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	08/14/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure one Resident (#132) had the right to participate in his/her discharge planning process, in a total sample of 32 residents. Specifically, the facility involved the family member of Resident #132 in the discharge planning and did not involve Resident #132 who remained his/her own healthcare decision maker. Findings include:Review of the facility's policy titled Discharge Summary and Plan, dated as last revised in March 2025, indicated: -Every resident has an individualized discharge plan, which begins at admission and is part of the comprehensive care plan-The discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and the representative to develop interventions to meet the resident's discharge goalsReview of the facility's policy titled Resident Rights, dated as last revised in February 2021, indicated but was not limited to:-These rights include the resident's right to self-determination and be supported by the facility in exercising his/her rights Resident #132 was admitted to the facility in May 2025 with diagnoses of congestive heart failure (CHF) and alcohol use disorder. Review of the Minimum Data Set (MDS) assessment, dated 6/5/25, indicated Resident #132 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident had a moderate cognitive impairment. Review of the medical record on 8/8/25 failed to indicate the physician of Resident #132 had invoked their Health Care Proxy, indicating Resident #132 was their own healthcare decision maker. During an interview on 8/8/25 at 8:32 A.M., Resident #132 said he/she resides in a home with his/her siblings who both help with daily living activities at home. Resident #132 said he/she has been at the facility for a while and did not know what the discharge plan was, and he/she was hoping to return to the home with their siblings. Review of the progress notes indicated a family meeting for Resident #132 was held on 7/11/25 with the following in attendance: Social Services, Rehabilitation Department, Nursing and the sister of Resident #132. The note indicated it was a discharge planning meeting with the goal for Resident #132 to live in an assisted living facility. The medical record failed to indicate Resident #132 was involved in the discharge planning process. During an interview on 8/8/25 at 10:47 A.M., the Physical Therapy Assistant said she believed the plan was for the Resident to discharge to an assisting living or some sort of group setting but had not heard anything official. During an interview on 8/12/25 at 12:00 P.M. , Resident #132 said he/she still did not know what the plan was for discharge or where he/she was going after residing at the facility. During an interview on 8/12/25 at 1:36 P.M., Physician #2 said Resident #132 had fluctuating cognition based on the resident's clinical conditions (infection, CHF). He had decided not to activate the Health Care Proxy and Resident #132 continued to make his/her own decisions. During an interview on 8/12/25 at 2:12 P.M., Social Worker #1 said the discharge planning meeting was held with the sibling of Resident #132 on 7/11/25 and Resident #132 did not attend, and the plan was for the Resident to move to an Assisted Living Facility (ALF). She said she had submitted the information to the ALF and the Resident was accepted. She said the Resident had a lot going on and believes the Resident was not invited to participate in the discharge planning meeting and thought the Health Care Proxy had been invoked and the sibling was making health care decisions. During an interview on 8/13/25 at 10:00 A.M., Social Worker #1 said she had reviewed the information and found that Resident #132 had not been invited to his/her discharge planning meeting and should have been.

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	225356	A. Building B. Wing	08/14/2025

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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. Based on record review and interviews, the facility failed to ensure for one Resident (#71), out of a sample of 32 residents, that informed, written consent was obtained for the administration of psychotropic medications, which include providing the Resident with information related to the risks and benefits of the medications, prior to administering them.Findings include:Review of the facility's policy titled Psychotropic Medication Use, dated as last revised February 2025, indicated but was not limited to:-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.Resident #71 was admitted to the facility in May 2025 and had diagnoses including depression. Review of the Minimum Data Set (MDS) assessment, dated 5/30/25, indicated Resident #71 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15, and was administered antidepressant medication daily.Review of Physician's Orders indicated but was not limited to:-Sertraline HCl (antidepressant) 50 milligrams (mg) one time a day for depression (5/25/25)-Lorazepam 1 mg one time a day every Monday, Wednesday and Friday for anxiety prior to going to dialysis (7/29/25)Review of Resident #71's Medication Administration Records (MAR) from May 2025 through August 2025 indicated Sertraline and Lorazepam had been administered as ordered by the physician.During an interview on 8/12/25 at 8:12 A.M., Resident #71 said he/she has never been provided with any information about medications for mood and is not taking any.Further review of the medical record failed to indicate Resident #71 was informed of the risks and benefits of Sertraline and Lorazepam and provided written, informed consent for their use.

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	225356	A. Building B. Wing	08/14/2025

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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 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. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on review of Resident Council Minutes, a resident group meeting, interviews, and record reviews, the facility failed to ensure grievances brought forward from the Resident Council were addressed and promptly resolved to ensure the residents felt their concerns were acted upon timely and included the facility response to the group.Findings include: Review of the facility's policy titled Resident Council, last revised February 2021, indicated but was not limited to the following:-The purpose of the Resident Council is to provide a forum for: -residents, families and resident representatives to have input in the operation of the facility; -discussion of concerns and suggestions for improvement; -consensus building and communication between residents and facility staff; and -disseminating information and gathering feedback from interested residents. -A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern.Review of the facility's policies titled Grievances/Complaints, Filing, revised 6/23/22 and Grievances/Complaints, Recording and Investigating, revised 4/12/18, indicated but were not limited to the following:-All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing including a rationale for the response.-The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as a corrective action recommended within five (5) working days of the filing of the grievance or complaint.Review of Resident Council minutes, dated 5/14/25, indicated but was not limited to:-Residents voiced concerns about not liking the food; food occasionally arrives cold.Review of a follow-up note regarding food complaints brought forward during the 5/14/25 resident council meeting, signed by the Administrator on 5/21/25 indicated but was not limited to:-Administrator immediately initiated a food committee program where monthly meetings are held amongst individual staff who want to participate.-The Culinary Director initiated an alert overhead page of when the food carts will be given to the units to alert staff when the carts are ready to be served.Review of Food Committee Meeting Minutes, dated 6/2/25, indicated four staff members (Director of Admissions, Assistant Director of Admissions, Food Service Director, Administrator) and no residents were in attendance. The residents' complaint of cold food at the 5/14/25 Resident Council Meeting was not addressed.Review of Resident Council minutes, dated 6/24/25, indicated the Administrator was present at the meeting. Residents voiced concerns about the food and would like a daily menu that has other options. The Administrator indicated she addressed the food concerns and let residents know about the new buffet style set-up dining plan to roll out in the next months.Review of Food Committee Meeting Minutes, dated 7/1/25, indicated three staff members (Director of Admissions, Assistant Director of Admissions, Food Service Director) and no residents were in attendance. The residents' complaint of cold food, not liking the food and wanting a daily menu with other options was not addressed. Review of Resident Council minutes, dated 7/22/25, indicated residents complained that they are served hot dogs a lot and they are cold, and eggs are cold at breakfast.On 8/8/25 at 10:30 A.M., the surveyor held a group meeting with 12 residents in attendance, 10 of which actively participated. The residents said complaints about cold food are voiced at every Resident Council Meeting with no improvement. They said all meals are cold every day of the week, and weekends are even worse. The residents said staff refuse to reheat their meals or call down to the kitchen for a new hot meal when asked. The residents said they have not been updated on any efforts to address their complaints of cold food, and nothing has changed. The residents said they are not aware of and have never been invited to participate in a food committee meeting but said they would love to be a part of a food committee. The residents said they do not know what alternative meals are available and when they tell staff that they don't like the food, they are told that it is their meal, and they need to eat it. The residents said they do not feel the Resident Council is effective in addressing their ongoing concerns.Review of the Grievance logs for May 2025 through August 2025 failed to indicate any grievances had been filed for the issues reported in resident council meetings.During an interview on 8/8/25 at 1:50 P.M., the Food Service Director said he is aware of the residents' complaints of cold food. He said he started to do overhead paging to alert staff when the food trucks leave the kitchen and are on their way to the unit but does not know what happens once the food trucks leave the main kitchen. He said he is not aware of any other interventions in place to address the residents' complaints of cold food. During an interview on 8/8/25 at 2:35 P.M., the Administrator said she is the Grievance Official and is responsible for investigation and resolution of grievances. The Administrator reviewed May 2025 through

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	08/14/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, record review, and interview, the facility failed to notify the Physician/Nurse Practitioner (NP)/Resident Representative timely of a change in condition for three Residents (#71, #132 and #24), out of a total sample of 32 residents. Specifically, the facility failed:1. For Resident #71, to notify the Physician/NP: a. when the Resident had a new onset of auditory hallucinations and alleged suicide attempt (pulled out dialysis fistula - a surgically created connection between an artery and a vein, typically in the arm, used to provide access for hemodialysis (a treatment that filters waste from the blood when the kidneys fail) during dialysis treatment at an outpatient dialysis center, and b. when the Resident pulled out his/her dialysis arterial needle (used to draw blood from the patient's arteriovenous fistula (AVF) or graft, and then venous needles return the purified blood) at an outpatient dialysis center; 2. For Resident #132, to notify the Physician that the Resident accessed a stairwell with 26 stairs and exited the facility to the parking lot where he/she was found by staff; and3. To inform the legal guardian (an individual appointed by the court to make decisions on behalf of an individual) of Resident #24 of a 5.0% significant weight loss occurring between 6/23/25 and 7/21/25. Findings include:Review of the facility's policy titled Change in a Resident's Condition or Status, last revised in February 2021, indicated but was not limited to: -Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident’s medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident rights, etc.) -The nurse will notify the resident's attending physician or physician on-call when there has been a(an): -accident or incident involving the resident -significant change in the resident’s physical/emotional/mental condition -need to alter the resident's medical treatment significantly -Unless otherwise instructed by the resident, a nurse will notify the resident’s representative when: -there is a need to change the resident’s room assignment -Regardless of the resident’s current mental or physical condition, a nurse or healthcare provided will inform the resident of any changes in his/her medical care or nursing treatments. 1. Resident #71 was admitted to the facility in May 2025 and had diagnoses including depression, chronic kidney disease, and end stage renal disease. Review of the Minimum Data Set (MDS) assessment, dated 5/30/25, indicated Resident #71 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15, and received antidepressant medication daily. (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record indicated a Nursing Note, dated 7/25/25, indicated Nurse #4 was contacted by the dialysis center to notify that Resident #71 pulled out his/her dialysis port and voiced to staff that he/she wants to bleed out and die. The note indicated Resident #71’s son was notified but failed to indicate the Resident’s physician or NP was notified. Review of a Nursing Note, dated 7/26/25 and written by Nurse #10, indicated Resident #71 returned to the facility from the emergency department on the 11:00 P.M. to 7:00 A.M. shift. The Resident was transported to the hospital emergency department directly from dialysis for an alleged suicide attempt whereby he/she allegedly pulled the dialysis needle out following hearing auditory hallucinations saying, you're going to die. The note failed to indicate the physician or NP was notified of the auditory hallucinations, alleged suicide attempt or being transported to the emergency department from dialysis. Review of a Nursing Note, dated 8/4/25, indicated while at dialysis, Resident #71 pulled out the arterial needle while the venous needle site was waiting to clot with the holding clamp. During interviews on 8/12/25 at 1:23 P.M. and 8/13/25 at 10:32 A.M., Physician #2 said he was not notified that Resident #71 had auditory hallucinations, pulled out his/her dialysis line from the fistula and said he/she wanted to bleed out and die at the dialysis center on 7/25/25. He said he last saw the Resident on 7/24/25 and was not notified of the Resident being sent to the hospital emergency department or having pulled out the dialysis arterial needle on 8/4/25. Physician #2 said that he would be notified of any changes because he has not had a NP working with him since March 2025. During an interview on 8/13/25 at 11:25 A.M., the Assistant Director of Nursing (ADON) said she did not recall anything about being informed or hearing about Resident #71 pulling out his/her dialysis needle from the fistula and having auditory hallucinations on 7/25/25. She said it was never mentioned in morning report. She said she was not aware that the Resident attempted to bite and pull the dialysis needles out on 7/28/25 or pulled out the dialysis arterial line on 8/4/25. During an interview on 8/13/25 at 11:29 A.M., Nurse #4 said on 7/25/25, the dialysis center called her to inform her that Resident #71 had auditory hallucinations and pulled out the dialysis port/needle and said he/she wanted to bleed out and die. Nurse #4 said the facility protocol is that the family and physician are notified and said she notified the family but did not notify the physician or NP. During an interview on 8/14/25 at 6:45 A.M., Nurse #10 said he was working on the unit the night Resident #71 returned from the hospital. He could not recall seeing any paperwork from the hospital, but the transport drivers told him the Resident had auditory hallucinations about wanting to die and pulled out his/her dialysis port. He said he did not notify the Physician or NP about the Resident’s auditory hallucinations or pulling out the dialysis port. 2. Resident #132 was admitted to the facility in May 2025 with diagnoses of congestive heart failure (CHF) and alcohol use disorder. Review of the care plans indicated Resident #132 was at risk for wandering and/or elopement. (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nursing progress notes indicated on 8/6/25 at around 1:00 P.M. Resident #132 opened the 2 East door into the hallway, exited the building and staff had found the Resident downstairs in the parking lot. An additional nursing progress note indicated Resident #132 was moved to the secure unit on 8/6/25. On 8/7/25 at 5:00 P.M., the surveyor observed the stairwell leading from resident unit: 2 East to an outside door. The stairwell had 11 concrete steps down to a landing where the stairs changed direction for another 11 concrete steps, then another landing and four more concrete steps until the bottom where there was an alarmed door to the outside. The surveyor observed an upside down wash basin on the second set of stairs and toiletries strewn across the bottom steps and landing. In addition, there were three pairs of socks and one pair of underwear which was labeled with the name of Resident #132. Review of a nursing progress note, dated 8/6/25 at 1:43 P.M., created on 8/8/25 at 8:44 A.M. by Unit Manager #1, indicated Resident was found in the parking lot, placed on 15-minute checks, moved to a secure unit, and the Physician was made aware. During an interview on 8/13/25 at 8:56 A.M., Unit Manager #2 said she had completed the nursing progress note on 8/8/25 and she had notified Physician #2 at the time of the incident. Review of the Physician Progress Note dated 8/7/25 indicated Resident #132 was oriented to self and continued to have some confusion. The Physician noted Resident #132 continued to have episodes of hallucinations and would have the Resident seen by psychiatric services. The Physician Progress Note failed to mention the Resident accessing the stairwell and exiting the facility the previous day. During an interview on 8/12/25 at 1:36 P.M., Physician #2 said he had been working extensively with Resident #132 who had been experiencing confusion and was attempting to determine if this was related to acute medical conditions such as a recent infection. He said he was aware Resident #132 would get confused and wander and had attempted to leave the facility and that was why the Resident was moved to the secure unit. He said he was not aware Resident #132 had accessed the stairwell and exited the facility on 8/6/25. The Physician reiterated that he knew the Resident was wandering but did not know the Resident was in a stairwell. 3. Resident #24 was admitted to the facility in January 2025 with diagnoses including cerebral infarction, severe protein-calorie malnutrition and muscle weakness. Resident #24 had an appointed guardian for decision making since admission to the facility. Review of the MDS assessment, dated 7/29/25, indicated Resident #24 had short- and long-term memory problems. The MDS assessment indicated he/she had a weight loss and was not on a prescribed weight loss regimen. Review of Resident #24’s Physician's Orders included but were not limited to: - 7/23/25: Regular Diet; pureed texture, thin consistency, 1:1 feed, sit upright/90 degree during feeding; (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 7/8/25: Enteral Feed: Every shift - Formula Type: Glucerna 1.5; Rate: 80 milliliters (mL)/hour; Total Nutrient: 960mL; Total Calories: 1440 CAL (calories); start at 6 P.M. and run until 6 A.M. or until 960 mLs have been infused, Tube Type: G-TUBE (gastrostomy tube - surgically placed device used for supplemental feeding, hydration, or medicine through direct access to the stomach); and - 8/4/25: Monthly weights; in the morning every 1 month starting on the first for 1 day Review of Resident #24’s weights in the electronic medical record indicated a 5.0% weight loss from 6/23/25 (134.0 pounds (lbs.)) to 7/21/25 (127.3 lbs.). During an interview on 8/7/25 at 10:26 A.M., Resident #24’s guardian said they were not notified by the facility of any recent weight loss or changes in weight. Review of the nutrition progress notes, dated 7/1/25, 7/8/25, 7/21/25, 7/23/25, and 7/30/25, failed to include documentation indicating the guardian was notified of the significant weight loss. During an interview on 8/11/25 at 12:55 P.M., Nurse #3 said the dietitian wound notify a guardian or health care proxy (HCP) of a significant weight loss. Nurse #3 said the notification would typically be documented in a progress note. During an interview on 8/11/25 at 12:57 P.M., the Dietitian said she follows Resident #24 to evaluate his/her nutritional status and weight loss. The Dietitian said she updates the team including a resident’s guardian or HCP when a significant weight loss occurs and documents the notification in a progress note. The Dietitian said she did not notify Resident #24’s guardian of his/her significant weight loss because Resident #24 is listed as their own responsible party in the electronic medical record. During an interview on 8/11/25 at 1:23 P.M., the Director of Nursing (DON) said Resident #24’s guardian should have been notified of Resident #24’s significant weight loss.

