STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225356	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Randolph	49 Thomas Patten Drive Randolph, MA 02368

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for two of six sampled residents (Resident #5 and #6), who were alert, oriented, and able to make their own health care decisions, the Facility failed to ensure that they obtained signed written consent for the administration of psychotropic medications, which include providing each resident with information related to the risks and benefits of the medications, prior to administering them. Findings include: Review of the Facility Policy Psychotropic Medication Use, dated as last revised 02/2025, indicated prior to the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal; -Non-pharmacological alternatives; -Indications and rationale for the recommendation; -Potential risks and benefits (including possible side effects, adverse consequences, and black box warnings); and -The resident's/representative's right to accept or decline the treatment. 1) Resident #5 was admitted to the Facility in May 2025, diagnoses included but not limited to, schizoaffective disorder and a history of falls. Review of Resident #5's Hospital Discharge summary, dated [DATE], indicated to administer the following; - Aripiprazole (Antipsychotic) 20 milligram (mg) tablet, give one tablet by mouth at bedtime; and - Olanzapine (Antipsychotic) 20 mg tablet, give one tablet by mouth at bedtime. Review of Resident #5's Physician's Orders, dated 05/21/25, indicated to administer the following; - Aripiprazole 20 milligram (mg) tablet, give one tablet by mouth at bedtime; and (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Olanzapine 20 mg tablet, give one tablet by mouth at bedtime. Review of Resident #5's Medication Administration Record (MAR), dated 05/22/25 through 05/27/25, indicated he/she had been administered five (5) doses of each of the psychotropic medications. However, review of Resident #5's Informed Consent for Psychotropic Administration Form, indicated signed written consent for the administration of his/her psychotropic medications was not obtained until 05/27/25 (six (6) days after he/she had already been started on the medications). 2) Resident #6 was admitted to the Facility May 2025, diagnoses include but not limited to, bipolar disorder and a fall with distal right femur fracture. . Review of Resident #6's Hospital Discharge summary, dated [DATE], indicated to administer the following; -Fluoxetine (Antidepressant) 10 mg capsule, give one capsule daily by mouth; and -Quetiapine (Antipsychotic) 100 mg tablet, give two tablets two times a day by mouth. Review of Resident #6's Physician's Orders, dated 05/23/25, indicated to administer the following; -Fluoxetine 10 mg capsule, give one capsule daily by mouth; and -Quetiapine 100 mg tablet, give one tablet two times a day by mouth. Review of Resident #6's Medication Administration Record (MAR), dated 05/23/25, indicated he/she had been administered four (4) doses of Fluoxetine and eight (8) doses of Quetiapine. However, review of Resident #6's Informed Consent for Psychotropic Administration Form, indicated signed written consent for the administration of his/her psychotropic medications was not obtained until 05/27/25 (four (4) days after he/she had already been started on the medications). During an interview on 05/27/25 at 1:36 P.M., Unit Manager #1 said that she was not aware that both Resident #5 and #6's psychotropic medication consent forms had not been obtained in a timely manner. Unit Manager #1 said that the Nurse that completes the admission of the resident is responsible for obtaining informed consent to administer psychotropic medication. During an interview on 05/27/25 at 2:34 P.M., the Assistant Director of Nurses (ADON) said that it is the responsibility of the admitting nurse to obtain informed consents for psychotropic medication and the consents must be obtained prior to administering any psychotropic medications. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/27/25 at 3:11 P.M., the Director of Nurses (DON) said that it is the Facility's expectation that the Nurse admitting each resident obtain informed consents for psychotropic medication from either the resident or the resident's responsible party, prior to administering any psychotropic medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed, interviews, and observations for three of five sampled residents (Resident #1, #2 and #4) and three non-sampled residents (NS RT #A, #B and #C), the facility the Facility failed to ensure 1) that the call bell system button was accessible and within reach for residents to call for assistance and 2) that staff responded to sounding call bells in a timely manner, per facility policy. Findings include: Review of the Facility Policy titled, Answering the Call Light, dated as last revised 9/2022, indicated that the purpose of answering a call light is to ensure timely response to the resident's requests and needs. The Policy further indicated that staff are to ensure that the call light is accessible to the resident when in bed, on the toilet, in the shower or bathing facility. 1) During a tour of the facility on 05/27/25, Surveyor #1 observed the following: -9:42 A.M., room [ROOM NUMBER], NS RT #A was in bed, the call bell was hanging on the wall, out of his/her reach -9:43 A.M., room [ROOM NUMBER], bed closest to door, NS RT #B was in bed, the call bell was on the floor, out of his/her reach -9:45 A.M., room [ROOM NUMBER], bed closest to door, NS RT #C was in bed, the call bell was wedged behind the bed, out of his/her reach Resident #1 was admitted to the Facility in February 2025, diagnoses include but not limited to vascular dementia, bipolar disorder and a history of falls During a telephone interview on 05/27/25 at 1:00 P.M., Family Member #1 said that each time she went to visit Resident #1, his/her call bell was never within his/her reach and he/she was not able to call for help. During a telephone interview on 06/05/25, Nurse #2 said that Resident #1's Family Member did complain that each time she was visiting, his/her call bell was out of his/her reach. Nurse #2 said that each time a staff member leaves a resident's room they must ensure that the call bell is left within reach