of Transfer/Discharge.-August 2025 Transfer 2: failed to indicate the facility completed the Discharge/Transfer Evaluations for this transfer.-October 2025: failed to indicate the HCP was provided a copy of the Notice of Transfer/Discharge. During an interview on 1/15/26 at 10:15 A.M., Nurse #2 said when a resident goes to the hospital the transfer/discharge notice and bed hold notice are part of the referral under evals and the nurse that is sending them out completes it with the HCP. During an interview on 1/16/26 at 12:46 P.M., the Director of Nurses (DON) and Consulting Staff #2 said the Transfer/Discharge and Bed Hold Notices should have been given to the HCP each time Resident #8 went to the hospital. Additionally, they said the boxes in the eval should have been checked and the name of who the notice was given to should be documented on each referral and they were incomplete. They said if the HCP is not in the building, then the nurse should call the HCP and email or mail the notices. The DON said the Social Worker (SW) should be following up to ensure they were sent to the correct person. During an interview on 1/16/26 at 2:35 P.M., Nurse #1 said the bed hold and transfer/discharge notices go to the HCP and that should be documented on the referral/evaluation. She said she thinks the SW usually follows up the next day to ensure they went out but she was not sure. During an interview on 1/15/26 at 12:11 P.M., Social Worker (SW) #2 said she mostly focuses on the MDS Assessments and the Evaluations because she was only in the building a couple days a week while SW #1 took on the Director role about a month ago. SW #2 said she and SW #1 are still figuring out everything that needs to be done and who is doing what with regard to paperwork versus the day to day follow up with resident issues. She said it is a work in progress right now.

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	225343	A. Building B. Wing	02/09/2026

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 0805 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, record review, and facility document review, the facility failed to ensure one Resident (#82), out of a total sample of 23 residents received food prepared in a form to meet the resident's individual dietary needs. Specifically, the facility failed to upgrade his/her diet per the Speech Language Pathologist (SLP) order for 14 days. Findings include: Review of the facility's policy titled Therapeutic Diets and Meal Plans, dated as last revised 6/2018, indicated but was not limited to the following:-The attending physician, license non-physician provider, or registered or licensed dietician with physician approval and as allowable by State Law, prescribe therapeutic diets.-Mechanically Altered Diet means one in which the texture of a diet is altered. When the texture is modified, the type of texture modification must be specific and part of the physician's or delegated registered or licensed dietician order.-The Speech Language Pathologist (SLP) may be consulted for evaluation of mechanically altered diets.-A physician's order is obtained for the appropriate therapeutic meal plan and/or mechanically altered diet.-A resident's therapeutic meal plan and/or mechanically altered diet is documented on the tray card, tray ticket, or individualized menu as a means of communication to the staff the prescribed diet.-Diet orders are written to conform to the terminology in the approved diet manual and therapeutic menu.-Diet orders that don't match the facility's standard terminology will be evaluated by the Registered Dietician (RD) to have then revised to the standard terminology. Review of the Menu Guide: [Corporate Name], dated Fall/Winter 2024/2025 indicated but was not limited to the following:-International Dysphagia Diet Standardization Initiative (IDDSI) Food Level 5/Minced and Moist Diet/(MM5) includes foods that are easy to swallow with no separate thin liquids because they are minced, soft, and moist and can be scooped and shaped. Review of the facility's Diet Texture Comparison Chart, dated September 2023, indicated but was not limited to the following:-IDDSI Diet: MM5 (minced and moist) / [Corporate Name] Diet: Dysphagia Mechanical.-All Diet orders must be written as [Corporate Name] diet orders.-Any resident admitted on an IDDSI diet must be evaluated by SLP to confirm appropriate [Corporate Name] diet order.-This chart is only to be used to convert an IDDSI Diet order to the safest texture until the resident is evaluated by SLP. Resident #82 was admitted to the facility in October 2025 with diagnoses which include obesity, dysphagia, and pneumonitis due to inhalation of food and vomit. Review of the Minimum Data Set (MDS) Assessment, dated 11/27/25, indicated Resident #82 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact and was on a mechanically altered diet. On 1/13/26 at 12:15 P.M., the surveyor observed Resident #82 sitting in bed with a pureed lunch meal in front of him/her. During an interview on 1/13/26 at 2:40 P.M., Resident #82 said he/she was still on a puree diet, did not know why, they wanted it changed, and said the pureed food is not good. The Resident said he/she only gets real food with the speech therapist like once a week. On 1/14/26 at 8:26 A.M., the surveyor observed Resident #82 sitting in bed with his/her breakfast tray in front of them. The plate had pureed pancakes and eggs on it. The meal ticket indicated his/her diet order was puree, No Added Salt (NAS), thin liquids. Resident #82 said their diet was supposed to be upgraded, but he/she gets the same stuff every day. Review of the SLP progress notes indicated but were not limited to the following:-1/2/26: Will upgrade to minced and moist consistency diet.-1/6/26: He/she is safest of Minced and Moist at this time. Review of the Active Physician's Orders indicated the following:-NAS Diet, Puree texture, thin liquids consistency. (11/25/25)-Discontinue (D/C) Pureed Diet. Upgrade diet to Minced and Moist Consistency. (1/2/26) Further review of the Diet Order to Upgrade diet to Minced and Moist indicated the following:-The order was written by the SLP.-The order category was entered as Other.-The order was signed by nursing and the physician. During an interview on 1/15/26 at 10:15 A.M., Nurse #1 said diet orders should be entered into the computer as a Diet order, not in the Other category. He said then the previous order should be discontinued and a diet slip filled out and sent to the kitchen to (continued on next page)

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	225343	A. Building B. Wing	02/09/2026

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 0805 Level of Harm - Potential for minimal harm Residents Affected - Some	notify them of the change. He said in this case the new order was entered into the wrong category, the previous order was never discontinued, and the diet slip was never sent to the kitchen. He said Resident #83 has two conflicting active orders and he would have to clarify and fix them. Review of the nursing progress note, dated 1/15/26 at 1:44 P.M., indicated Nurse #1 was advised by the Dietician that the facility did not have a Minced and Moist consistency diet and he/she was to remain on pureed diet until re-evaluated by SLP. During an interview on 1/16/26 at 12:28 P.M., the Director of Nurses (DON) and Consulting Staff #2 said when SLP enters a new diet order the nurse is supposed to confirm it, complete and sign the new order, discontinue the previous order, and send the diet slip to the kitchen. They said these things did not happen. During an interview on 1/16/26 at 4:00 P.M., SLP/Rehab Staff #1 said the Minced and Moist diet converts to the facility Dysphagia Mechanical and that is what he recommended and thought Resident had been on for the last two weeks. He said no one from the facility had reached out to clarify the diet and he did not know why they did not implement the order properly. He said he normally writes the order; the nurse adjusts and clarifies it if needed, discontinues the previous order, and notifies the kitchen. He said he sees Resident #82 regularly, but he gets a regular solid consistency tray for food trials in place of what the kitchen had on the tray ticket, so he does not see what the tray ticket has printed on it. During an interview on 1/20/26 at 1:20 P.M., Corporate Food Service Manager (FSM)/Consulting Staff #4 said the IDDSI Minced and Moist Diet would convert to the [Corporate Name] Dysphagia Mechanical diet and the facility does offer that diet. During an interview on 1/20/26 at 1:20 P.M., Consulting Staff #2 said they do offer the Dysphagia Mechanical diet which is what the Minced and Moist would convert to.