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	225356	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and document review, the facility failed to promptly resolve a grievance for a missing delivery for one Resident (#17), out of a total sample of 32 residents. Findings include: Review of the facility's policy titled Grievances/Complaints, Filing, dated as revised April 2017, indicated but was not limited to the following: - Residents and their representatives had the right to file grievances, either orally or in writing, to the facility staff- the Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative- upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings within 5 working days of receiving the complaint/grievance- the resident filing the grievance, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems- the Administrator will make such reports orally within 5 working days of the filing of the grievance with the facility- a written summary of the investigation will also be provided to the resident, and a copy will be filed in the business office Review of the facility's policy titled Grievances/Complaints, Recording and Investigating, dated as edited 4/12/2018, indicated but was not limited to the following: - all grievances filed within the facility will be investigated and corrective actions will be taken to resolve the grievances- upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations- the investigation and report will include, as applicable: date and time of alleged incident, circumstances surrounding the alleged incident, location of the alleged incident, names of any witnesses and their account of the incident, resident's account of alleged incident, recommendations for corrective actions- the grievance officer will record and maintain all grievances and complaints on the resident grievance/complaint log- the resident grievance/complaint investigation form will be filed with the Administrator within 5 working days of the incident- the resident filing the grievance, will be informed of the findings of the investigation, as well as any corrective actions recommended within 5 working days of filing the grievance Resident #17 was admitted to the facility in July 2024 and has diagnoses including: Chronic obstructive pulmonary disease (COPD - a group of lung diseases that blocks proper airflow and makes it difficult to breathe) and anxiety disorder. Review of the Minimum Data Set (MDS) assessment, dated 7/22/25, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. During an interview on 8/7/25 at 9:09 A.M., Resident #17 said that he/she had items missing without any resolution and he/she had reported it to the Director of Nurses (DON). Resident #17 said he/she had placed an order of items via DoorDash and received notification on their phone that the items had been delivered, but upon going downstairs to the lobby to collect the items, about 30 minutes later, the items were gone. Resident #17 said the DON informed him/her that she would initiate a grievance for him/her at that time, but he/she has not heard back since. Resident #17 said no one ever follows up on concerns so they aren't sure what the point of reporting them is. Review of the facility's Grievance Book and logs on 8/8/25 at 11:17 A.M., from June 2025 to August 2025 failed to indicate a grievance was filed for the Resident's missing items/delivery. During an interview on 8/12/25 at 12:49 P.M., Social Worker #2 said she was not aware of any missing deliveries for the Resident, and she doesn't recall seeing anything about it in the grievance book. She said she would check with the regular full time social worker since missing items would be a concern that would need to be addressed. During an interview on 8/12/25 at 1:08 P.M., the DON said the Resident did report a grievance to her about a missing delivery and said the Resident had informed her the items were missing by the time he/she got downstairs to pick them up. She said she will look into where the grievance is as she is unsure at this time. During an interview with the Director of Social Services and Social Worker #2 on 8/13/25 at 8:24 A.M., the Director of Social Services said she was made aware of the Resident having a missing package that was delivered a few weeks ago. She said a grievance should have been completed and the grievance process should be completed, but she has not seen a form regarding the incident. She said any grievance should be resolved within five days of it being filed or voiced. Social Worker #2 said she inquired with the Administrator about the grievance after she had spoken to the surveyor yesterday, and the Administrator told her that she was handling it. During an interview on 8/13/25 at 8:47 A.M., Resident #17 said the Administrator came in to speak with him/her about the grievance the day prior and he/she showed her the DoorDash receipts for the items purchased from [local pharmacy] on 7/20/25. The receipt confirmed the package was delivered at the facility. The Resident said the Administrator told him/her they were concerned about the lack of photograph in the delivery confirmation and did not resolve her issue or grievance yet. The

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	08/14/2025

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

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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 review and interview, the facility failed to ensure for one Resident (#33), from a total sample of 32 residents, that each resident's drug regimen was free from unnecessary psychotropic medications to promote or maintain the Residents' highest practicable mental, physical, and psychosocial well-being. Specifically, the facility failed for Resident #33, to ensure a gradual dose reduction (GDR) was attempted, unless documented by the prescriber as clinically contraindicated in the medical record.Findings include:Review of the facility's policy titled Psychotropic Medication Use, revised February 2025, indicated but was not limited to the following:-Residents on psychotropic medication receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, to determine whether the continued use of the medication is benefitting the resident, to find an optimal dose, or in an effort to discontinue the medication.-Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes:a) determining adequate indications for use;b) establishing appropriate dose;c) adequate monitoring for efficacy and adverse consequences;d) determining appropriateness of gradual dose reduction; ande) preventing, identifying, and responding to adverse consequences-Residents are monitored for adverse consequences associated with psychotropic medications, including:d) neurologic effects - agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinsonism, tardive dyskinesia, cerebrovascular events Resident #33 was admitted to the facility in March 2024 and has diagnoses including dementia and unspecified psychosis.Review of the Minimum Data Set assessment, dated 4/19/25, indicated Resident #33 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 4 out of 15, and received antipsychotic medication daily.Review of the medical record indicated Physician's Orders for:-Risperidone (antipsychotic) 0.25 milligrams (mg), one tablet two times a day for agitation (initiated 3/22/24)-Behavior Tracking: Agitation, every shift (4/1/24)Review of August 2024 through August 2025 Medication Administration Records (MAR) indicated Risperidone was administered as ordered by the physician.Review of the historic Physician's Orders indicated Resident #33 has been receiving Risperidone 0.25 mg two times a day since admission in March 2024.Review of Resident #33's physician and Nurse Practitioner (NP)'s notes, dated 9/11/24, 12/26/24 and 4/24/25, failed to indicate the Resident's treatment with Risperidone has been evaluated for a GDR and failed to indicate a documented clinical rationale for a GDR of Risperidone was contraindicated. During an interview on 8/12/25 at 1:23 P.M., Physician #2 said he and his NP rely on the consultant psychiatric NP for documenting recommendations in their notes for continued use of psychotropic medications. He said neither he nor his NP had evaluated or documented a clinical rationale for the continuation of Risperidone. He said the Resident has been on the same dose of Risperidone since admission and has not had a GDR.

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	08/14/2025

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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 upon hospitalizations or discharge for three Residents (#142, #143, and #9), out of a total of 32 sampled residents and 3 closed records.Findings include: Review of the facility’s policy titled Transfer or Discharge Notices, dated as revised March 2025 indicated but was not limited to: A. Notice of Transfer or Discharge (Anticipated) - under the following circumstances, the notice of transfer is given as soon as it is practicable but before the transfer or discharge: The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; the resident's health improves sufficiently to allow a more immediate transfer or discharge; an immediate transfer or discharge is required by the residents urgent medical needs; or a resident has not resided in the facility for 30 days -The resident and representative are notified in writing of the following information: The specific reason for the transfer or discharge, the effective date of the transfer or discharge, the specific location to which the resident is being transferred or discharged , an explanation of the residents right to appeal the transfer or discharge to the state, the notice of facility bed hold and policies B. Notice of Transfer or Discharge (Emergency) -when a resident is sent emergently to an acute care setting, this is considered a transfer, not discharge, because the resident’s return is generally expected -Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable -Notice of facility Bed-Hold and Return policies are provided to the resident and representative within 24 hours of emergency transfer 1. Resident #142 was admitted to the facility in April 2025 with medical diagnoses including acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and type 2 diabetes without complications. Review of the electronic medical record census history indicated Resident #142 was transferred to the Hospital emergency room on 6/11/25 due to a change in condition. Further review of the medical record failed to indicate a Notice of Transfer/Discharge was issued to Resident #142 or his/her Representative prior to the hospital transfer. During an interview on 8/13/25 at 11:15 A.M., Social Worker #2 said Nurses are responsible for the completion of Transfer/Discharge and Bed Hold Notices. (continued on next page)

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	08/14/2025

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Care One at Randolph	49 Thomas Patten Drive Randolph, MA 02368

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 8/13/25 at 3:00 P.M., Nurse #7 said the Bed Hold and the Notice of Transfer/Discharge were not completed on 6/11/25. During an interview on 8/13/25 at 3:15 P.M., Nurse #11 said if a copy of the Notice of Transfer and Bed Hold is not in the record, they were not done. During an interview on 8/13/25 at 12:37 P.M., Unit Manager #1 said the Notice of Transfer/Discharge should be done when a resident is being transferred to the hospital. He said in this case, they were not done. 2. Resident #143 was admitted to the facility in February 2024 with medical diagnoses including cirrhosis of liver, paroxysmal atrial fibrillation, and chronic kidney disease. Review of the electronic medical record census history indicated Resident #143 was transferred to the Hospital emergency room on 6/2/25 due to a serious change in condition. Further review of the medical record failed to indicate a Notice of Transfer/Discharge was issued to Resident #143 or his/her Representative prior to the hospital transfer. During an interview on 8/14/25 at 08:40 A.M., the Assistant Director of Nurses (ADON) said the Notice of Transfer and Bed Hold were not done. During an interview on 08/14/25 at 09:10 A.M., Unit Manager #2 said the Bed Hold and Notice of Transfer were not done. During an interview on 08/14/25 at 9:50 A.M., the Director of Nurses (DON) said the Notice of Transfer and Bed Hold were not done. 3. Resident #9 was admitted to the facility in May 2025 with diagnoses which included: COPD, falls, and hyponatremia (low sodium). Review of Resident #9’s medical record indicated he/she was transferred to the hospital on 5/31/25, 6/1/25, 6/3/25, 6/6/25, 6/13/25, and 6/23/25. Further review of the medical record failed to indicate Bed Hold notices and Intent to Transfer notices had been provided to Resident #9 on 5/31/25, 6/1/25, 6/3/25, or 6/6/25. On 8/13/25 at 10:23 A.M., the Director of Social Services (DOSS) and the surveyor reviewed the Bed Hold and Transfer Notice Binder, and the DOSS said she had no evidence of Bed Hold or Transfer notices for Resident #9 on 5/31/25, 6/1/25, 6/3/25, or 6/6/25. The DOSS said she does not complete Bed Hold or Transfer notices for residents who are sent to the hospital emergently and that nursing should do it with the transfer paperwork. During an interview on 8/13/25 at 11:42 A.M., Nurse #7 said when a resident is emergently sent to the hospital the nurse should complete the Bed Hold and Intent to Transfer notices and provide them to the resident prior to transfer. (continued on next page)

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	08/14/2025

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 8/13/25 at 11:52 A.M., Unit Manager #2 reviewed Resident #9’s medical record and could not locate a Bed Hold or Transfer notice for 5/31/25, 6/1/25, 6/3/25, or 6/6/25. Unit Manager #2 said Bed Hold and Transfer notices should be completed when a resident is transferred to the hospital. During an interview on 8/13/25 at 12:19 P.M., the DON said Resident #9 did not have any overflow records. During an interview on 8/14/25 at 2:16 P.M., the DON said Bed Hold and Transfer notices should be completed when a resident is emergently sent to the hospital.

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	08/14/2025

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to accurately complete a Level I Pre-admission Screening and Resident Review (PASARR) for three Residents (#1, #5, and #8), out of a total sample of 32 residents, resulting in the Residents being admitted to the facility without the determination of whether they screened positive for intellectual disability (ID)/developmental disability (DD) or serious mental illness (SMI) requiring further evaluation. Findings include:Review of the Nursing Facility Bulletin 169: Updates to Nursing Facility Regulations: PASRR for Intellectual Disability (ID), Developmental Disability (DD), and Serious Mental Illness (SMI), dated October 2021, indicated the following:A Level I Screening identifies whether an applicant for admission to a nursing facility has, or may have, ID, DD, and/or SMI (i.e. a positive Level I Screening). Effective October 29, 2021, a Level I Screening must be conducted using the revised Preadmission Screening and Resident Review (PASRR) Level I Screening Form, PASRR-L1 (10/21). If the individual has a positive Level I Screening, the screener must refer the individual to the appropriate PASRR authority for a Level II Evaluation or Abbreviated Level II Evaluation, as applicable, unless the individual satisfies all of the criteria for an Exempted Hospital Discharge. 1. Resident #1 was admitted to the facility in January 2025 with diagnoses including adjustment disorder and dementia. Review of Resident #1's Minimum Data Set (MDS) assessment, dated 7/14/25, indicated the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Review of Resident #1's Level I PASARR indicated the Level I PASARR was submitted for review after admitting into the facility. During an interview on 8/12/25 at 12:04 P.M., the Admissions Coordinator said that Resident #1's Level I PASARR should have been completed before or upon admission but was not completed. The Admissions Coordinator said that the missed PASARR submission was identified on facility audit and completed in March 2025. 2. Resident #5 was admitted to the facility in June 2024 with diagnoses including paranoia. Review of Resident #5's Level I PASARR indicated the Level I PASARR was submitted for review after admitting into the facility. Further review of Resident #5's Level I PASARR indicated the staff member completing the form failed to identify the Resident's documented diagnosis of paranoia. During an interview on 8/12/25 at 5:02 P.M., the Admissions Coordinator said Resident #5's full past medical history including the diagnosis of paranoia may not have been available or may have been missed when the Level I PASRR was initially completed. 3. Resident #8 was admitted to the facility in January 2025 with diagnoses including post-traumatic stress disorder, agoraphobia, and substance use disorder. During an interview on 8/11/25, the Regional Social Worker said that the Level I PASARR was not completed at or before time of admission, but the issue was identified on a facility internal audit and the PASARR was completed and submitted.