of the resident. Resident #2 was admitted to the Facility in December 2020, diagnoses include but not limited to osteoarthritis, muscle weakness, and chronic kidney disease. During an observation on 11:30 A.M., Resident #2 was observed out of bed in his/her wheelchair, positioned to the left side of his/her bed, the call bell was observed hanging behind the bed on the right side of the bed, out of his/her reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/27/25 at 11:30 A.M., Resident #2 said he/she is aware of how to call the staff for assistance but said the call bell is never within his/her reach, especially when he/she is sitting in his/her wheelchair beside his/her bed. 2) Resident #4 was admitted to the Facility in May 2025, diagnoses include open lesion and cellulitis to left upper arm, diabetes mellitus, seizure disorder, chronic ulcer to left lower extremity and history of a right above the knee amputation. During an observation on 05/27/25 at 9:35 A.M., the Surveyor observed the call bell monitoring device (monitors and records the length of time a call bell is ringing) at the second floor nurses station. The System indicated that the call bell for room [ROOM NUMBER] W had been sounding (going off) for 30 minutes, at which point a Certified Nurse Aide (CNA) finally entered the room, attended to the resident, turned off the call bell and the monitoring device at the nurses station reset. During an observation on 05/27/25 at 11:50 A.M., the Surveyor again observed the call bell central monitoring device at the nurses station on the second floor. The System indicated that the call bell for room [ROOM NUMBER] W had been sounding (going off) for 20 minutes, at which point a CNA was observed entering the room, attended to the resident, turned off the call bell and the monitoring device at the nurses station reset. During an interview on 05/27/25 at 11:51 A.M., Resident #4 (who resided in room [ROOM NUMBER] W) said that he/she normally has to wait a long time before any staff member answers his/her call bell. Resident #4 said that he/she could be having a seizure or be really sick and no one responds timely when he/she puts the call light on. During an interview on 05/27/25 at 1:59 P.M., Nurse #2 said that call light are to be left within reach of the residents at all times when they are in their room and should be answered in a timely manner. During an interview on 05/27/25 at 1:11 P.M., Unit Manger #1 said that call bells should always be left within reach of the resident while they are in their room. Unit Manager #1 said that call bells needed to be answered timely by staff and that 20 to 30 minutes response time, was not considered timely. During an interview on 05/27/25 at 3:11 P.M., the Director of Nurse (DON) said the Facility's expectation is that call bells are left within reach of each resident when a staff member leave a room. The DON said call bells need to be answered in a timely manner.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for two of six sampled residents, (Resident #3 and #5), the facility failed to ensure that upon admission, nursing developed and implemented baseline care plans with interventions, treatments, goals and outcomes that addressed the residents' overall immediate care needs. Findings include: Review of the Facility Policy titled Baseline Care Plans, dated as last revised 03/2022, indicated that a baseline care plan will be developed for each resident within 48-hours of admission to meet the resident's immediate health and safety needs. The Policy further indicated the baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan. The baseline care plan is updated as needed to meet the residents' needs until the comprehensive care plan is developed. 1) Resident #3 was admitted to the Facility in May 2025, diagnoses included acute respiratory failure, Stage Four(IV, full thickness tissues loss with exposed areas) pressure ulcer, larynx cancer with a tracheostomy (tube surgically placed into the trachea to breath), and dysphagia with a gastrostomy (tube placed into the stomach for nutrition) tube. Review of Resident #1's Acute Rehabilitation Discharge summary, dated [DATE], indicated his/her immediate care needs were identified as followed; -Tracheostomy care with the use of oxygen; -Indwelling catheter in place; -Gastrostomy care; -Treatment of Stage IV pressure ulcer; and -Enhanced Barrier Precautions. Review of Resident #3's Medical Record indicated there was no documentation to support that Baseline Care Plans were developed and implemented, or that Comprehensive Care Plans that addressed these areas of concern were in place within 48 hours of his/her admission or prior to 05/07/25 (day of survey). 2) Resident #5 was admitted to the Facility in May 2025, diagnoses include but not limited to; rectal prolapse (portion of the large intestine slips out side the anus), vaginal prolapse (pelvic floor muscles weaken causing the bladder, bowels, or uterus to sag into the vagina), rectal wound, schizoaffective disorder, and a history of falls. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's Hospital Discharge summary, dated [DATE], indicated his/her immediate care needs were identified as followed; -Antipsychotic medication use; -Fall risk; -Alteration in comfort secondary to bilateral knee pain; and -Rectal Wound. Review of Resident #5's Medical Record indicated there was no documentation to support that Baseline Care Plans were developed and implemented, or that Comprehensive Care Plans that addressed these areas of concern were in place within 48 hours of his/her admission or prior to 05/7/25 (day of survey). During an interview on 05/27/25 at 1:59 P.M., Nurse #1 said that the Unit Manager is responsible for creating the Baseline Care Plans for the resident. Nurse #1 said that she has never done a Baseline Care Plan. During an interview on 05/27/25 at 2:34 P.M., the Assistant Director of Nurses (ADON) said that the Unit Manager and admitting nurse are responsible for creating the resident's baseline care plans. During an interview on 05/27/25 at 3:11 P.M., the Director of Nurses (DON) said that it is the Facility's expectation that the nurse admitting the resident should initiate the base line care plan and the Unit Manager is expected to double check the next day for the completion of the baseline care plan.