

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2025
NAME OF PROVIDER OR SUPPLIER  The Guardian Center		STREET ADDRESS, CITY, STATE, ZIP CODE  888 North Main Street Brockton, MA 02301	

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 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.  (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on records reviewed and interviews for one of three sampled residents (Resident #2), who had an invoked Health Care Proxy (HCP), the Facility failed to ensure that nursing staff promptly notified his/her Health Care Agent (HCA) when he/she experienced a significant change in status with a decline in condition, related to the development of deep tissue injuries (DTI, damage of soft tissue beneath intact skin) to his/her heels. Findings include: Review of Facility Policy titled Change in a Resident's Condition or Status, dated as revised 02/2021, indicated that the Facility promptly notifies the resident, his/her attending physician and the resident's representative of changes in the residents' medical/mental conditions and/or status. Resident # 2 was admitted to the Facility in February 2020, diagnoses included vascular dementia, diabetes mellitus, depression and anxiety. Review of Resident # 2's Physician's Orders, dated 11/06/22, indicated his/her Health Care Proxy had been invoked. Review of Resident #2's Annual Minimum Data Set (MDS) Assessment, dated 09/09/25, indicated he/she scored a ten (10) out of 15 on his/her Brief Interview for Mental Status (BIMS) (13-15 cognitively intact, 8-12 moderate cognitive impairment and 0-7 severe cognitive impairment), indicating he/she had moderate cognitive impairment. Review of Resident #2's Nurse Progress Note, dated 10/31/25, indicated that bilateral heels had been observed with unstageable pressure injuries. The Progress Note further indicated that the Family and Provider had been notified. Review of Resident #2's Weekly Skin Assessment, dated 10/31/25, indicated he/she had a right heel DTI two (2) centimeters (cm) by (x) 2.6 cm and a left heel DTI 1.6 cm x 2.4 cm. During a telephone interview on 12/09/25 at 1:09 P.M., Family Member #2 said that on 11/04/25 she had been visiting with Resident #2 in the afternoon and that Resident 2 had complained about being cold. Family Member #2 said that she was adjusting his/her blankets and noticed that Resident #2 had purple booties on both of his/her feet, that she lifted his/her feet, removed the booties to put on socks and noticed an area of deep purple and black on Resident #2's heels. Family Member #2 said that she took pictures of Resident #2's heels, sent them via her phone to Resident #2's HCA and said that the HCA was not aware of the newly developed areas. During a telephone interview on 12/18/25 at 11:00 A.M., Nurse #2 said that she had documented that both the provider and family (HCA) were made aware of the new skin developments, however, Nurse #2 said she only notified the provider, and that she had not informed the HCA. Nurse #2 said that she thought the Unit Manager had notified the HCA. During an in-person interview on 12/09/25 at 2:03 P.M., the Unit Manager said that she that according to the Nurses note and incident report, dated 10/31/25, it looked as if Nurse #2 had made the HCA aware of the new pressure injuries identified to Resident #2's heels. During a telephone interview on 12/22/25 at 1:49 P.M., the Unit Manager said she did not recall notifying Resident #2's HCA of the new pressure areas. The Unit Manager said Nurse #2 should not have documented that the HCA had been notified unless she made the notification herself. During an in-person interview on 12/10/25 at 9:39 A.M., the Director of Nurses (DON) said that because the skin incident report and the Nurse Progress note, both dated 10/31/25, indicated that Nurse #2 had notified the HCA, that she assumed that the proper notification had been made. During a telephone interview on 12/22/25 at 2:47 P.M., the DON said it is the Facility's expectation that nursing promptly notify a resident's HCA of any significant change and once the Nurse is certain that the notification has been made, then the nurse should document it on the appropriate forms.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on records reviewed and interviews for one of three sampled residents (Resident #2), the Facility failed to ensure they maintained complete and accurate medical/clinical records, including but not limited to the documentation of notification to a Health Care Agent (HCA) of newly observed pressure injuries. Findings include: Review of the Facility Policy titled Charting and Documentation, dated as last revised 07/2017, indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The Policy further indicated that documentation of procedures and treatments will include care-specific details, including: -The notification of family, physician, or other staff, if indicated. Resident # 2 was admitted to the Facility in February 2020, diagnoses included vascular dementia, diabetes mellitus, depression and anxiety. Review of Resident #2's Nurse Progress Note, dated 10/31/25, indicated that bilateral heels had been observed with Deep Tissue (pressure) Injuries (DTI, damage of soft tissue beneath intact skin). The Progress Note further indicated that the HCA and Provider had been notified. Review of Resident Skin Incident Report, dated 10/31/25, indicated the provider and the HCA were notified of the discovery of Resident #2's new pressure injuries to his/her heels. During a telephone interview on 12/18/25 at 11:00 A.M., Nurse #2 said that she had documented that both the provider and family (HCA) were aware of the new skin developments, however, Nurse #2 said that she only notified the provider, and she had not notified the HCA. Nurse #2 said that she thought the Unit Manager had notified the HCA. During an in-person interview on 12/09/25 at 2:03 P.M., the Unit Manager said that she that according to the Nurses note and incident report, dated 10/31/25, Nurse #2 had indicated that she made the HCA aware of the new pressure injuries identified to Resident #2's heels. During a follow-up telephone interview on 12/22/25 at 1:49 P.M., the Unit Manager said she did not recall notifying Resident #2's HCA of the new pressure areas. The Unit Manager said Nurse #2 should not have documented that the HCA had been notified unless she (Nurse #2) had made the notification herself. During an in-person interview on 12/10/25 at 9:39 A.M., the Director of Nurses (DON) said that because the skin incident report and Nurse Progress note, that were dated 10/31/25, both indicated that Nurse #2 had notified Resident #2's HCA, said she assumed that the proper notification had been made. During a follow-up telephone interview on 12/22/25 at 2:47 P.M., the DON said it is Facility's expectation that nursing promptly notify a resident's HCA of any significant change and once the Nurse is certain that the appropriate notification has been made, then the nurse should document it on the appropriate forms.</p>		