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	08/14/2025

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Care One at Randolph	49 Thomas Patten Drive Randolph, MA 02368

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop, implement and individualize comprehensive care plans for three Residents (#71, #33, and #8), out of a total sample of 32 residents. Specifically, the facility failed:1. For Resident #71, to develop and implement a person-centered care plan with measurable objectives and timeframes: a. to address recent onset of auditory hallucinations and self-injurious behavior/alleged suicide attempt; andb. to address the use of Sertraline (selective serotonin reuptake inhibitor used to treat anxiety) and Lorazepam (antianxiety) that identified resident specific targeted behaviors, non-pharmacological interventions, and measurable goals of treatment;2. For Resident #33, to ensure a comprehensive care plan was developed to address the use of Risperidone (antipsychotic) and Mirtazapine (antidepressant) that identified resident specific targeted behaviors, non-pharmacological interventions, and measurable goals of treatment; and 3. To ensure a comprehensive care plan was developed to address Resident #8's chronic left leg wounds. Findings include:Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, revised 3/2022, included but was not limited to: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident’s physical, psychosocial and functional needs is developed and implemented for each resident. -The comprehensive, person-centered care plan: a) includes measurable objectives and timeframes; b) describes the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being; -Assessments of residents are ongoing and care plans are revised as information about the residents and residents’ conditions change. -The interdisciplinary team reviews and updates the care plan: a) when there has been a significant change in the resident’s condition; b) when the desired outcome is not met; c) when the resident has been readmitted to the facility from a hospital stay; and d) at least quarterly, in conjunction with the required quarterly MDS assessment. 1. Resident #71 was admitted to the facility in May 2025 and had diagnoses including brain aneurysm with subsequent hemorrhagic stroke, chronic kidney disease, end stage renal disease, and depression. Review of the Minimum Data Set (MDS) assessment, dated 5/30/25, indicated Resident #71 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15, administered antidepressant medication daily and received dialysis treatments. (continued on next page)

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	08/14/2025

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Review of the medical record indicated Resident #71 has a history of refusing multiple dialysis treatments. Review of the medical record indicated on 7/25/25, Resident #71 was transported to the hospital emergency department (ED) directly from the dialysis center after pulling out his/her dialysis port and telling staff that he/she wants to bleed out and die after hearing auditory hallucinations saying, you're going to die.' The Resident returned to the facility during the 11:00 P.M. to 3:00 A.M. shift. Review of the hospital emergency department encounter notes, dated 7/25/25, indicated Resident #71 presented to the ED from dialysis as hemodialysis staff was concerned about suicidality after the Resident removed the dialysis line from his/her fistula. The notes indicated the Resident said he/she overheard someone say, “you are going to die anyways” and became frustrated, angry and removed the dialysis line saying, “I might as well get it over with”. Review of comprehensive care plans failed to indicate a person-centered care plan had been developed to address Resident #71’s self-injurious behavior/suicidal thoughts. Review of a Nursing Note, dated 7/28/25, indicated the dialysis center reported Resident #71 was agitated, demanding termination of treatment, attempted to bite and pull dialysis needles and treatment was terminated for safety. The physician was notified and ordered Ativan 1 milligram (mg) to be administered prior to dialysis. Review of a Nursing Note, dated 8/4/25, indicated Resident #71 pulled out the arterial needle (draws blood from the body to the dialyzer- filter that cleans a patient's blood when their kidneys are unable to perform this function) while the venous needle (returns purified blood to the patient) site was waiting to clot with a holding clamp. Further review of comprehensive care plans failed to indicate a person-centered care plan had been developed to address Resident #71’s continued self-injurious behavior. During an interview on 8/12/25 at 1:38 P.M., the Director of Social Services (DSS) said she participates in the development of social service care plans and will update them whenever there is a change in the resident's status. She said she was notified that while at dialysis, the Resident pulled out his/her port and said he/she wanted to die. The DSS said she saw the Resident a few days afterward and that the Resident said it was in the moment and didn't really mean it. She reviewed Resident #71’s comprehensive care plans and said she did not update or develop a care plan to address the Resident’s self-injurious behaviors/alleged suicide attempt but should have. b. Review of the medical record indicated Physician's Orders for: -Sertraline HCl 50 mg one time a day for depression (5/25/25) -Lorazepam 1 mg one time a day every Monday, Wednesday and Friday for anxiety prior to going to dialysis (7/29/25) Review of May 2025 through August 2025 Medication Administration Records (MAR) indicated Sertraline and Lorazepam were administered as ordered by the physician. (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of comprehensive care plans included but was not limited to: -Focus: At risk for changes in mood related to depression (initiated: 5/28/25) -Interventions: Administer medications per physician’s order; assess for physical/environmental changes that may precipitate change in mood; attempt psychotropic drug reduction per physician’s orders; observe for mental status/mood state changes when new medication is started or with dose changes; offer choices to enhance sense of control validate feelings of loss. -Goal: Will accept care and medication as prescribed Further review of comprehensive care plans failed to indicate a care plan had been developed for the use of Sertraline and Lorazepam that identified resident-specific symptoms or targeted behaviors, resident-specific non-pharmacological approaches, and measurable goals of treatment to meet the Resident's needs. During an interview on 8/12/25 at 8:42 A.M., the Assistant Director of Nursing (ADON) reviewed Resident #71’s medical records. The ADON said Resident #71 has depression and is treated with Sertraline and was recently started on Lorazepam for anxiety prior to dialysis because he/she refuses treatment sometimes. She reviewed the comprehensive care plans and said the care plans should include resident-specific targeted symptoms or behaviors, resident-specific interventions, and nonpharmacological interventions but they do not. 2. Resident #33 was admitted to the facility in March 2024 and has diagnoses including dementia and unspecified psychosis. Review of the MDS assessment, dated 4/19/25, indicated Resident #33 had severe cognitive impairment as evidenced by a BIMS score of 4 out of 15, and received antipsychotic and antidepressant medication daily. Review of the medical record indicated Physician's Orders for: -Risperidone 0.25 mg, one tablet two times a day (initiated 3/22/24) -Mirtazapine 15 mg, one tablet in the evening (initiated 3/22/24) Review of June 2025 through August 2025 MAR indicated Risperidone and Mirtazapine were administered as ordered by the physician. Review of comprehensive care plans included but was not limited to: -Focus: At risk for behavior symptoms related to unspecified dementia, refusal of care daily (initiated: 4/1/24) -Interventions: Administer medications per physician’s order; attempt psychotropic drug reduction per physician’s orders; consistent care givers, reapproach as needed (PRN); observe for mental status/behavioral changes when new medication started or with changes in dosage; psych referral as needed (continued on next page)

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	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Goal: Will reduce risk of behavioral symptoms Further review of comprehensive care plans failed to indicate a care plan had been developed for the use of Risperidone and Mirtazapine that identified resident-specific symptoms or targeted behaviors, resident-specific interventions, including non-pharmacological approaches, and measurable goals of treatment to meet the Resident's needs. During an interview on 8/12/25 at 8:42 A.M., the ADON reviewed Resident #33's medical record and said the Mirtazapine for Resident #33 is used as an appetite stimulant and she is not aware of any targeted symptoms or behaviors for the use of Risperidone. She reviewed the comprehensive care plans and said the care plans should include resident-specific targeted symptoms or behaviors, resident-specific interventions, and nonpharmacological interventions but they do not. During an interview on 8/14/25 at 2:16 P.M., the Director of Nursing (DON) said all care plans should be personalized and individualized to meet the residents’ needs and keep them safe. 3. Resident #8 was admitted to the facility in January 2025 with diagnoses including left lower extremity wound with history of wet gangrene (a serious bacterial infection that causes tissue death) status post multiple debridement's (a medical procedure that involves the removal of dead, damaged, or infected tissue) and staged grafting (a surgical procedure designed to repair and restore damaged or missing skin using healthy donor skin from another area of the body). Review of the comprehensive MDS assessment, dated 7/8/25, indicated Resident #8 was cognitively intact as evidenced by a BIMS score of 15 out of 15 and had an infection of the foot and surgical wounds. Review of Resident #8’s Physician's Orders indicated but was not limited to: -LYMPHADEMIC WOUND OF THE LEFT CALF FULL THICKNESS DRESSING TREATMENT PLAN Steroid cream prescription apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days: Triamcinolone 1% to the wound bed for hypergranulation; Wet to dry apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days ABD pad apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days; Gauze roll (kerlix) 4.5 apply once daily (7/31/25) -LYMPHADEMIC WOUND OF THE LEFT SHIN FULL THICKNESS DRESSING TREATMENT PLAN Steroid cream prescription apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days: Triamcinolone 1% to the wound bed for hypergranulation; Wet to dry apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days ABD pad apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days; Gauze roll (kerlix) 4.5 apply once daily (7/31/25) Review of Resident #8’s hospital History and Physical, dated 12/26/24, indicated the Resident had required several admissions for wound management dating back to 12/2023 with left lower extremity gangrene and cellulitis and had undergone multiple surgical debridement procedures and skin grafts. On 8/7/25 at 8:53 A.M., Nurse #3 said Resident #8 had wounds on his/her right leg and coccyx. (continued on next page)

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	08/14/2025

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/7/25 at 10:32 A.M., the surveyor observed Resident #8 out of bed in his/her wheelchair with a dressing on his/her left leg. Resident #8 said he/she had a wound on his/her left leg and is seen by the facility’s consulting wound physician. On 8/11/25 at 11:53 A.M., the surveyor observed Resident #8 in his/her wheelchair with a dressing on his/her left leg. Review of comprehensive care plans failed to indicate a care plan had been developed to address the Resident's chronic left lower extremity wound. During an interview on 8/12/25 at 9:37 A.M., the Assistant Director of Nursing (ADON) said that Resident #8 has wounds on his/her left leg. The ADON said that she used to attend wound rounds with the facility’s consulting wound physician, and the Resident has had wounds on his/her left leg since he/she was admitted to the facility.

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	225356	A. Building B. Wing	08/14/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide services that met professional standards of practice for seven Residents (#28, #43, #39, #5, #4, #71, and #1), out of a total sample of 32 residents. Specifically, the facility failed: 1. For Resident #28, to ensure vital sign parameters were adhered to prior to medication administration as per physician's orders;2. For Resident #43, to ensure his/her left built-up palm guard was implemented per physician's orders;3. For Resident #39,a. To ensure hospital medication reconciliation was completed and medications were implemented, andb. To ensure his/her air settings and right heel off-loading boots were implemented per physician orders;4. For Resident #5, to ensure his/her right-hand carrot orthotic and left-hand palm guard were implemented per physician's orders;5. For Resident #4, to ensure physician's orders for opioid administration were followed for Resident #4;6. For Resident #71, to ensure the physician's order for a Lidocaine 5% pain medication patch was complete and applied in accordance with the physician's order; and7. For Resident #1, to ensure he/she had an Abnormal Involuntary Movement Scale (AIMS) completed after initiation of Seroquel (antipsychotic medication). Findings include: Review of [NAME], Manual of Nursing Practice 11ed, dated 2019, indicated the following: -The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. -In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. 1. Review of the facility's policy titled Administering Medications, dated as revised April 2019, indicated but was not limited to the following: - Medications are ordered in accordance with prescriber orders - the following information is checked/verified for each resident prior to administering medications: vital signs - if necessary Resident #28 was admitted to the facility in July 2025 with diagnoses including: hypertension (high blood pressure (HTN)) and Osteomyelitis (an infection in the bone). Review of the current Physician's Orders for Resident #28 indicated but were not limited to the following: (continued on next page)

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	08/14/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Vital signs every shift (7/22/25) - Lisinopril 10 milligrams (mg) Give 1 tablet by mouth one time a day for HTN Hold for systolic blood pressure (SBP) < (less than)100 (7/24/25) On 8/8/25 at 9:14 A.M., the surveyor observed Nurse #1 administer Lisinopril (a medication used to treat high blood pressure) 10mg to Resident #28. She was not observed to take or verify the Residents' blood pressure prior to administering the medication to ensure his/her SBP was not less than 100 and the vital signs were not observed to be documented on the medication administration record (MAR) at the time of medication administration. Review of the MAR for Resident #28 at 10:35 A.M. on 8/8/25 failed to indicate vital signs, including a blood pressure, had been obtained or documented for Resident #28. During an interview on 8/8/25 at 12:18 P.M., Nurse #1 reviewed the MAR for Resident #28 and said she missed that the Lisinopril order had blood pressure parameters and that is why she did not check the Resident's blood pressure prior to administering his/her medication. She said she should have checked the blood pressure to see if the SBP was <100 and she did not. She said not following the parameter orders is a medication error and she understands she should have completed that piece of the order. During an interview on 8/12/25 at 1:41 P.M., Physician #2 said his expectation is that the nurses are following his orders as they are written and they should not deviate from them. During an interview on 8/12/25 at 3:46 P.M., the Director of Nurses (DON) was made aware of the observation during medication pass. She said the expectation is that the nurses are following the physician's orders as they are written and the nurse should have verified the blood pressure for Resident #28 prior to administering the Lisinopril since the order contained hold parameters but, in this instance, it appears she did not. 2. Review of the facility’s policy titled Assistive Devices and Equipment, dated as revised February 2021, indicated but was not limited to: - our facility maintains and supervises the use of assistive devices and equipment for residents - recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan - staff are trained and demonstrate competency in the use of devices prior to assisting or supervising the residents - the following factors are addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment: appropriateness for resident condition, personal fit, device condition, staff practices (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #43 was admitted to the facility in January 2025 with diagnoses including: nonpyrogenic thrombosis of intercranial venous system (formation of blood clots in the veins of the brain not causing or related to the production of pus), focal traumatic brain injury, and traumatic subarachnoid hemorrhage (bleeding in the space between the brain and tissue covering the brain). Review of the Minimum Data Set (MDS) assessment, dated 7/22/25, indicated but was not limited to the following: Cognition: C1000 = significant impaired cognition Functional Abilities: GG0115 = Upper and lower extremities with impairment on both sides Active diagnoses: I5500 = TBI (total brain injury) On 8/7/25 at 8:55 A.M., the surveyor observed Resident #43 in bed with a partially closed left hand that the Resident was not moving. During an interview on 8/7/25 at 11:47 A.M., the Guardian for Resident #43 said she had brought up concerns to the facility about hand contractures and was told the Resident would see therapy for this, but that people with their conditions tended to develop contractures at baseline. She said she has never seen any type of splinting device or any device in the Resident's hand to prevent contractures and to the best of her knowledge they do not have anything to that effect. Review of the Occupational Therapy (OT) evaluation, notes and discharge summary for start of care 5/6/25, indicated but were not limited to the following: Diagnosis: contracture of the left hand, encounter for surgical aftercare following surgery on the nervous system Goals: greater than (>) 75% (percent) of staff will demonstrate carry over of previously established left palm guard wearing during the day and remove at night (baseline 5/6/25 - inconsistent carry over) Current referral: patient was d/c (discharged) with palm guard to wear during the daytime and remove prior to nighttime on left hand Upper extremity ROM (range of motion) - impaired on both sides at shoulder, elbow/forearm, wrist, hand, thumb, index finger, middle finger, ring finger and little finger OT Notes: 6/8/25 - pt approached following A.M. care, left palm guard not donned (put on) at this time - therapy communication to nursing form initiated to encourage staff carryover of palm guard use 6/12/25 - education to caregivers left palm guard, management and wear schedule on during the day off at night 6/16/25 - education to caregivers regarding care and management of left palm guard, demonstrated insight regarding functional care and management with palm guard (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/18/25 - education to caregivers on palm guard management Review of the July and August 2025 Activities of daily living (ADL) care tasks indicated Resident #43 was dependent upon the staff for all care tasks. Review of the current Physician's Orders for Resident #43 indicated but were not limited to the following: - Patient to trial right hand orthotic (4/28/25) - Wear left built-up palm guard during the daytime, remove at bedtime - two times per day remove per schedule (3/10/25) Review of the Treatment Administration Record (TAR) for Resident #43 for July and August of 2025 indicated but was not limited to the following: - wear left built-up palm guard during daytime, remove at bedtime, two times a day and remove per schedule: remove at 8:59 A.M., apply at 9:00 A.M., remove at 4:59 P.M., apply at 5:00 P.M. Further review of the TAR indicated the licensed nursing staff were signing off the left palm guard was removed for 1 minute twice daily at 8:59 A.M., and 4:59 P.M., and then applied twice daily at both 9:00 A.M., and 5:00 P.M. Throughout the survey the surveyor made the following observations of Resident #43: 8/7/25: No left palm guard was in place at 8:55 A.M., or 4:00 P.M. 8/8/25: No left palm guard was in place at 8:12 A.M., 12 noon, or 2:23 P.M. 8/12/25: No left palm guard was in place at 8:48 A.M., or 2:06 P.M. During an interview on 8/8/25 at 11:33 A.M., the Director of Rehabilitation Services (DOR) said the rehab department maintains all therapy to nursing communication sheets which are essentially education sign offs to the nursing staff indicating they understand the needs of the residents on or previously on rehab services. Review of the Therapy communication to nursing forms, dated 3/10/25 and 6/8/25, indicated but were not limited to the following: March 2025: Recommendations for nursing follow through: Don left hand palm guard for daytime wear (on with A.M. care); remove palm guard at night (at P.M. care); complete skin check for redness or irritation prior to wear of orthotic 18 staff members signed the March 2025 education of Resident #43's left palm guard schedule, including Nurse #2 and Certified nurse assistant (CNA) #2 (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	June 2025: The following was addressed: Left hand orthotic wear; Recommendations for nursing follow through: Left hand palm guard to be worn during the daytime and removed during nighttime care 14 staff members signed the June 2025 education of Resident #43's left palm guard schedule, including Unit manager #1, CNA #1 and CNA #2 During an interview on 8/8/25 at 2:26 P.M., CNA #1 said Resident #43 is totally dependent on the staff for care. She said they do not put any devices on the Resident and she does not remember the Resident using any splints or devices to his/her hand or wrist area. During an interview on 8/8/25 at 2:27 P.M., CNA #2 said Resident #43 is dependent on staff for all care and does not wear any devices or splints on his/her left hand or wrist and she doesn't recall seeing one, but perhaps the night shift manages that. During an interview on 8/8/25 at 2:28 P.M., Nurse #1 said Resident #43 is total care and she doesn't believe they wear any splints or devices on their hand, and she has not put any on the Resident today and doesn't recall seeing any available. Review of the current care plans for Resident #43 indicated but were not limited to the following: - At risk for alteration in skin integrity related to (r/t) impaired mobility and incontinence (initiated: 1/29/25) Encourage and assist to reposition; use assistive devices as needed (initiated: 1/29/25) - Neurological deficiencies r/t traumatic brain injury (revised: 1/20/25) Therapy evaluation and treatment as ordered (initiated: 1/20/25) - ADL self-care deficit r/t disease process, and physical limitations r/t TBI (revised: 1/29/25) Therapy evaluation and treatment per physician orders (initiated: 1/29/25); OT to trial bilateral hand orthotics (initiated: 2/3/25) The care plans failed to indicate the Resident was to wear a left palm guard during the day and remove at night During an interview on 8/12/25 at 1:41 P.M., Physician #2 said his expectation is that the nurses are following physician's orders and that this Residents' left-hand splint/palm guard should be on daily, as ordered. During an interview on 8/12/25 at 2:08 P.M., CNA #5 said the CNAs are made aware of any resident needing splints or other devices either through reviewing the CNA Care Kardex or if they are new, in report by the nurses. She said she is not aware of any hand splint of device being needed for Resident #43. (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CNA Care Kardex, dated 8/12/25, indicated OT to trial bilateral hand orthotics, but failed to indicate Resident #43 was to wear a left palm guard during the daytime. During an interview on 8/12/25 at 2:14 P.M., Nurse #2 said she is the primary day shift nurse for Resident #43. She said the Resident wears a left palm guard hand splint at night and the device is off during the day. She said that is what the nurses are documenting on the TAR. She reviewed the record and said there is no indication the Resident requires a left-hand splint or palm guard on the CNA Care Kardex and she wasn't aware until now, that the Resident was wearing the palm guard during the day and if it is signed off on the TAR it occurred within the process of the nurses just signing things off. She went to the room with the surveyor and verified the Resident was not wearing their left palm guard at this time. She searched the room for the device, including the drawers, bureau, closet, bedside table, and resident's chair, and said no device could be found and it seems the Resident should be wearing the device but is not and she is unsure of the last time the Resident had the device. During this time the Respiratory Therapist entered the room at approximately 2:19 P.M., and said he is in the Resident's room providing care multiple times a day and he hasn't seen the palm guard in a while, but he does not have anything to do with the Resident wearing that device. During an interview on 8/12/25 at 2:35 P.M., the DOR said Resident #43 is supposed to be wearing a left palm guard and that remains the recommendation of the skilled rehabilitation team for this Resident. During this conversation Nurse #2 entered the room and requested a new device for Resident #43 since the old one could not be found. Review of Resident #43's progress notes, including nursing notes and provider notes, from March 2025 to current, failed to indicate the Resident was not wearing their palm guard or any explanation as to why the palm guard was not in use as ordered. During an interview on 8/12/25 at 2:44 P.M., the DON was made aware of the surveyor's observations and the lack of use of the left palm guard device for Resident #43, while the nurses were signing off the device was in place. The DON said they probably signed it off not fully reading it and realizing what they were signing. She reviewed the orders and said the orders are written strangely and the palm guard originally started as a trial and that may be why the information for daily wear of the device is not on the Resident's care plan or CNA care Kardex. She said Resident #43 should be wearing his/her left palm guard in accordance with the physician's orders. 3a. Review of the facility’s policy titled Reconciliation of Medications on Admission, dated as revised July 2017, indicated but was not limited to: -The purpose of this procedure is to ensure medication safety by accurately accounting for the resident’s medications, routes and dosages upon admission or readmission to the facility -Steps in the procedure: 1. If a medication history has not been obtained from the resident or family, complete this first. 2. Ask the resident to list all physicians and pharmacies from which he or she has obtained medications. (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Using an approved medication reconciliation form or other record, list all medications from the medication history, the discharge summary, the previous Medication Administration Record (MAR) (if applicable), and the admitting orders. 4. List the dose, route and frequency for all medications. 5. Review the list carefully to determine if there are discrepancies/conflicts. 6. If there is a discrepancy or conflict in medications, dose, route or frequency, determine the most appropriate action to resolve the discrepancy. 7. Document findings and actions. Resident #39 was admitted to the facility in December 2024 with diagnoses which included necrotizing fasciitis (bacterial infection that destroys skin and soft tissue, including the connective tissue surrounding muscles and organs), cellulitis of right lower limb (skin infection that affects the deeper layers of the skin and underlying tissues) and peripheral vascular disease (PVD, a condition where the blood vessels in the arms, legs, and other extremities become narrowed or blocked). Review of the MDS assessment, dated 7/1/25, indicated Resident #39 was cognitively intact as evidenced by a BIMS score of 14 out of 15. Review of Resident #39’s medical record indicated he/she was hospitalized and readmitted to the facility in April 2025. Review of the April 2025 Hospital Discharge summary indicated but was not limited to: -History and Physical: he/she presented to the hospital with elevated white blood cell count (WBC, a type of blood cell that plays a crucial role in the body's immune system, elevated levels can be indicative of infection) and admitting diagnoses included cellulitis -Home Medication List: New Medications include doxycycline (antibiotic) 100 milligrams (mg) by mouth every 12 hours and cefpodoxime (antibiotic) 200 mg by mouth twice per day -Current Medications: cefpodoxime 200 mg by mouth twice daily and doxycycline 100 mg by mouth every 12 hours -Patient Visit Information: You received IV antibiotics for management of an infection in your legs. You have now switched to antibiotics by mouth and will continue these through 4/29/25. Prescriptions: doxycycline 100 mg by mouth every 12 hours and cefpodoxime 200 mg by mouth twice a day. Review of Resident #39’s April 2025 MAR included but was not limited to: - doxycycline 100 mg by mouth two times per day was administered through 4/29/25 Further review of Resident #39’s April 2025 MAR failed to indicate cefpodoxime had been implemented. (continued on next page)

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	08/14/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/12/25 at 3:52 P.M., Nurse #4 said when a resident is readmitted to the facility the hospital paperwork should be reviewed, and new orders and recommendations are implemented. During an interview on 8/12/25 at 11:39 A.M., Nurse Practitioner #1 said when residents are admitted , or they return from the hospital she tries to see them within a few days and complete a medication reconciliation. Nurse Practitioner #1 said she did not recall the April hospitalization and was not sure why the cefpodoxime was not implemented. During an interview on 8/12/25 at 12:07 P.M., Physician #1 said he does not recall specifics of Resident #39’s April hospitalization but would expect the hospital discharge orders to match the admission orders. Physician #1 said if the discharge orders were not implemented there should be documentation in the record as to why. During an interview on 8/12/25 at 4:11 P.M., Unit Manager #1 said when a resident is admitted or readmitted from the hospital a medication reconciliation should be completed. Unit Manager #1 said two nurses should sign a medication reconciliation form to verify the discharge paperwork had been reviewed and implemented. Unit Manager #1 reviewed Resident #39’s medical record and said he/she did not have orders for cefpodoxime in April 2025 and there was no evidence a medication reconciliation was completed in April of 2025. Unit Manager #1 reviewed the discharge record and said there was a check mark next to the cefpodoxime on multiple pieces of the discharge paperwork indicating the order was reviewed and should have been implemented. b. Review of Resident #39’s Physician's Orders indicated but were not limited to: -Air mattress to bed check placement and function and keep settings at 160 every shift, 8/8/25 -Right heel off-loading boot in bed, 5/5/25 Review of Resident #39’s August 2025 TAR indicated his/her air mattress order had been signed off every shift. Further review of Resident #39’s August TAR failed to indicate evidence his/her right off-loading boot had been signed off as completed. On the following dates and times, the surveyor observed Resident #39 in bed, not wearing the right heel off-loading boot with his/her air mattress set to 355: -8/11/25 at 10:25 A.M. and 4:30 P.M. -8/12/25 at 8:01 A.M. and 1:49 P.M. During an interview on 8/12/25 at 3:52 P.M., Nurse # 4 said Resident #39 has an order for a right heel off-loading and his/her air mattress should be set at 160. During an interview on 8/12/25 at 4:11 P.M., Unit Manager #1 said orders for off-loading boots and air mattresses should be followed as ordered. During an interview 8/14/25 at 2:16 P.M., the DON said physician's orders should be followed. (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #5 was admitted to the facility in June 2024 with diagnoses including hand contracture and chronic pain. Review of the MDS assessment, dated 5/27/25, indicated Resident #5 was moderately cognitively impaired as evidenced by a BIMS score of 11 out of 15 and had impaired range of motion on both sides in his/her upper and lower extremities. Review of Resident #5’s Physician's Orders indicated but was not limited to the following: -Patient to wear right hand carrot orthotic during the daytime and remove with PM care every day and evening shift, dated 4/22/25 -Patient to wear left palm guard overnight and removed in the morning, dated 3/28/25 Review of Resident #5’s July and August 2025 TAR failed to indicate the right-hand carrot or left palm guard had been applied as ordered. Review of Resident #5’s Occupational Therapy Orders, dated 3/26/25, indicated but was not limited to: -resident to wear left palm guard overnight and remove in the morning On 8/8/25 at 8:43 A.M., the surveyor observed Resident #5 in bed with his/her hands covered by a sheet. Resident #5 said he/she was supposed to have something in his/her hands, but he/she did not. During an interview on 8/8/25 at 8:50 A.M., Certified Nursing Assistant (CNA) #8 said Resident #5 has devices ordered for both hands and does not push them off or remove them once they have been applied. On 8/12/25 at 3:00 P.M., the surveyor observed Resident #5 sitting in his/her wheelchair at a musical activity. Resident #5 did not have his/her carrot orthotic in place in his/her right hand. On 8/12/25 at 4:33 P.M., the surveyor observed Resident #5 lying in bed in his/her room. Resident #5 showed the surveyor his/her hands and he/she did not have his/her carrot orthotic in place in his/her right hand. On 8/14/25 at 6:51 A.M., the surveyor observed Resident #5 lying in bed in his/her room with no devices in either hand. Resident #5 said the facility was supposed to put something on his/her left hand at night and the right hand during the day. Resident #5 said he/she did not remember the last time the left-hand device was applied. On 8/12/25 at 4:30 P.M., Unit Manager #3 said Resident #5 wears a carrot orthotic in his/her right hand during the day and should have it in place. Unit Manager #3 and the surveyor observed Resident #5 without the carrot orthotic in place. Unit Manager #3 located the Resident’s carrot orthotic in his/her nightstand. (continued on next page)

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	08/14/2025

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/14/25 at 6:55 A.M., Nurse #13 said she worked the night shift on Resident #5’s unit regularly and her current position was a night nurse. Nurse #13 said Resident #5 does not wear anything on his/her left hand. Nurse #13 said a left palm guard was not on her radar, and she did not recall a time it was applied to or worn by Resident #5. Nurse #13 reviewed the physician's orders and said Resident #5 should have a left palm guard on at night and she would have to check to see if the Resident had one. Nurse #13 and the surveyor observed Resident #5 in his/her bed without the left palm guard in place. Nurse # 13 located Resident #5’s the left palm guard in his/her nightstand. During an interview on 8/14/25 at 11:06 A.M., the DOR said Resident #5 should have been wearing a left palm guard at night prior to 8/14/25. The DOR said the left-hand palm guard had been discontinued due to left hand wounds on 8/14/25. During an interview on 8/14/25 at 8:59 A.M., Physician #2 said devices (palm guard and orthotic carrot) should be worn as ordered. During an interview on 8/14/25 at 7:22 A.M., Unit Manager #3 said Resident #5 should wear his/her left palm guard at night as ordered. During an interview on 8/14/25 at 2:16 P.M., he DON said devices should be worn per physician's orders. 5. Review of the facility’s policy titled Pain Assessment and Management, dated as revised April 2025, indicated but was not limited to: -The medication regimen is implemented as ordered. Results Of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications. Resident #4 was admitted to the facility in March 2025 with diagnoses which included cerebral infarction (stroke), low back pain, and chronic pain. Review of the MDS assessment, dated 5/2025, indicated Resident #4 was cognitively intact as evidenced by a BIMS score of 14 out of 15. Further review of the MDS assessment indicated he/she received scheduled and as needed medication for pain. Review of Resident #4’s Physician's Orders indicated but were not limited to: -oxycodone 5 mg by mouth every six hours as needed for severe pain (7-10), hold for sedation/drowsiness Review of Resident #4’s July and August 2025 MAR indicated: - July: as needed oxycodone was administered a total of 48 times, on 38 occasions the reported pain level was less than 7 -August: as needed oxycodone was administered a total of 22 times, on 19 occasions the reported pain level was less than 7 (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/13/25 at 3:44 P.M., Nurse #12 said Resident #4 received oxycodone 5 mg for pain as needed, that his/her pain ranged between a 4-5 and was never as high as a 7. During an interview on 8/14/25 at 6:57 A.M., Nurse #13 said Resident #4 had orders for as needed oxycodone every six hours for pain. Nurse #13 reviewed the physician's order and said the medication should be administered when his/her pain was a 7 or higher. During an interview on 8/14/25 at 7:22 A.M., Unit Manager #3 reviewed Resident #4’s physician's orders and said the oxycodone should not have been administered for pain less than 7 out of 10. During an interview on 8/14/25 at 2:16 P.M., the DON said physician's orders should be followed as prescribed. 6. Resident #71 was admitted to the facility in May 2025 and had diagnoses including hemiplegia (paralysis on one side of the body), hemiparesis (muscle weakness or partial paralysis on one side of the body) following a stroke and osteoarthritis. Review of the MDS assessment, dated 5/30/25, indicated Resident #71 was cognitively intact as evidenced by a BIMS score of 13 out of 15, was dependent on staff for activities of daily living, had frequent pain and received scheduled and as needed pain medication. Review of the medical record indicated but was not limited to the following Physician’s Orders: -Lidocaine Patch 5%, apply to left ankle topically in the evening for pain remove and discard patch within 12 hours (5/25/25) Review of May 2025 through August 2025 MARs/TARs indicated the Lidocaine Patch 5% was applied to Resident #71’s left ankle as ordered by the physician at 7:00 P.M. The MAR/TARs failed to indicate when the Lidocaine 5% patch was removed each day. During an interview on 08/12/25 at 8:12 A.M., the surveyor observed Resident #71 sitting reclined in bed with his/her johnny (hospital gown) hanging off his/her left shoulder exposing a rectangular shaped patch, unsigned and undated, adhered to the Resident’s left shoulder. The Resident said he/she has a lot of pain, and the patch helps. During an interview on 8/12/25 at 8:35 A.M., the Assistant Director of Nursing (ADON) reviewed Resident #71’s physician’s orders for Lidocaine 5% patch and said it is to be applied to the left ankle topically in the evening for pain and remove and discard the patch within 12 hours. She said the order is not written properly. She said the order should include the time for the patch to be removed and an area for staff to document its removal. At this time, the surveyor and ADON went to the Resident’s room. The ADON noted the patch to the Resident’s left shoulder and identified it as a pain patch. She said the Resident should not have a pain patch on his/her left shoulder because the order indicates it to be applied to the left ankle. (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/14/25 at 7:02 A.M., Nurse #11 reviewed the physician’s orders for lidocaine patch to be applied to the left ankle. The nurse said she applied the Lidocaine 5% patch to the Resident’s right ankle at 5:00 P.M. last evening because the resident told her his/her right ankle hurt and not the left ankle. Nurse #11 said she has been busy and has not removed the patch yet this morning. She said according to the order, it is supposed to be removed within 12 hours, which would have been by 5:00 A.M. today. During an interview on 8/14/2025 at 2:16 P.M., the DON, she said the order for 5% lidocaine patch order is bizarre and should include when to apply it and when to remove it. 7. Review of the facility’s policy titled Psychotropic Medication Use, revised February 2025, indicated but was not limited to the following: -Residents on psychotropic medication receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, to determine whether the continued use of the medication is benefitting the resident, to find an optimal dose, or in an effort to discontinue the medication. -Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes: a) determining adequate indications for use; b) establishing appropriate dose; c) adequate monitoring for efficacy and adverse consequences; d) determining appropriateness of gradual dose reduction; and e) preventing, identifying, and responding to adverse consequences -Residents are monitored for adverse consequences associated with psychotropic medications, including: d) neurologic effects – agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinsonism,

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	225356	A. Building B. Wing	08/14/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, and records reviewed, the facility failed to provide care, consistent with professional standards of practice for one Resident (#39), out of a total sample of 32 residents. Specifically, the facility failed to ensure his/her wound (non-pressure related) recommendations were implemented. Findings include:Resident #39 was admitted to the facility in March 2025 with diagnoses which included necrotizing fasciitis (bacterial infection that destroys skin and soft tissue, including the connective tissue surrounding muscles and organs), cellulitis of right lower limb (skin infection that affects the deeper layers of the skin and underlying tissues) and peripheral vascular disease (PVD, a condition where the blood vessels in the arms, legs, and other extremities become narrowed or blocked). Review of the Minimum Data Set (MDS) assessment, dated 7/8/25, indicated Resident #39 did not have impaired memory and he/she made reasonable and consistent decisions. Review of Resident #39's care plans indicated but was not limited to:-Resident #39 was at risk for alteration in skin integrity related to history of pressure ulcers, impaired mobility, and recent surgery. Date Initiated: 3/11/25 -Resident #39 had actual skin breakdown on his/her sacrum, and right lateral ankle. Date Initiated: 3/11/25 (revised on 5/15/25) Review of Resident #39's medical record indicated he/she was followed by a Wound Consultant. Review of Resident #39's Wound Evaluation and Management Summary Report, completed by the Wound Consultant, dated 3/26/25, indicated but was not limited to:-Skin tear wound of right knee: apply betadine (an antiseptic used for skin disinfection) once daily Review of Resident #39's March and April 2025 Treatment Administration Records (TAR) indicated the 3/26/25 right knee skin tear recommendation was not implemented. Further review of the TAR indicated there was no treatment to the right knee after 3/27/25. Review of Resident #39's Wound Evaluation and Management Summary Report, completed by the Wound Consultant, dated 4/2/25, 4/9/25, and 4/30/25 indicated but was not limited to:-Skin tear right knee: apply Xeroform (a type of dressing made of used to promote a moist environment, assist in the removal of dead tissue and promote healing) gauze to wound bed and cover with a bordered silicone foam dressing daily Review of Resident #39's April and May 2025 TAR indicated the 4/2/25, 4/9/25, and 4/30/25 right knee skin tear recommendations were not implemented. Further review of the TAR indicated there was no treatment order for the right knee until 5/5/25. Review of Resident #39's Wound Evaluation and Management Summary Report, completed by the Wound Consultant, dated 4/2/25, 4/9/25, 4/30/25, and 5/7/25, indicated but was not limited to:- Surgical wound of right medial calf: apply alginate calcium (used for moderately to heavily draining wounds and promotes healing), apply skin prep (a protective barrier applied to the skin before the application of adhesives) to periwound and cover with a bordered silicone foam dressing daily Review of Resident #39's April and May 2025 TARs indicated the 4/2/25, 4/9/25, 4/30/25, and 5/7/25, right medial calf surgical wound recommendations were not implemented. Review of Resident #39's Wound Evaluation and Management Summary Reports, completed by the Wound Consultant, dated 6/11/25, 6/18/25, 6/25/25, 7/2/25, 7/15/25, 7/23/25, 7/30/25, and 8/6/25 indicated but was not limited to:-surgical wound of sacral/perineal: apply alginate calcium (used for moderately to heavily draining wounds and promotes healing) to wound bed followed by superabsorbent gelling fiber (used to absorb and retain wound fluid, creating a moist environment that promotes healing and aids in removal of dead tissue) and cover with bordered silicone dressing daily Review of Resident #39's June, July and August 2025 TARs indicated the 6/11/25, 6/18/25, 6/25/25, 7/2/25, 7/15/25, 7/23/25, 7/30/25, and 8/6/25 sacral/perineal surgical wound recommendations were not implemented. Further review of the TARs indicated the sacral/perineal surgical wound recommendation was not implemented until 8/12/25. Review of Resident #39's Wound Evaluation and Management Summary Report, completed by the Wound Consultant, dated 7/2/25, indicated but was not limited to:-arterial wound of right lateral ankle: start doxycycline (antibiotic) 100 milligrams (mg) by mouth twice daily for six weeks related to exposed bone and abnormal labs Review of Resident #39's July 2025 TAR indicated he/she was not started on doxycycline or any other antibiotics prior to his/her unrelated hospitalization on 7/8/25. Review of Resident #39's medical record failed to indicate why the wound consultant recommendations were not approved. During an interview on 8/12/25 at 1:25 P.M., Nurse #5 said the wound consultant makes recommendations and the facility staff get the recommendations approved by the provider. Nurse #5 said if the recommendations were not approved there should be a note in the resident's record. During an interview on 8/12/25 at 1:49 P.M., Nurse #4 said wound consultant recommendations were reflected on the wound evaluation and management summary report. Nurse #4 said the facility staff reviews the wound evaluation and management summary

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	225356	A. Building B. Wing	08/14/2025

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure for one Resident (#101), out of a total sample of 32 residents, that footcare was provided in accordance with professional standards to help prevent potential foot problems. Findings include: Review of the facility's policy titled Foot Care, dated as revised October 2022, indicated but was not limited to the following: - residents receive appropriate foot care and treatment in order to maintain foot health- residents are provided with foot care and treatment in accordance with professional standards of practice- trained staff may provide routine foot care (e.g., toenail clipping) within professional standards of practice for residents without complicating disease processes- residents with foot disorders or medical complications associated with foot complications are referred to qualified professionals. Foot disorders that require treatment include nail disorders. Resident #101 was admitted to the facility in May 2025 with diagnoses including: Chronic obstructive pulmonary disease (COPD - a group of lung diseases that blocks proper airflow and makes it difficult to breathe), pan lobular emphysema (a disease preventing adequate gas exchange in the lungs, and chronic respiratory failure with hypoxia (the absence of enough oxygen in the tissue to sustain bodily functions). Review of the Minimum Data Set (MDS) assessment, dated 5/16/25, indicated the Resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. During an interview on 8/7/25 at 9:14 A.M., Resident #101 said he/she had requested to see a podiatrist to cut their toenails because their feet were out of control. During an observation with interview on 8/8/25 at 9:40 A.M., Resident #101 informed Nurse #1 that he/she needed their toenails cut. Nurse #1 told the Resident that she believed they were on the podiatry list but didn't know when that would happen. The Resident said he/she believed the podiatrist had already come in but did not see them. The nurse informed the Resident she would look into it and get back to him/her. Review of the medical record for Resident #101 indicated but was not limited to the following: - the Resident had signed a consent for podiatry services on 5/10/25- the record failed to indicate any consultants had seen the Resident for podiatry services- the physician orders failed to indicate an order was received for consultant podiatry services- review of the care plans failed to indicate the Resident had any foot health concerns - review of the last 90 days of progress notes, including nursing, provider, and social services, failed to indicate the Resident had seen or had an appointment with podiatry services or that the condition of his/her toenails and foot health were addressed in any way During an interview with observation on 8/8/25 at 12:25 P.M., the surveyor observed Nurse #1 request to see Resident #101's toenails. The nurse assisted the Resident in removing their socks and the Resident had scaly, flaking skin on both feet, long mycotic nails (thick, brittle) with yellow toenail beds and jagged chipped edges. The nails appeared thick and had multiple layers of brittle flaking nail that hung over the edge of the toes. The nurse agreed with the Resident that his/her toenails were in bad condition and in need of podiatry services. The Resident said no one at the facility has taken care of them since admission. The nurse said she would have to double check to see if the Resident is on the list for the next podiatrist visit to the building. During an interview on 8/12/25 at 11:39 A.M. , Nurse #2 said last Thursday (8/7/25) the Resident had complained about his/her toenails and she was going to try to help him/her out with nail care since they are not diabetic, but when she saw the issue with the stacked layered nails that were very thick and long she knew tools other than regular clippers and files would be necessary and the Resident would have to wait for podiatry intervention. She said the Unit manager controls the list for podiatry and she is unsure when they are due to come in or when they were last here. She said she doesn't know when or if the Resident was actually put on the list for podiatry. During an interview on 8/12/25 at 2:25 P.M., Unit Manager #1 said she faxed the podiatry enrollment form for the Resident back when they had signed it in May 2025. She said she last had contact with the podiatry consultant by email on 5/15/25 and the Resident was not on that list to be seen. She said to the best of her knowledge the Resident had not been seen by podiatry services, but his/her feet appeared to be in poor condition, and she would ask the Resident about going out to a podiatrist in the community. She said the facility does not have the necessary tools to manage the Resident's toenails in house and the podiatry consultants are not good with their communication. During an interview on 8/13/25 at 7:19 A.M., the Director of Nurses (DON) said there is no one person responsible for overseeing all the consultant services or podiatry services and the process is for the Unit managers to get the consent signed by the residents and then fax it to the enrollment number on the form and then they receive an email a few days before the service is coming into the facility with a list of residents who will be seen. She said she checked the last

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	225356	A. Building B. Wing	08/14/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an environment free from accident hazards for one Resident (#132), in a total sample of 32 residents. Specifically, the facility failed to identify and intervene when the facility staff were writing secure keypad codes on door frames, including a stairwell where Resident #132, who was at risk for falls, at risk for wandering, at risk for eloping, and was experiencing confusion, accessed and descended 26 concrete stairs which lead to an alarmed exit door. Findings include:Resident #132 was admitted to the facility in May 2025 with diagnoses of congestive heart failure (CHF) and alcohol use disorder. Review of the care plans indicated Resident #132 was at risk for wandering and/or elopement, initiated 5/31/25 with interventions including implementing a scheduled toileting program, implementing scheduled hydration and schedule time for regular walks/appropriate activity. An additional care plan indicated Resident #132 was at risk for elopement, initiated 6/13/25 with interventions including a wander guard bracelet and when exhibiting exit seeking behavior to redirect to an appropriate area and provide supervision. Review of the care plans indicated Resident #132 was at risk for falls with interventions including assisting with ambulation and transfers, utilizing therapy recommendations. The care plan did not indicate what the therapy recommendations were. Review of the Elopement Evaluation, dated 6/13/25, indicated Resident #132 was looking for a ride from the facility and wandering behavior was likely to affect the safety or well-being of self or others. Review of the medical record indicated on 8/6/25 at around 1:00 P.M. Resident #132 opened the stairwell door next to his/her room, entered the stairwell, exited the building, and was found outside in the parking lot. Review of the nursing progress notes indicated on 6/16/25 Resident #132 was confused, asking to leave the facility on multiple occasions and tried to take the back stairs next to his/her room to go outside, and many other times he/she stood next to the elevator waiting for any opportunity to leave. Review of the medical record failed to indicate Resident #132 was moved away from the stairwell following attempts to get into the stairwell. Review of the progress notes indicated the following:6/18/25: Resident with increased confusion7/17/25: Resident with delusions7/21/25: Resident with a urinary tract infection and started on intravenous (IV) antibiotics8/4/25: mental status continues to fluctuate8/6/25 at 7:44 A.M.: Resident keeps talking with someone and acting like someone is coming to pick him/her up. In hallway at 4:00 A.M., wanted to go out and meet someone. 8/6/25 at 1:00 P.M.: Resident opened the 2 East door into the hallway, exited the building and staff had found the Resident downstairs in the parking lot. On 8/7/25 at 5:00 P.M., the surveyor observed the stairwell exit door next to where Resident #132 resided from admission through 8/6/25. The exit door went from the resident unit to a stairwell and down the stairs led to an outside door. The stairwell had 11 concrete steps down to a landing where the stairs changed direction for another 11 concrete steps, then another landing and four more concrete steps to the bottom where there was an alarmed door to the outside. The surveyor observed an upside-down wash basin on the second set of stairs and toiletries strewn across the bottom steps and landing. In addition, there were three pairs of socks and one pair of underwear which was labeled with the name of Resident #132. The surveyor returned to the resident unit and observed the stairwell exit door. There was a keypad to release the alarm mechanism for the door. In the door frame, at the keypad level, written in pen/pencil was the code to un-alarm the door. Review of the Physical Therapy (PT) Recert, Progress Report and Updated Therapy Plan, dated 8/4/25, indicated Resident #132 ambulated with a rolling walker with stand by assist, was unable to ambulate uneven surfaces and required contact guard assist for 4 stairs. On 8/7/25 at 5:03 P.M., the surveyor entered the code for the exit door and did not open the door. The door stayed un-alarmed for 1 minute and 54 seconds. During an interview at this time, Unit Manager #1 said she had no idea how long the door stayed un-alarmed for after entering the code. During an interview on 8/8/25 at 8:32 A.M., Resident #132 said he/she did attempt to leave the facility to meet his/her brother for supper. The Resident said he/she did not think he/she made it outside. When the surveyor inquired about the stairs the Resident said, I took the stairs or a hot air balloon. When the surveyor inquired about the Resident entering the numbers on the keypad to the stairs the Resident replied, I should play [NAME]. On 8/8/25 at 10:15 A.M., the surveyor observed the 2 East exit door to the stairwell to continue to take 1 minute and 54 seconds to re-alarm and the keypad code continued to be written on the doorframe. During an interview on 8/8/25 at 10:30 A.M., Certified Nursing Assistant (CNA) #1 said Resident #132 would get up and walk on his/her own and needed to be reminded to use the rolling walker. She said the Resident did not have a walking or hydration schedule

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	08/14/2025

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

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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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on interviews and record review, the facility failed to ensure two Residents (#33 and #7), in a sample of 32 residents, were seen by the Physician at least every 30 days for the first 90 days after admission and at least every 60 days thereafter, with alternate visits by a Nurse Practitioner (NP) as indicated. Specifically, the facility failed:1. For Resident #33, to ensure the Resident was seen by the Physician or NP at least every 60 days after the first 90 days after admission; and2. For Resident #7, to ensure the Resident was seen and evaluated by a Physician or NP at least every 60 days. Findings include:1. Resident #33 was admitted to the facility in March 2024 with diagnoses including malnutrition, dementia and hypertension. Review of the Physician's Progress Notes indicated Resident #33 was seen by the Physician for an initial visit in March 2024. The Physician's Progress Notes indicated that the Resident was not seen by the Physician again until 12/26/24. All interval visits between March 2024 and November 2024 were conducted by the NP. Further review of the medical record indicated Resident #33 was seen by the Physician on 12/26/24 and was not seen again by the Physician or NP until 4/24/25, a span of 119 days. Since 4/24/25, Resident #33 has not been seen by the Physician or NP, a span of 112 days. During an interview on 8/12/25 at 12:08 P.M., the Medical Director said his expectation is that patients will be seen at least every 60 days and can alternate with a Physician’s Assistant or NP. During a telephonic interview on 8/12/25 at 1:23 P.M. Physician #2 said his patients should be seen by either himself or a NP every 1 to 2 months unless he is notified of an acute issue. Physician #2 reviewed his notes and said Resident #33 was not seen every 60 days as required and he should have seen the Resident every 120 days. He said he doesn't have a system in place to alert him when his patients are due to be seen. 2. Resident #7 was admitted to the facility in June 2023 with diagnoses including dementia and seizures. Review of Resident #7’s Progress Notes indicated that the Resident was last seen by his/her attending physician on 5/30/24 and by the physician assistant on 7/26/24, 12/18/24, and 6/20/25. During an interview on 8/11/25 at 3:17 P.M., the Director of Nursing (DON) said Resident #7’s attending physician was the facility’s medical director. The DON said she called the attending physician’s office to make sure there were no other visit notes missing from the Resident’s record that the facility had not received since 5/30/24 and there was not. During an interview on 8/12/25 at 12:07 P.M., Physician #1 said the facility informs him when residents are due to be seen and sometimes, he is behind on his visits because he relies on the facility to tell him. Physician #1 said he was aware that he had not seen Resident #7 for about one year and he should have been seen sooner.

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	08/14/2025

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

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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	08/14/2025

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to provide the necessary Behavioral Health care and services to attain or maintain the highest practicable mental and psychosocial well-being for one Resident (#71), out of a total sample of 32 residents. Specifically, the facility failed to ensure that Resident #71's Behavioral Health Services providers were informed and provided appropriate psychiatric follow-up when the Resident was sent to the emergency room from the dialysis center for a concern of a suicide attempt after hearing auditory hallucinations, verbalizing wanting to die, and pulling out a dialysis line. Findings include:Review of the facility's policy titled Behavioral Assessment, Intervention, and Monitoring, revised February 2025, indicated the following:- Behavioral Interventions refers to individualized, nonpharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical, or psychosocial well-being.- The nursing staff identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition including: * Onset, duration, intensity and frequency of behavioral symptoms * Any precipitating or relevant factors or environmental triggers (e.g., medication changes, infection, recent transfer from hospital) and * New onset or changes in behavior will be documented.- The interdisciplinary team (IDT) thoroughly elevates new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition.- The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly.-Safety strategies will be implemented immediately if necessary, to protect the resident and others from harm.- Interventions are individualized and part of an overall care environment that supports physical, functional, and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities.-The care plan includes, as a minimum: * A description of the behavioral symptoms * Targeted and individualized interventions for the behavioral and/or psychosocial symptoms; * The rationale for interventions and approaches; * Specific and measurable goals for targeted behaviors; and * How the staff will monitor for effectiveness of the interventions- Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of psychoactive medication to manage behavioral symptoms.Review of the facility's policy titled Suicide Threats, last revised December 2007, indicated but was not limited to:-Staff shall report any resident threats of suicide immediately to the nurse supervisor/charge nurse.-The nurse supervisor/charge nurse shall immediately assess the situation and shall notify the charge nurse/supervisor and/or director of nursing services of such threats.-After assessing the resident in more detail, the nurse supervisor/charge nurse shall notify the resident's attending physician and responsible party and shall seek further direction from the physician.-If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until the physician has determined that a risk of suicide does not appear to be present.Resident #71 was admitted to the facility in May 2025 and had diagnoses including brain aneurysm with subsequent hemorrhagic stroke, chronic kidney disease, end stage renal disease, and depression.Review of the Minimum Data Set (MDS) assessment, dated 5/30/25, indicated Resident #71 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15, expressed little interest or pleasure in doing things, feeling down, depressed or hopeless, trouble falling or staying asleep or sleeping too much, feeling tired or having little energy nearly every day, was administered antidepressant medication daily and received dialysis.Review of the medical record indicated a Nursing note, dated 7/25/25, indicating Resident #71 was transported to the hospital emergency department (ED) directly from the dialysis center after pulling out his/her dialysis port and telling staff that he/she wants to bleed out and die after hearing auditory hallucinations saying, you're going to die.' The note failed to indicate the Resident's physician was notified.Review of the hospital emergency department encounter notes, dated 7/25/25, indicated Resident #71 presented to the ED from dialysis as hemodialysis staff was concerned about suicidality after the Resident removed the dialysis line from his/her fistula. The notes indicated the Resident said he/she overheard someone say, you are going to die anyways and became frustrated, angry and removed the dialysis line saying, I might as well get it over with. The Resident did not receive a psychological assessment while in the ED. Discharge documentation included a referral for follow-up with a behavioral health provider.Further review of the clinical record failed to

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	08/14/2025

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

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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 monthly medication regimen reviews (MRR) were communicated to the physician and addressed in a timely manner for two Residents (#33 and #15), out of a total sample of 32 residents. Specifically, the facility failed:1. For Resident #33, to ensure April 2025 consultant pharmacist recommendations were provided to the physician/nurse practitioner (NP) for review and response to the recommendation; and2. For Resident #15, to maintain the facility policy of documenting monthly MRR in the medical record, ensure the physician documented review of the April 2025 irregularity in the medical record and ensure the irregularity was addressed timely.Findings include:Review of the facility's policy titled Medication Regimen Reviews, last revised in May 2019, indicated the following: -The consultant pharmacist performs a medication regimen reviews (MRR) for every resident in the facility receiving medications -Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity -If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or the administrator. -the attending physician documents in the medical record that the irregularity has been reviewed and what (if any) actions was taken to address it -copies of the medication regimen review reports, including physician responses, are maintained as part of the permanent medical record 1. Resident #33 was admitted to the facility in March 2024 with diagnoses including dementia, malnutrition, and hypertension. Review of the Minimum Data Set (MDS) assessment, dated 6/17/25, indicated Resident #33 had a severe cognitive deficit as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15. Review of the consultant Pharmacist’s MRR: Listing of Residents Reviewed with No Recommendation for the time period of 4/1/25 to 4/28/25, indicated Resident #33 was not listed on the document. Review of Resident #33’s medical record failed to indicate a pharmacy recommendation from April 2025 and failed to indicate any evidence that the Physician or NP was made aware of a recommendation made in April 2025. During an interview on 8/13/25 at 12:18 P.M., the Director of Nursing (DON) said Resident #33’s name is not listed on the Pharmacy’s April 2025 report which indicates the Resident has a pharmacy recommendation. She said the recommendation should be in the medical record and will search for it. During a subsequent interview on 8/14/25 at 2:16 P.M., the DON said she could not find Resident #33's pharmacy recommendation for April 2025. (continued on next page)

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	08/14/2025

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further documentation was provided to survey team by the time of the exit conference. 2. Resident #15 was admitted to the facility in March 2023. Review of the electronic and paper medical record indicated the last monthly MRR documented for Resident #15 was in March of 2025. Review of the medical record failed to indicate if the consultant Pharmacist had completed the monthly MRR from April through July of 2025 and if the Pharmacist had noted any irregularities during the review. Upon request the DON provided Consultant Pharmacist's MRR: Listing of Residents Reviewed with No Recommendation for the surveyors to review for the months of April 2025, May 2025, June 2025 and July 2025. Review of the Consultant Pharmacist's MRR: Listing of Residents Reviewed with No Recommendation, provided by the DON and not part of the medical record for the time period of 4/1/25 to 4/28/25, indicated Resident #15 was not listed on the document. The surveyor requested the consultant Pharmacist recommendations. Review of the Consultant Pharmacist Recommendations to Physician form indicated on 4/27/25 the Pharmacist recommended the physician consider adding rinse mouth after use following the administration of Flovent (a steroid inhaler). The form indicated the Physician Assistant agreed to this order change on 6/25/25, two months after the recommendation was made. The Consultant Pharmacist Recommendation to Physician form was not part of the medical record and there was no additional documentation from a physician to indicate the irregularity had been reviewed. During an interview on 8/13/25 at 12:23 P.M., the DON said the Consultant Pharmacist had not been documenting monthly MRRs in the electronic medical record. She said the Consultant Pharmacist sends the reports to the facility and any irregularities are provided to the physicians. She said she was not sure why the April 2025 recommendation for Resident #15 was not addressed for two months.

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	08/14/2025

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Care One at Randolph	49 Thomas Patten Drive Randolph, MA 02368

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, and interview, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with acceptable professional standards for one Resident (#39), of 32 sampled residents and in four of five medication carts observed. Specifically, the facility failed to:1.For Resident #39, ensure Dakins Solution (a dilute solution of sodium hypochlorite (bleach) historically used as an antiseptic for wound cleaning) was stored in a locked compartment;2. On the 3 East Unit, ensure the medication cart was locked and secured while unattended; and3. Ensure that medications and biologicals were stored in accordance with professional standards of practice in three of four observed medication carts.Findings include:Review of the facility’s policy titled Medication Labeling and Storage, dated as revised February 2023, indicated but was not limited to: -Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise available to others. -Medications for external use, as well as hazardous drugs and biologicals, are clearly marked as such, and are stored separately from other medication. -Antiseptics, disinfectants, and germicides used in any aspect of resident care must have legible, distinctive labels that identify the contents and the directions for use and shall be stored separately from regular medications. -Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication labels include, at a minimum: medication name (generic and/or brand), prescribed dose, strength, expiration date (when applicable), resident’s name, route of administration, and appropriate instructions and precautions. -Multi-dose vials that have been opened or accessed (e.g., needle punctured are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial) Review of the facility’s policy titled Administering Medications, dated as revised April 2019, indicated but was not limited to: -During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. 1.On the following dates and times, the surveyor observed full strength Dakins solution in Resident #39's room: -8/11/25 at 10:25 A.M. and 4:30 P.M. -8/12/25 at 8:01 A.M. and 1:49 P.M. (continued on next page)

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	08/14/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/12/25 at 3:52 P.M., Nurse #4 said Dakins solution should be stored in a bag and in the treatment cart. Nurse #4 said it was a strong antiseptic and should not have been left in the Resident's room. During an interview on 8/12/25 at 4:11 P.M., Unit Manager #1 said antiseptics should be stored in the treatment cart when not being used and should not be left in a Resident's room. During an interview on 8/14/25 at 2:16 P.M., the Director of Nurses (DON) said drugs and biologicals should be stored in locked compartments and should not be left in a Resident's room. 2. On 8/14/25 at 6:49 A.M., on the 3 East Unit, the surveyor observed the Short Hall medication cart in front of the nurses' station. The medication cart was unlocked with the third drawer ajar approximately 10 inches. The surveyor observed a resident walking independently in the hallway and no facility staff were observed in the area. During an interview on 8/14/25 at 6:53 A.M., Nurse #13 said she thought she shut the medication drawer when she walked away, and the medication cart should be locked when unattended. During an interview on 8/14/25 at 7:22 A.M., Unit Manager #3 said medication carts should be locked when the nurse cannot see it. During an interview on 8/14/25 at 2:16 P.M., the DON said medication carts should be locked when unattended. 3. On 8/12/25, the surveyor observed three of four medications carts to have medications not stored in accordance with professional standards of practice as follows: -Review of a Medication Cart on 2-West Unit with Nurse #5 indicated multiple unidentified loose pills were found in compartments 1, 2, and 4 of the top drawers; and multiple loose unidentified pills were found inside the left side of the second drawer. On further observation two vials of Novolin Insulin regular 100 units/milliliter in use and undated with a date opened. During an interview on 8/12/25 at 10:35 A.M., Nurse #5 said she was not aware there were so many loose pills in her medication cart and did not think the insulin needed to be dated when opened. -Review of the Medication Cart on the 2- East Unit with Nurse #2 revealed the following medications, opened, and undated with a date they were opened or a date to be used by: -two vials of Novolin (R) 100 units/ml (used to treat high blood sugar) -two Budesonide Inhalers (used to manage asthma and chronic obstructive pulmonary disease (COPD)) -one Trelegy Ellipta (a maintenance inhaler prescribed for the long-term, once-daily treatment of COPD and asthma in adults) -one Symbicort inhalation Aerosol 80-4.5 MCG/ACT (Budesonide-Formoterol Fumarate Dihydrate) -one Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) (continued on next page)

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	08/14/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-one vial Insulin Lispro Injection Solution (used to treat high blood sugar) -one Lantus Subcutaneous Solution 100 UNIT/ML (used to treat high blood sugar). During an interview on 8/12/25 at 11:22 A.M., Nurse #2 said she was not aware that the medications in the cart were not labeled with a date opened. - Review of the medication cart on the 3-West with Nurse #14 revealed two vials of Humulin (R) insulin (used to treat high blood sugar) in use and not labeled with an opened date. During an interview on 8/12/25 at 12:10 P.M., Nurse #14 said she did not know why the insulins in her cart were not labeled with the date they were opened. During an interview on 8/12/25 at 10:55 A.M., the Assistant Director of Nursing (ADON) and Unit Manager #2, said the nurses are to review the drawers for loose pills and added they were not stored properly. During an interview on 8/13/25 at 8:30 A.M., Nurse #14 said Insulin must be labeled with a start and an end date, upon opening, prior to first use. During an interview on 8/13/25 at 8:40 A.M., Unit Manager #2 said the expectation is for the nurses to label the insulins with a start and end date prior to use. During an interview on 8/13/25 at 11:40 A.M., Unit Manager #1 said all medications are to be labeled with opening and ending date prior to using.

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	08/14/2025

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

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. (continued on next page)

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	08/14/2025

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

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to ensure laboratory results were reported and acted on timely for one Resident (#9), out of a total sample of 32 residents. Specifically, the facility failed to report his/her 6/12/25 and 6/20/25 sodium (a vital electrolyte that helps regulate fluid balance, blood pressure, nerve and muscle function with a reference range of 136 to 145 milliequivalents per liter (mEq/L) levels to the provider resulting in a delayed hospital transfer on two occasions.Findings include:Review of the facility's policy titled Lab and Diagnostic Test Results, dated as revised 11/2018, indicated but was not limited to:-When test results are reported to the facility, a nurse will first review the results. If staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting or documenting the results and their implications another nurse in the facility should follow or coordinate the procedure-A nurse will identify the urgency of communicating with the attending physician based on physician request, the seriousness of any abnormality, and the individual's current condition-Identifying situations that warrant immediate notification: nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results: whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors) Resident #9 was admitted to the facility in May 2025 with diagnoses which included hyponatremia (low sodium). Review of Resident #9's medical record indicated he/she was transferred to the hospital on 6/13/25 and 6/23/25 due to low sodium levels. Review of Resident #9's 6/12/25 lab result indicated but was not limited to:-Collection date and time: 6/12/25 at 7:15 A.M. -Received date and time: 6/12/25 at 9:57 A.M.-Reported date and time: 6/12/25 at 10:47 A.M.-Reviewed By Physician #1 on 6/13/2025 10:15 A.M. Review of the nursing/clinical progress note, dated 6/13/25, indicated but was not limited to:-Writer was notified by MD about resident Sodium level of 120, and resident needed to be transferred to the emergency room. Review of the MD progress note, service date 6/13/25, indicated but was not limited to:-Sodium was critically low at 120. This had resulted yesterday but was not reported to either me or to the nursing by lab [sic]. Director of nursing apprised to follow-up on the failure to report a critical lab. During a telephonic interview on 8/12/25 at 10:24 A.M., the Lab Representative said the 6/12/25 critical Sodium level of 120 was faxed to the facility at 10:48 A.M., and posted to the electronic record at 10:50 A.M. Review of Resident #9's 6/20/25 lab result indicated but was not limited to:-Collection date and time: 6/20/25 at 12:50 P.M.-Received date and time: 6/20/25 at 2:25 P.M.-Reported date and time: 6/20/25 at 3:23 P.M. -Reviewed By Facility Staff on 6/23/25 at 1:37 P.M. Review of the nursing/clinical note, dated 6/21/25, indicated but was not limited to:- Labs done on 6/20/25 to be reported to MD (Vis a vis). Will continue to monitor. Further review of the medical record failed to indicate evidence that any form of provider notification regarding Resident #9's 6/20/25 lab results had occurred. Review of the nursing/clinical note, dated 6/23/25, indicated but was not limited to:-MD notified writer that resident sodium level of 120 and needed to be transferred to the emergency room Review of the MD progress note, service date 6/23/25, indicated but was not limited to:-Repeat sodium is 120. This was not reported to me over Friday. Patient was sent emergently to emergency room for further evaluation. During a telephonic interview on 8/12/25 at 10:24 A.M., the Lab Representative said the 6/20/25 critical Sodium level of 120 was faxed to the facility a total of six times and a lab representative called the facility three times but got disconnected after speaking with the receptionist each time. During an interview on 8/12/25 at 1:25 P.M., Nurse #5 said labs could be viewed in the resident's electronic record or off the fax machine. Nurse #5 said abnormal lab results should be reported to a provider right away. During an interview on 8/12/25 at 3:21 P.M., the Assistant Director of Nurses (ADON) said nurses were responsible for knowing who had labs drawn and monitoring for the results. The ADON said that when the labs result, they are faxed to the facility and uploaded into the resident's electronic record, and they should be reported to the provider, a progress note should be completed, and the lab should be marked as reviewed. During a telephonic interview on 8/12/25 at 1:43 P.M., Physician # 2 said critical labs should be reported to the provider immediately. Physician #2 said the facility did not report the critically low sodium levels to him and he would have sent the Resident to the hospital immediately. During an interview on 8/14/25 at 2:16 P.M., the Director of Nurses (DON) said the lab did not call and notify the staff of the critical result and the facility was following up on that. The DON said the lab did not have a stop sign (visual identifier used to inform staff there is an abnormality) on the lab to indicate it was critical. The DON said when abnormal and critical labs result, the facility should notify the provider. The DON said she

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	08/14/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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	08/14/2025

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential of foodborne illness to residents who are at high risk. Specifically, the facility failed to:1. Properly label and date food products and maintain safe/clean equipment in four of four unit nourishment kitchenettes; and2. Handle ready-to-eat food (food which does not require cooking or further preparation prior to consumption) utilizing proper hand hygiene to prevent cross contamination (transfer of pathogens from one surface to another). Findings include:Review of the facility's policy titled Foods Brought by Family/Visitors, dated October 2017, indicated but was not limited to the following:- Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents.- Food brought by family/visitors that is left with resident to consume later will labeled (sic) and stored in a manner that is clearly distinguishable from facility-prepared food.- Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the use by date.- The nursing staff will discard perishable foods on or before the use by date.- The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following:- 3-301.11 Preventing Contamination from Hands. (A) FOOD EMPLOYEES shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT.- 3-304.15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. 1. On 8/7/25 at 1:20 P.M., the surveyor made the following observations in the Three East Unit Kitchenette:- The refrigerator contained an opened bottle of Thick and Easy Nectar Consistency Orange Juice. The sticker on the bottle indicated a received date of 7/22/25. No other open or use by date was noted on the bottle. The manufacturer's recommendation on the bottle indicates to discard ten days after opening.- The refrigerator contained an opened bottle of Thick and Easy Nectar Consistency Cranberry Juice. There was no open or use by dates indicated on the bottle. The manufacturer's recommendation on the bottle indicated to discard 10 days after opening.- The refrigerator contained two opened Thick and Easy Nectar Consistency Thickened Dairy Beverage bottles. Neither bottle was labeled with an open or use by date. The manufacturer's recommendation on the bottle indicated to discard 10 days after opening.- The inside of the microwave was noted to have food splatter and residue on the top and sides. The top and bottom of the microwave had peeling/bubbling of the white plastic inner lining. On 8/7/25 at 1:44 P.M., the surveyor made the following observations in the Three [NAME] Unit Kitchenette:- In the refrigerator, a plate containing a peanut butter and jelly sandwich covered by saran wrap was noted on the bottle shelf. There were no dates on the sandwich indicating when it was made and when it should be discarded. - The microwave was noted to have a brown/yellow substance underneath the glass dish. On 8/7/25 at 1:52 P.M., the surveyor made the following observations in the East Two Unit Kitchenette:- The inside of the microwave was noted to have food splatter/residue to the top and bottom. On 8/7/25 at 1:57 P.M., the surveyor made the following observations in the Two [NAME] Unit Kitchenette:- The refrigerator contained an opened bottle of Vanilla Med Pass 2.0 Fortified Nutritional Shake - Nectar Consistency. The bottle was not dated. The manufacturer's recommendation on the bottle indicated to discard four days after opening.- The inside of the microwave had food residue/splatter noted to the top and bottom. The top inside portion of the microwave was also noted to have black/white bubbling/cracking of the plastic inner lining.- Two Simply Thick Easy Mix Dispenser bottles were stored on the countertop next to the sink with product dripping out of the container's pumps as well as covering the bottles. The label on the bottle indicated the pump should be wiped gently with an alcohol wipe at the end of the day. On 8/11/25 at 8:15 A.M., the surveyor made the following observations in the Three East Unit Kitchenette:- The inside of the microwave was noted to have food splatter and residue on the top and sides. The top and bottom of the microwave had peeling/bubbling of the white plastic inner lining. On 8/11/25 at 8:20 A.M., the surveyor made the following observations in the Three [NAME] Unit Kitchenette:-

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	08/14/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed:1.To maintain an infection prevention and control program which included a complete and accurate system of surveillance to identify any trends or potential infections; 2. For Resident #10, to ensure the tubing for a gastrostomy tube (g-tube, a feeding tube inserted through the abdominal wall) was not in contact with the tubing for a urinary catheter;3. For Resident #17, to ensure nasal cannula (NC) tubing for oxygen delivery through the nose, was stored in a sanitary way to prevent the possibility of contamination from germs when not in use; 4. For Resident #101, to ensure handheld nebulizer (HHN) tubing and mouthpiece set up, as well as a non-rebreather oxygen delivery device were stored in a sanitary way to prevent them from possible contamination from germs and environmental debris in between uses; 5. For Resident #28, to ensure the intravenous (IV) connection hub (end of port line from the Resident's peripherally inserted central catheter (PICC)) was scrubbed clean per the facility policy and standard of IV care for 15 seconds, prior to hooking up medication delivery tubing to the device; 6. For Resident #39, to ensure infection control practices were maintained while performing wound care; and7. To ensure infection control practices were maintained during medication administration. Findings include:Review of the facility's policy titled Surveillance of Infections, dated as last revised September 2017, indicated the following: -the purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections, to guide appropriate interventions, and to prevent further infections -infections that will be included in routine surveillance include those with: evidence of transmissibility in a healthcare environment, available processes and procedures that reduce the spread of infection, clinically significant morbidity or mortality associated with infection, and pathogens associated with serious outbreaks -the infection preventionist is responsible for gathering and interpreting surveillance data -the surveillance should include a review of any or all of the following information to help identify possible indicators of infections: laboratory records, skin care sheets, infection control rounds, verbal reports, infection documentation records, temperature logs, pharmacy records, antibiotic review, transfer log/summaries -for residents with infections that meet the criteria for definition of infection for surveillance, collect the following as appropriate: identifying information (resident’s name), diagnoses, admission date, date of onset of infection (onset of symptoms or date of positive diagnostic test), infection site (be as specific as possible), pathogens, risk factors, pertinent remarks including if the resident is hospitalized or expires, treatment measures and precautions -using the current suggested criteria for healthcare-associated infections, determine if the resident has a healthcare-associated infection (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/12/25 at 3:30 P.M., the Infection Control Preventionist (IP) said he was responsible for the infection surveillance, and the information was logged in to the electronic medical record in a form for each individual resident and then the Infection Surveillance Monthly Report was generated from that information. Review of the facility's Infection Surveillance Monthly Report with the IP for the months of June 2025, July 2025, and August 2025 indicated the following: -June 2025: The Summary by Infection Category indicated there were 10 infections in the “Other” category out of a total of 20 infections. Review of the 10 residents in the “other” infection category listed the infections as “unknown.” 12 out of 20 residents did not have any signs or symptoms of infection listed 13 out of 20 residents did not have treatment measures or precautions listed -July 2025: The Summary by Infection Category indicated there were 11 infections in the “Other” category out of a total of 23 infections. Review of the 11 residents in the “other” infection category listed the infections as “unknown.” 14 out of 23 residents did not have any signs or symptoms of infection listed 15 out of 23 residents did not have treatment measures or precautions listed -August 2025: The Summary by Infection Category indicated there were 12 infections in the “Other” category out of a total of 24 infections. Review of the 12 residents in the “other” infection category listed the infections as “unknown.” 15 out of 24 residents did not have any signs or symptoms of infection listed 16 out of 24 residents did not have treatment measures or precautions listed (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the continued interview on 8/12/25 at 3:30 P.M, the IP said there was no way for him to know what the infections were for these residents in the “other” category without going through each individual medical record. He said he previously recorded the surveillance information on paper, and all of the information was available, but now that it was electronic some of the information was missing including types of infection, signs and symptoms, and treatments. A. Resident #28 was admitted to the facility in July 2025 with a diagnosis of right ankle osteomyelitis (a bone infection). Review of the medical record for Resident #28 indicated the Resident was to receive intravenous (IV) antibiotics through 8/31/25. Review of the July and August 2025 Infection Surveillance Monthly Report failed to include Resident #28. During the continued interview on 8/12/25 at 3:30 P.M, the IP said Resident #28 should have been included on the surveillance. B. Resident #113 was admitted to the facility in September 2024. Review of the August 2025 Infection Surveillance Monthly indicated Resident #113 had an infection in the category of “other” with a symptom of diarrhea and an infection onset date of 1/6/25. There was no additional information on the surveillance to indicate what the infection was or how it was treated. During the continued interview on 8/12/25 at 3:30 P.M, the IP said he could not remember what type of infection Resident #113 had with an onset date of January 2025 and was not sure if the Resident should have continued on the infection surveillance form through August 2025. C. Resident #9 was admitted to the facility in May 2025. Review of the August 2025 Infection Surveillance Monthly indicated Resident #9 had an infection in the category of “other” with an onset date of 6/20/25 and treated with an antibiotic. The Status column indicated the infection resolved on 8/11/25. During the continued interview on 8/12/25 at 3:30 P.M, the IP said he did not know what infection Resident #9 had or when it had resolved as it was not listed on the surveillance. During an interview on 8/13/25 at 4:00 P.M., the Regional Clinical Coordinator said the infection surveillance should capture all the resident’s information and the electronic system was designed to have all the information. 2. Resident #10 was admitted to the facility in April 2024. Review of the Minimum Data Set (MDS) assessment, dated 7/15/25, indicated Resident #10 had an indwelling urinary catheter and a feeding tube. (continued on next page)

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	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/7/25 at 9:20 A.M., the surveyor observed Resident #10 in bed with their feeding tube pump running. The formula was connected by a tube to the Resident’s abdomen. The surveyor observed the tube to come from the formula bottle, through the pump, down to the side of the bed where it crossed through the call light cord and a bed cord, leaned against the urinary catheter tubing (which had urine in it) and then under the sheet to the Resident’s abdomen. The surveyor observed a strong smell of urine and liquid on the ground directly below the urinary catheter bag. On 8/8/25 at 9:27 A.M., the surveyor observed Resident #10 in bed with their feeding tube pump running. The surveyor observed the tube to come from the formula bottle, through the pump, down the side of the bed where it rested against the urinary catheter tubing (which had urine in it). During an interview on 8/12/25 at 4:00 P.M., the IP said the expectation is that the tube for the feeding and the tube for the urinary catheter do not touch as this was a breach of infection control practices. 3. Resident #17 was admitted to the facility in July 2024 and has diagnoses including: Chronic obstructive pulmonary disease (COPD - a group of lung diseases that blocks proper airflow and makes it difficult to breathe); and chronic peripheral venous insufficiency (a condition in which the veins primarily in the legs have difficulty returning blood to the heart). Review of the MDS assessment, dated 7/22/25, indicated the Resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. During an interview on 8/7/25 at 9:09 A.M., the Resident said he/she has been on oxygen (O2) via NC for quite a while and the facility staff changes the tubing on their regular O2 tank and portable O2 tank about once a week. The Resident said he/she keeps a small portable O2 tank on their wheelchair (w/c) with its own tubing. The NC O2 tubing was observed to be directly on his/her w/c seat, not stored in a bag or in a manner to prevent it from possible germs or environmental debris. The Resident said there is no bag that the tubing is kept in, and it is just kept on his/her w/c like that. Throughout the survey, the surveyor made the following observations of Resident #17's NC O2 tubing: 8/7/25 at 9:09 A.M. - NC attached to w/c portable O2 tank lying directly on the w/c seat, not stored in a manner to prevent it from possible contamination of germs or environmental debris, no respiratory storage bag or plastic bag observed in the room. 8/8/25 at 8:23 A.M. - NC attached to w/c portable O2 tank lying directly on the w/c seat, not stored in a manner to prevent it from possible contamination of germs or environmental debris; the Resident said that is how it always is when he/she is not using it because they have nowhere else to store it. 8/8/25 at 8:58 A.M. - Nurse #1 entered the Resident's room to refill the portable O2 tank on the back of the w/c. The Nurse picked up the tubing from the w/c seat, disconnected it from the portable tank and placed it on the bed linens. (continued on next page)

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	08/14/2025

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Care One at Randolph	49 Thomas Patten Drive Randolph, MA 02368

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/8/25 at 9:07 A.M. - the Respiratory therapist (RT) returned the Resident's portable O2 tank to them placing it on the rear of the w/c and left the room. The RT did not address or notice the O2 tubing sitting on the Resident's bed linens, not secured in a way to prevent it from germs. The Resident said he/she would use the tubing that was on the bed linens and placed it on their face once getting into their w/c and adjusting their O2. 8/12/25 at 11:15 A.M. - NC O2 tubing coiled up on the seat of the Resident's w/c, not stored in a respiratory bag or sanitary way to prevent it from possible contamination of germs or environmental debris. 8/13/25 at 8:41 A.M. - NC O2 tubing resting directly on the seat of the w/c. The Resident got up out of bed, picked up the tubing and placed it on his/her face for transport to the bathroom. The Resident said no one had brought them a storage bag yet, so they didn't have any other options; no storage bag was observed in the room. Review of Resident #17's current Physician's Orders indicated but was not limited to the following: -Change all disposable oxygen supplies every week and as needed. Label and date all supplies (5/30/25) During an interview on 8/8/25 at 12:22 P.M., Nurse #1 said that when any form of O2 tubing is not in use it should be stored in a plastic respiratory bag that is dated and labeled. She said this morning she removed the portable O2 oxygen tubing directly from the Resident #17's w/c seat and it was not stored in a respiratory bag, and she then placed it on the bed and did not provide a clean NC for the Resident after that as she should have. She said not having the O2 tubing stored in a respiratory bag is an infection control concern since the tubing could potentially get dirty from germs. During an interview on 8/12/25 at 11:46 A.M., the RT said all respiratory equipment including O2 tubing, non-rebreathers, HHN devices and ambu-bags should be stored in a respiratory plastic bag when not in use that is dated and labeled to prevent any possible contaminants getting on the tubing or devices. He said putting respiratory bags in place for the O2 tubing, non-rebreathers and HHN devices is nursing's responsibility, but if he notices it when he is in and out of rooms, he will take care of it. During an interview on 8/12/25 at 1:24 P.M., the IP said all O2 equipment and tubing is to be stored in a respiratory storage bag when not in use by the resident. He said not being stored in this way potentially exposes the tubing and devices to germs and environmental contaminants and is an infection control concern. He viewed the storage of Resident #17's NC O2 tubing and said the tubing just lying on the w/c seat is not sanitary or an appropriate manner for the storage of the tubing. 4. Resident #101 was admitted to the facility in May 2025 with diagnoses including: COPD, panlobular emphysema (a disease preventing adequate gas exchange in the lungs), and chronic respiratory failure with hypoxia (the absence of enough O2 in the tissue to sustain bodily functions). Review of the MDS assessment, dated 5/16/25, indicated the Resident was cognitively intact with a BIMS score of 15 out of 15. (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/7/25 at 9:14 A.M., the Resident said he/she does not recall having any type of storage bag for their HHN tubing and mouthpiece or the non-rebreather mask on the back wall. The Resident said the non-rebreather has been hanging off the valve on the back of the wall for a little while and usually the HHN tubing and mouthpiece are usually left on the bedside table or in the nightstand drawer. Throughout the survey, the surveyor made the following observations of Resident #101's NC respiratory tubing/equipment: 8/7/25 at 9:14 A.M. and 4:22 P.M., - non-rebreather mask and tubing hanging off the suction valve on the wall behind the Resident's bed, and the Resident's HHN tubing and mouthpiece lying in the top drawer of the bedside table, not stored in a respiratory bag or any sanitary manner to protect it from environmental debris or potential contamination of germs. 8/8/25 at 8:50 A.M., non-rebreather mask and tubing hanging off the suction valve on the wall behind the Resident's bed, and the Resident's HHN tubing and mouthpiece lying in the top drawer of the bedside table, not stored in a respiratory bag or any sanitary manner to protect it from environmental debris or potential contamination of germs. 8/8/25 at 9:03 A.M., Nurse #1 removed Resident #101's HHN device and mouthpiece from the open top drawer of the bedside table (stored in the drawer on top of grooming supplies not in a respiratory bag or stored in a sanitary way), opened up a vial of nebulizer medication pouring it into the HHN device closing the device and handing it to the Resident for him/her to receive their aerosolized medication. The nurse was not observed to clean or disinfect the HHN device or mouthpiece prior to providing it to the Resident for medication administration. At 9:13 A.M., Nurse #1 observed the Resident complete their HHN medication and then throw the HHN and mouthpiece into the drawer. At 9:40 A.M., the nurse re-entered the room and the surveyor did not observe her clean or disinfect the HHN or mouthpiece or provide a new HHN tubing or mouthpiece to the Resident or provide him/her with a respiratory storage bag for the device. 8/8/25 at 12:24 P.M., non-rebreather mask and tubing hanging off the suction valve on the wall behind the Resident's bed, and the Resident's HHN tubing and mouthpiece lying in the top drawer of the bedside table, not stored in a respiratory bag or any sanitary manner to protect it from environmental debris or potential contamination of germs. During an interview on 8/8/25 at 12:23 P.M., Nurse #1 said that when any form of respiratory tubing or equipment is not in use, it should be stored in a plastic respiratory bag that is dated and labeled. She said this morning during medication pass she removed Resident #101's HHN set up, tubing and mouthpiece from the top bedside table drawer and it was not stored in a respiratory bag but lying directly on top of items in the drawer. She said the HHN set up and mouthpiece was exposed to all the grooming supplies in the drawer and was not stored in a sanitary manner to protect it from germs and she should not have used it to administer the Resident's morning nebulizer medication but didn't think anything of it. She said after the fact she should have made sure the equipment was cleaned and stored in a sanitary way, and she did not. (continued on next page)

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	08/14/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/12/25 at 11:46 A.M., the RT said all respiratory equipment including O2 tubing, non-rebreathers, HHN devices and ambu-bags should be stored in a respiratory plastic bag when not in use that is dated and labeled to prevent any possible contaminants getting on the tubing or devices. He said putting respiratory bags in place for the O2 tubing, non-rebreathers and HHN devices is nursing's responsibility, but if he notices it when he is in and out of rooms, he will take care of it. During an interview on 8/12/25 at 1:24 P.M., the IP said all O2 equipment and tubing is to be stored in a respiratory storage bag when not in use by the resident. He said not being stored in this way potentially exposes the tubing and devices to germs and environmental contaminants and is an infection control concern. He viewed the storage of Resident #101s HHN with mouthpiece and non-rebreather and said the respiratory tubing and devices were not stored in a sanitary or appropriate manner. 5. Review of the facility's policy titled Central Venous Catheter Flushing and Locking, dated as revised June 2025, indicated but was not limited to the following: - disinfect needleless access device (hub) with a disinfectant wipe for at least 15 seconds and allow to air dry When giving medications: - perform hand hygiene, put on gloves, disinfect needleless access device (hub) with a disinfectant wipe, flush with prefilled syringe, connect primed tubing, administer medication at ordered rate Resident #28 was admitted in July 2025 with diagnoses including: osteomyelitis (inflammation of a bone caused by infection). Review of the current Physician's Orders for Resident #28 indicated but were not limited to the following: - Ceftriaxone Sodium Injection Solution Reconstituted 1 GM (Ceftriaxone Sodium) - Use 2 gram intravenously (IV) in the morning for right ankle infection until 08/31/25 (7/22/25) On 8/8/25 at 9:21 A.M., the surveyor observed Nurse #1 ready the 2 grams of Ceftriaxone IV medication bag for administration and prime the tubing. She then was observed to use an alcohol wipe to disinfect the hub of Resident #28's PICC line wiping the hub for approximately 3-4 seconds before flushing the line and attaching the IV tubing for medication administration. During an interview on 8/8/25 at 12:18 P.M., Nurse #1 said she thought the IV connection hub only needed to be scrubbed for between 3-5 seconds and was unaware that the facility policy and standard was 15 seconds prior to accessing the PICC line. During an interview on 8/12/25 at 1:26 P.M., the Staff Development Coordinator (SDC) said nurses have competencies on IV management completed annually and he would provide the competency form for Nurse #1 to the survey team. (continued on next page)

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	225356	A. Building B. Wing	08/14/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/12/25 at 2:40 P.M., the Director of Nursing (DON) said she is unsure of how long the nurses are required to scrub the hub of a PICC line prior to attaching anything to it. Upon review of the policy, she said she isn't sure if they are trained to the 15 second timeframe in the policy. Review of Nurse #1's education file indicated she had completed a competency on IV Medication administration in the last 12 months, in October of 2024. Further review of the competency form in use by the facility failed to indicate the connection hub was to be scrubbed for 15 seconds and instead indicated cleanses the valve with alcohol prep correctly. During an interview on 8/12/25 at 3:46 P.M., the DON said the policy should be followed for IV flushing and locking. During an interview on 8/13/25 at 11:11 A.M., the IP, who also serves as the facility SDC, said the hub of a needleless connector is to be scrubbed for disinfection for 15 seconds according to the standard and facility policy. He said the competencies do not say 15 seconds but that is the expectation and how the nurses are trained. He was made aware of Nurse #1 only scrubbing the hub of Resident #28's IV PICC line for 3-4 seconds and said the policy and standard were not met in that instance. 6. Review of the facility’s policy titled Handwashing/Hand Hygiene, dated as revised March 2024, indicated but was not limited to: -Hand Hygiene is indicated: immediately before touching a resident; before performing an aseptic task; after contact with blood, body fluids, or contaminated surfaces; after touching a resident; after touching the resident’s environment, before moving from work on a soiled body site to a clean body site on the same resident; and immediately after glove removal Review of the facility’s policy titled Dry/Clean Dressings, dated as revised September 2013, indicated but was not limited to: -position resident and adjust clothing to provide access to affected area -wash and dry your hands thoroughly -put on clean gloves, loosen tape and remove soiled dressing -pull glove over dressing and discard into plastic or biohazard bag -wash and dry your hands thoroughly -open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface -label tape or dressing with date, time, and initials, place on clean field -using clean technique open other products (i.e., prescribed dressing: dry, clean gauze) -wash and dry your hands thoroughly (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-put on clean gloves -assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage -cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward) -use dry gauze to pat the wound dry -apply the ordered dressing and secure with tape or bordered dressing per order. Label with date and initials to top of dressing. -discard disposable items into the designated container -remove disposable gloves and discard into designated container, wash and dry your hands thoroughly Resident #39 was admitted to the facility in March 2025 with diagnoses which included necrotizing fasciitis, cellulitis of right lower limb, and chronic wounds. On 8/12/25 at 1:49 P.M., the surveyor observed Nurse #4 complete Resident #39’s wound care with assistance from Nurse #2 as follows: -Nurses #4 and #2 performed hand hygiene and donned (put on) personal protective equipment (PPE) including gloves and a gown A. Right lateral ankle wound care: -Nurse #4 removed the previously applied/soiled dressing (Nurse #4 failed to remove the soiled gloves after removing the soiled dressing and perform hand hygiene) -Nurse #4 grabbed a package of xeroform (a type of wound dressing, commonly used as a primary contact layer for wounds, providing a moist, non-adherent environment that promotes healing) and opened the packaging (Nurse # 4 failed to perform hand hygiene and don clean gloves) -Nurse #2 soaked gauze with normal saline and handed it to Nurse #4 -Nurse #4 washed the wound with the normal saline soaked gauze pads and patted the wound dry -Nurse #4 applied xeroform to the wound bed followed by an abdominal pad (a highly absorbent dressing used to manage heavily draining wounds) and wrapped it with kerlix and secured the dressing with tape -Nurse #4 then removed her gloves and applied clean gloves (Nurse #4 did not perform hand hygiene prior to applying clean gloves) B. Sacral (bone at end of spine) wound care: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nurse #4 applied clean gloves (Nurse #4 failed to perform hand hygiene prior to donning clean gloves) -Nurse #4 turned the Resident onto his/her side (touching his/her blanket, drawsheet and brief) to see his/her sacral wound -Nurse #4 removed her gloves and applied new gloves (Nurse #4 failed to perform hand hygiene prior to donning clean gloves) -Nurse #4 removed the previously applied/soiled dressing -Nurse #4 removed her gloves and applied new gloves (Nurse #4 failed to perform hand hygiene prior to donning clean gloves) -Nurse #4 washed the wound bed with normal saline and patted the wound dry -Nurse #4 discarded the material used to cleanse the wound and previous dressing -Nurse #4 applied new gloves and applied calcium alginate (dressing material frequently used for wounds with moderate to heavy drainage) to wound bed and covered it with bordered gauze (Nurse #4 failed to perform hand hygiene prior to donning clean gloves) -Nurse #4 removed her gloves and repositioned the patient During an interview on 8/12/25 at 3:52 P.M., Nurse #4 said she should have performed hand hygiene prior to applying clean gloves and she should have changed gloves when going from dirty/soiled to clean. During an interview on 8/12/25 at 4:11 P.M., Unit Manager #1 said nurses should perform hand hygiene when gloves are removed and prior to applying new gloves. Unit Manager #1 said gloves should be changed after touching soiled material. During an interview on 8/14/25 at 2:16 P.M., the DON said infection control practices should be maintained during dressing changes. 7. Review of the facility’s policy titled Administering Medications, dated as revised April 2019, indicated but was not limited to: -Staff follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. On 8/14/25 at 6:53 A.M., the surveyor observed Nurse #13 preparing medication at her medication cart. Nurse #13 dropped a pill onto the top of her medication cart and picked it up with her ungloved hand and placed it into the medication cup. Nurse #13 continued to prepare medication and then handed the resident the medication cup for consumption. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/14/25 at 6:55 A.M., Nurse #13 said when the pill fell onto the medication cart she should have thrown the medication away and prepared a new one. Nurse #13 said touching the medication with her ungloved hand was frowned upon. During an interview on 8/14/25 at 7:22 A.M., Unit Manager #3 said nurses should not touch medication with an ungloved hand. Unit Manager #3 said if a medication falls onto a surface a new one should be prepared. During an interview on 8/14/25 at 2:16 P.M., the DON said infection control practices should be maintained during medication administration.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide education, assess eligibility, and offer influenza (flu) vaccinations and pneumococcal vaccinations per the Centers for Disease Control and Prevention (CDC) recommendations for four Residents (#28, #39, #9, and #90), out of a sample of five residents. Specifically, the facility failed to ensure:1. Staff offered, assessed, and provided education on the CDC recommended pneumococcal vaccines (an active immunizing agent used to prevent infection caused by certain types of pneumococcal bacteria) for Residents #28, #39, #9, and #90; and2. Staff administered the seasonal influenza vaccine to Resident #90 who had a signed consent form to receive the vaccine. Findings include: 1. Review of the facility's policy titled Pneumococcal Vaccine, dated as last revised in October 2023, indicated the following:-all residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections-upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series-administration of the pneumococcal vaccines are made in accordance with current CDC recommendations at the time of the vaccinationReview of the CDC guidelines for Pneumococcal Vaccine indicated the following:-Adults [AGE] years of age or older have the option to receive supplemental PCV20 or PCV21 (not both) if they previously completed the pneumococcal vaccine series with PPSV23-Adults [AGE] years of age or older have the option to receive supplemental PCV20 or PCV21 (not both) if they previously completed the pneumococcal vaccine series with both PCV13 and PPSV23 and meet the following criteria:-Previously received one dose of PCV13 (but not PCV15, PCV20, or PCV21) at any age, and-Previously received all recommended doses of PPSV23 (including 1 dose of PPSV23 at or after [AGE] years of age) A. Resident #28 was admitted to the facility in July 2025. Review of the medical record indicated Resident #28 had received the PPSV23 vaccine in 2013 and had not been administered any other pneumococcal vaccines and was therefore eligible for an additional vaccine. Review of the paper medical record included an Influenza and Pneumococcal Vaccine Consent and Tracking Form. The form did not indicate the vaccines had been reviewed with Resident #28 and was blank. During an interview on 8/13/25 at 9:12 A.M., Unit Manager #1 said the admitting nurse should have reviewed the vaccines with the Resident and she was not sure why the form was blank. B. Resident #39 was admitted to the facility in March 2025. Review of the medical record indicated Resident #39 had received the PCV13 vaccine in 2019 and had not been administered any other pneumococcal vaccines and was therefore eligible for an additional vaccine. Review of the paper medical record included an Influenza and Pneumococcal Vaccine Consent and Tracking Form. The form did not indicate the vaccines had been reviewed with Resident #39 and was blank. During an interview on 8/13/25 at 9:12 A.M., Unit Manager #1 said the admitting nurse should have reviewed the vaccines with the Resident and she was not sure why the form was blank. C. Resident #9 was admitted to the facility in May 2025. Review of the medical record indicated Resident #9 had received the PPSV23 vaccine in 2013 and the PCV7 vaccine in 2016 (9 years prior) and had not been administered any other pneumococcal vaccines and was therefore eligible for an additional vaccine after five years. Review of the paper medical record included an Influenza and Pneumococcal Vaccine Consent and Tracking Form. The form did not indicate the vaccines had been reviewed with Resident #9 and was blank. During an interview on 8/13/25 at 9:18 A.M., Unit Manager #2 said the process was for the nurse working on the admission to review vaccines with the Resident or representative. He said he could not speak to why the form was blank. D. Resident #90 was admitted to the facility in July 2024. Review of the medical record indicated Resident #90 had not received any pneumococcal vaccines prior to or since admission. Review of the paper medical record included an Influenza and Pneumococcal Vaccine Consent and Tracking Form. The form indicated the vaccines had been reviewed with the responsible person for Resident #90 and consent was provided on 7/2/24. During an interview on 8/13/25 at 9:41 A.M., Unit Manager #4 reviewed the consent form and the medical record and said the family consented to the pneumococcal vaccine and could not find that it was administered. She said the Infection Control Preventionist was responsible for tracking and administering the pneumococcal vaccines. 2. Review of the facility's policy titled Influenza Vaccine, dated as last revised in March 2022, indicated the following:-Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident