STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225400	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Wakefield	One Bathol Street Wakefield, MA 01880

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, records reviewed and interviews, the facility failed to ensure one Resident (#77), out of a total sample of 23 residents, received the necessary care and treatment, consistent with professional standards of practice, to prevent the development of pressure ulcers. Specifically for Resident #77 who was assessed by nursing to be at high risk for skin breakdown and who experienced pain and limited mobility in his/her left lower extremity following a surgical repair, the facility failed to a. ensure nursing consistently implemented diabetic foot care, implemented weekly skin checks, and implemented interventions when the Physical Therapy Assistant (PTA) identified an area of red and non-blanchable skin on Resident #77's left heel, consistent with a stage one pressure injury (intact skin with non-blanchable redness of a localized area usually over a bony prominence) on 2/2/26, and the facility failed to provide a recommended prevalon boot for Resident #77's left heel wound, subsequently the left heel wound deteriorated to an unstageable pressure ulcer (known but not stageable due to coverage of wound bed by slough and/or eschar) on 2/11/26. Despite the PTA identifying the skin breakdown on 2/2/16 and again on 2/11/26 nursing did not identify the area until 2/19/26 and b. once the area was identified the facility failed to ensure that nursing consistently implemented an air mattress as ordered by the physician. Findings include: Review of the facility policy titled Pressure Ulcer/ Injury Risk Assessment, dated 3/2022, indicated the purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk for developing pressure injuries. Steps in the Procedure 1.Gather assessment tools and documentation and conduct the assessment in the manner most appropriate to the resident's condition and willingness to participate.2.If necessary, allow the resident to take rest periods during the assessment.3.Conduct a structured pressure ulcer/injury risk assessment using a facility-approved tool.4.Conduct a comprehensive skin assessment with every risk assessment.a. When conducting a skin assessment, provide for the resident's privacy.b. Once inspection of skin is completed document the findings on a facility-approved skin assessment tool.c. If a new skin alteration is noted, initiate a (pressure or non-pressure) form related to the type of alteration in skin.5. Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments, the condition of the skin, the resident's overall clinical condition, and the resident's stated wishes and goals.a. The interventions must be based on current, recognized standards of care.b. The effects of the interventions must be evaluated.c. The care plan must be modified as the resident's condition changes, or if current interventions are deemed inadequate. Resident #77 admitted to the facility in January 2026 with diagnosis including diabetes, disorders of bone density, obesity, heart failure, and periprosthetic fracture around internal prosthetic left knee joint. Review of Resident #77's most recent Minimum Data Set assessment, dated 2/2/26, indicated the Resident had a moderate cognitive impairment as evidenced by a Brief Interview of Mental Status score of 12 of 15. Resident #77 did not reject care, and he/she was coded as experiencing pain as almost constantly: which impacted sleep, therapy activities, and day to day activities. Resident #77 experienced functional range of motion on the lower extremity on one side and he/she was dependent on facility staff for lower body dressing and putting on and taking off footwear. The MDS assessment indicated Resident #77 was assessed to be at risk for developing pressure injuries and was admitted with one (continued on next page)

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister). On 2/25/2026 at 10:08 A.M., the surveyor observed Resident #77 in bed on a standard mattress. Resident #77 said I am in so much pain, you need to get someone for me, I have an appointment I cannot miss, I haven't seen my orthopedic yet, I am supposed to go to the hospital at 11:00 A.M., to get my sutures removed!. The surveyor observed a dressing on Resident #77's knee area that was peeling, there were two occlusive dressings, covered by ABD pads, and wrapped coban (a lightweight, breathable, and water-resistant bandage). The surveyor observed a black area on Resident #77's left heel, and he/she said he/she got the wound at the facility. Review of Resident #77's plan of care titled Resident is at risk for skin breakdown related to pain, diabetes, and limited mobility with a goal of Resident will not show signs of skin breakdown, dated as initiated 1/28/26, indicated:-Weekly skin check by licensed nurse.-Pressure redistribution surface to bed and chair.-Observe skin condition daily with activities of daily living (ADL) care and report abnormalities.-Provide preventative skin care i.e lotions barrier creams as ordered.-Turn and reposition to meet needs. Review of Resident #77's plan of care titled Wound Management Post-Surgical - General, dated 1/28/26, indicated: - Encourage Resident to elevate legs Review of Resident #77's plan of care titled Documented Pressure Ulcer Documented Pressure Ulcer (on admit) _X_ Wound on coccyx [sic], dated as 1/28/26, indicated:- Encourage the use of lifting devices while in bed - Monitor bony prominences for redness Review of Resident #77's SECTION Custom Skin & Wound - Norton Plus Assessment, dated 1/30/26, indicated Resident #77 scored a 7 indicating that he/she was assessed by nursing to be at high risk for skin breakdown. Review of Resident #77's physician's orders, dated 1/28/26, indicated:-Diabetic Foot Care/Check Daily Observation of feet, toes, ankles, soles noting any alteration in skin integrity, color, temperature, and cleanliness. Inspect shoes for proper fit and excessive wear, check pedal pulses. CODE: 1= no alteration noted CODE: 2= New alteration noted CODE: 3= Previously noted alteration Pedal Pulse (PP): P=Palpable NP=Non-Palpable every evening shift for diabetes. Review of Resident #77's Treatment Administration Record (TAR), dated 2/1/26 through 2/28/26, indicated Nursing documented the diabetic foot care as code 1 - no alteration noted. However, record review indicates Resident #77 had documented a left heel pressure ulcer on 2/19/26. During an interview on 2/27/26 at 6:40 A.M., Nurse #3 said that Resident #77 was admitted to the facility after a fall with fracture. Nurse #3 said that Resident #3 had limited mobility in the left leg and he/she had lots of pain in his/her left leg. Nurse #3 said that although he documented that he completed diabetic foot care for Resident #77, he did not complete diabetic foot care because Resident #77 had a surgical incision around his/her left knee and he was not allowed to take off the ace wrap that was located from the thigh down to the toes on the left foot. Nurse #3 and the surveyor reviewed Resident #77's physician's orders and there was no order for an ace wrap. Nurse #3 said that at times the ace wrap would come loose and he would need to reapply the ace wrap to Resident #77's left leg, but he did not assess Resident #77's left heel. Nurse #3 said he was surprised that Resident #77 got a new pressure ulcer on his/her left foot because he thought the ace wrap would have protected the heel. Record review indicated between 2/1/26 and 2/18/26 Nurse #3 documented eight times he completed diabetic foot care and coded ?1- no issues.' Review of Resident #77's physician's order, dated 1/28/26, indicated:-Monitor dressing with wound to left femur (thigh bone, upper leg) related to status post-surgery. Keep dressing dry and intact. If become saturated remove immediately and apply dry sterile dressing and monitor for continued drainage. every shift for status post-surgery. Further review of the order failed to include the use of an ace wrap. Review of Resident #77's physician's order, dated 1/28/26, indicated:- Skin check and complete UDA (user defined assessment), every evening shift, every Friday. Review of Resident #77's Treatment Administration Record (TAR), dated 2/6/26, 2/13/26, and 2/20/26 indicated Nurse #2 documented that she completed a skin check under the UDA assessment however there was no documentation to support these assessments were completed. Review of Resident #77's Skin Check. - V 4 assessment, dated 1/27/26, indicated:- (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Redness purple bruises noted over the left hip and bilateral abdominal folds. Bruising observed on bilateral upper extremities; patient reports bruising is secondary to intravenous (IV) insertion. Heels dry. Left knee to ankle unable to be assessed. Review of Resident #77's Admit/Readmit Screener* - Copy V3 assessment, dated 1/27/26, indicated:-skin warm and dry with normal turgor. Redness noted on left hip and abdominal folds. open, erythematous area noted on the coccyx. Heels dry. Bruising observed on bilateral lower extremities (BLE); bruising due to IV insertion. Review of Resident #77's SECTION Custom Skin Check - V 4 assessment, dated 2/3/26, indicated:- Redness purple bruises noted over the left hip and bilateral abdominal folds. Bruising observed on bilateral upper extremities; patient reports bruising is secondary to IV insertion. Heels dry. Left knee to ankle unable to be assessed. During an interview on 3/3/26 at 6:39 A.M., Nurse #2 said that she was familiar with Resident #77 and had been his/her nurse for quite some time. Nurse #2 said that Resident #77 was admitted to the facility after a fall, he/she had pain from a fracture, and had a surgical incision on the left knee. Nurse #2 said that Resident #77's left leg was wrapped in an ace wrap, and she was unable to visualize his/her left foot, and this ace wrap was not to be removed. Nurse #2 said that at times Resident #77's left leg ace wrap would come off, and the ace wrap would need to be reapplied, and she said she did not look at the heels each time she needed to reapply the ace wrap. Nurse #2 and the surveyor reviewed the physician's orders and there was no order to apply an ace wrap to Resident #77's left lower leg. Nurse #2 said she completed the skin check on 2/3/26 and said that Resident #77's heels were dry and intact, as documented, and she was able to see the heels since the ace wraps were off. Nurse #2 said that she does not recall completing any additional skin check for Resident #77 during his/her stay, but she said that skin checks are supposed to be documented on the TAR and an assessment is to be opened and completed in the assessment tab of the electronic health record (EHR). Record review indicated Nurse #2 documented she completed skin checks on the TAR on 2/6/26, 2/13/26, and 2/20/26 however there was no supporting documentation these were completed. Nurse #2 said that Resident #77 is diabetic, and he/she requires diabetic foot care. Nurse #2 said that nurses complete diabetic foot care and they document the findings on the TAR. Nurse #2 said she was unable to complete diabetic foot care on Resident #77's left foot because it was covered with an ace wrap. Record review indicated Nurse #2 documented she completed diabetic foot care on the TAR eight times between 2/1/26 and 2/18/26, and coded ?1-no issues'). Nurse #2 said that after the left heel pressure ulcer was identified on 2/19/26 Resident #77 now required prevalon boots and an air mattress. Review of Resident #77's, Occupational Therapy Evaluation and Plan of Treatment, dated 1/28/26, indicated: - Functional Skills: putting on/ taking off footwear, coded as dependent.- Condition Assessment: Sensation / Sensory Processing - impaired (neuropathy in feet). Review of the Physical Therapy Encounter note, dated 2/2/26, indicated the following:- Discussed with morning Certified Nursing Assistant (CNA) for left lower extremity support of pillowcase to improve patient's comfort.- Patient and caregiver training: Ongoing staff training. Discussed patient's left heel for benefit of prevalon boot (a specialized heel protector designed to prevent pressure ulcers by keeping the heel elevated and off the bed surface) while in bed. Review of the Physical Therapy Encounter note, dated 2/11/26, indicated the following:- Provided nursing/patient with two prevalon boots to improve heel circulation for off-loading weight on heels. Patient pending ultrasound for left heel according to nursing. Patient present with left heel eschar and ace wraps removed from left lower extremity. During an interview on 2/26/26 at 1:33 P.M., the Physical Therapy Assistant (PTA) said that he was familiar with Resident #77's care. The PTA said that Resident #77 had an ace wrap on his/her left leg, and he said that the ace wrap was not consistently applied in the same manner to Resident #77' left foot. The PTA said that there were times the ace wrap was not applied below the ankle and that during his assessments of Resident #77's circulation, sensation, and motor function (CSM) of Resident #77's left lower extremity he could see Resident #77's left heel. The PTA said that Resident #77 admitted without a pressure injury on his/her left heel.The PTA and the surveyor reviewed the encounter notes for Resident #77 and he said that on 2/2/26 Resident #77 presented (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	with a red non-blanchable area to his/her left heel, which was new. The PTA said he discussed his concerns with nursing staff, and he told them that Resident #77 needed offloading and he wanted Resident #77 to have a prevalon boots. The PTA said that during his treatment on 2/11/26 and previous treatments between 2/2/26 and 2/11/26, he noticed there were no prevalon boots for Resident #77 and his/her heels were directly touching the standard mattress. The PTA said on 2/11/26 he provided Resident #77 with prevalon boots, and he needed to search for some in the facility since nursing did not obtain any prevalon boots, and he said the left heel wound was now eschar, as documented in his note. The PTA said that he makes recommendations verbally to nursing staff and he cannot put orders or recommendations into the electronic health record (EHR). Review of Resident #77's Nurse Practitioner note, dated 2/10/26, indicated:Chief Complaint: Reporting decreased sensation in distal lower extremities. He/she is feeling hopeless about his/her back pain and future ambulating.Review of systems: Bilateral Lower Extremity leg, decreased mobility.Skin: Surgical incision with sutures intact.Plan: Surgical Incision Open to Air with approximated with sutures. Review of Resident #77's Nurse Practitioner note, dated 2/11/26, indicated:-Chief Complaint: Pain in the left lower extremity, guarding with palpation.-Review of systems: Bilateral Lower Extremity pain, decreased mobility, and anxiety.-Assessment/Plan: Fracture - reporting pain on palpation, adding ultrasound to assess for deep vein thrombosis. Review of Resident #77's Nurse Practitioner note, dated 2/17/26, indicated:Chief Complaint: Reporting nerve pain with numbness and tingling. During an interview on 2/27/26 at 10:52 A.M., the Nurse Practitioner said she had evaluated Resident #77 multiple times during his/her admission to the facility. The NP said that Resident had pain in the left lower leg and Resident #77 was admitted after a fall with surgical repair. The NP said that Resident #77 had a surgical incision and a dressing on his/her left leg and that dressing was supposed to be removed at the orthopedic follow up on 2/4/26, which the appointment was missed. The NP said she was not supposed to take the dressing off Resident #77's leg, but on 2/10/26 Resident #77 had begun to complain about numbness in the left lower foot and he/she had increased edema. The NP said on 2/10/26 she removed the ace wrap and gauze layers from Resident #77's left leg, and she said she left the initial surgical dressing intact. The NP said that she did not assess Resident #77's left heel, but she ordered diagnostic testing to rule out deep vein thrombosis due to Resident #77 increased edema in the left lower extremity. The NP said that she did not assess Resident's 77 heels until after the pressure ulcer was discovered on 2/19/26. The NP said that Resident #77's left heel pressure wound is managed by the Wound NP. During an initial interview on 2/26/26 at 3:06 P.M., the Assistant Director of Nursing (ADON) said that she completes weekly wound rounds on the residents with the Wound Nurse Practitioner. The ADON said that Resident #77 admitted to the facility he/she did not have any pressure injuries on his/her heels. The ADON said on 2/19/26 while doing a routine wound care round with the Wound NP, she said she observed a pressure ulcer on Resident #19's left heel. The ADON said that the area looked like a blister that had reabsorbed. The ADON said that on 2/19/26 the ace wrap that was on Resident #77's left leg was loose and his/her left heel was visible. The ADON said that she reviewed the incident report for the pressure ulcer, and she said that during some interviews with direct care staff such as CNAs, she said that the CNA's said that they had observed the pressure injury shortly after Resident #77 admitted to the facility. The ADON said that prevalon boots should have been implemented upon admission to prevent skin breakdown. Review of Resident #77's nursing note, dated 2/19/26, indicated:- Unstageable pressure injury noted to left heel this day. Review of Resident #77's SECTION Custom Weekly Skin Check assessment, dated 2/19/26, indicated:- unstageable wound noted to left heel.During an interview on 2/26/26 at 3:13 P.M., the Unit Manager said Resident #77 was admitted to the facility with a Norton Score of 7 which indicated he/she is at high risk for skin breakdown. The Unit Manager said that Resident #7 had a surgical incision and had a lot of pain in his/her left leg which was limiting his/her mobility and he/she was working with therapy on getting in and out of bed to help prevent pressure ulcer development. The Unit Manager said wound rounds are completed (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	weekly by the ADON and Wound NP. The Unit Manager said that Resident #77 was admitted to the facility without a pressure injury on his/her left heel and she was made aware of the new area on 2/19/26 by the ADON. The Unit Manager said that Resident #77 was being seen weekly by the Wound NP for a pressure ulcer on his/her coccyx that evolved into moisture associated skin damage (MASD). The Unit Manager said that it is important for weekly skin checks and diabetic foot care to be completed accurately so that nursing can identify potential areas of skin breakdown and put interventions in place. The Unit Manager and the surveyor reviewed Resident #77's physician's orders she said there was no order for an ace wrap for Resident #77's left leg. The Unit Manager said that there were no formal interventions put in place to prevent skin breakdown upon admission. The Unit Manager said that once the pressure ulcer on the left heel was discovered on 2/19/26, she obtained physician's orders and implemented prevalon boots and an air mattress. The Unit Manager said Nurses are aware of new interventions by report each shift and by physician's orders. The Unit Manager said that CNAs are aware of interventions by verbal report each and reading the electronic care card. Review of the CNA care card on 2/26/26 failed to include documentation to support that Resident #77 required an air mattress or prevalon boots. Review of Resident #77's Wound Assessment Report, dated 2/19/26, indicated left heel pressure ulcer, unstageable, measurements:Length: 3.5 centimeters (cm)Width: 5 cm Review of the Wound Care Specialist note, dated 2/19/26, indicated:- Additionally, there is a new wound noted to the left heel. The patient has a recent history (1/22/26) of left lower extremity surgery - increasing the patient's immobility and risk of pressure related injuries. The left heel is covered with stable, dry eschar obscuring the wound base, consistent with an unstageable pressure injury. There is no overt drainage or malodor; however, the patient reports significant localized pain to the heel, raising concern for possible underlying soft tissue infection or osteomyelitis, particularly in the postoperative setting. Given the presence of heel eschar and reported pain, I recommend obtaining an x-ray of the left heel to evaluate for bony involvement, as well as laboratory studies. I will initiate an appropriate local wound care plan today, maintaining the eschar intact if it remains dry and stable, as heel eschar may serve as a biologic cover in the absence of infection. Continue aggressive offloading with Prevalon boots at all times and place patient on pressure-redistributing air mattress. During an interview on 2/27/26 at 12:07 P.M., the Wound NP said that she was familiar with Resident #77, and she had seen him/her on 2/5/26 and 2/12/26 for Moisture Associated Skin Damage (MASD) to his/her buttocks. The Wound NP said that she does not conduct a comprehensive skin assessment during her weekly evaluations and she only looks at areas that the facility staff ask her to look at. The Wound NP said that she did not assess Resident #77's heel until 2/19/26 when the ADON requested her to evaluate the wound. The Wound NP said that she recommended pressure relieving booties and an air mattress once the wound was found. The Wound NP said that she did not remove the left leg surgical incision dressing. Review of Resident #17's Social Service note, dated 2/24/26, indicated:- Interdisciplinary team (IDT) family meeting held this date with Resident and family in attendance. Rehab continues to work with Resident with Medicare part B services. Skilled services complete with last covered day 2/26/26. Resident declined to appeal. Goal of care to remain and discharge home to community with services when rehab goals met and medically stable. Wound on lower extremity limiting progress with non-weight bearing status. During an interview on 2/26/26 at 4:10 P.M., CNA #3 said that Resident #77's left heel has had an area since around the time of his/her admission. CNA #3 said that Resident #3 had an ace wrap on his/her left leg and the ace wrap would come off and the area was there. CNA #3 said that she would notify the nurses and the nurses would need to come in and put the ace wrap back on his/her foot. CNA #3 said that Resident #77 wears prevalon boots now and he/she likes the boots. CNA #3 said that Resident #77 has a regular air mattress. CNA #3 said that she is aware of Resident #77's care needs by reading the electronic care card. During an interview on 2/26/26 at 12:59 P.M., CNA #2 said that Resident #77 has an area on his/her left heel, and she said it's been there for a while but couldn't remember how long. CNA #2 said that Resident #77 uses a regular mattress and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	does not have an air mattress. CNA #2 said that she is aware of Resident #77's care needs by reading the electronic care card. During an interview on 3/3/26 at 8:05 A.M., the Director of Rehabilitation (DOR, an Occupational Therapist) said he was familiar with Resident #77. The DOR said that he was made aware of the PTAs concerns on 2/2/26 and again on 2/11/26, and he had seen the wound. The DOR said that the PTA reported these concerns to nursing and the PTA requested nursing to apply prevalon boots. The DOR said that therapy does not have any writing privileges in the EHR and all communication is verbal. The DOR said that he is part of the IDT, and he knows that the left heel pressure ulcer was discussed with nursing prior to 2/19/26. During a follow up interview on 3/3/26 at 8:55 A.M., the ADON said that Resident #77's left heel was unavoidable because of his/her comorbidities. The ADON said she was involved with reviewing the incident accident report for the new pressure ulcer and she said that the Unit Manager gathered statements and she was aware that there were some inconsistencies of when the wound was discovered and by whom. The surveyor along with the ADON reviewed Resident #77's TAR for diabetic foot care, weekly skin checks, left femur dressing order, and the PT encounter notes with the ADON. The ADON said she was not aware that nursing was not completing the diabetic foot care as ordered, nursing was not conducting skin checks as ordered, and the ADON said she was not aware the PTA found the area on 2/2/26 as a red non-blanchable area and again on 2/11/26 as eschar. The ADON then said that if interventions were not followed the wound would have been avoidable and the ADON said that interventions should have been put in place immediately when the PTA found the area to prevent avoidable breakdown. During an interview on 2/26/26 at 2:09 P.M., the Physician said that he did not see Resident #77 until 2/22/26 and at that time Resident #77 had a thick black necrotic area on his/her left heel and this was the first time he evaluated the Resident. The Physician said that due to the size of the pressure ulcer when he first evaluated it on 2/22/26 he wanted nursing staff to obtain an x-ray to rule out osteomyelitis to ensure the wound would heal. The Physician said the wound is followed and managed by Wound NP, and he would expect nursing to implement recommendations by the wound nurse. The Physician said that Resident #77 was admitted with limited mobility of the left leg, and he would have expected the nursing staff to implement interventions such as booties for Resident #77 to prevent skin breakdown upon admission. The Physician said for Resident #77 that the left heel that pressure ulcer is avoidable since the Resident was not provided interventions upon admission. The Physician said that if Physical or Occupational Therapy made recommendations to nursing, nursing should have implemented interventions. The Physician said he wound want the air mattress implemented. b.) Review of Resident #77's physician's order, dated 2/19/26, indicated:-May have therapeutic air Mattress in place. Set to patient's comfort level. check function and placement. every shift for maintenance. On 2/25/26 at 7:53 A.M., 9:22 A.M., and at 10:08 A.M., the surveyor observed Resident #77 in bed, he/she was on a regular mattress. There was an air mattress on and functioning in the empty bed next to Resident #77's bed. On 2/26/26 at 6:36 A.M. and 9:24 A.M., the surveyor observed Resident #77 in bed, he/she was on a regular mattress. During an interview on 2/26/26 at 12:35 P.M., Resident #77 was up in the wheelchair, wearing a regular shoe. Resident #77 said that he/she did have an air mattress and Resident #77 the air mattress stopped working around a week ago and they put it on the other bed to see if they could get it to work. Resident #77 said he/she would like the air mattress. On 2/26/26 at 4:30 P.M., the surveyor observed Resident #77 in bed, he/she was on a regular mattress. On 3/2/26 at 8:40 A.M., the surveyor observed Resident #77 in bed, he/she was on a regular mattress. On 3/3/26 at 6:37 A.M., the surveyor observed Resident #77 in bed, he/she was on a regular mattress. During an interview on 2/26/26 at 2:46 P.M., Nurse #3 said that Resident #77 refuses his/her air mattress. During an interview on 3/3/26 at 6:39 A.M., Nurse #2 said that Resident #77 uses an air mattress for pressure ulcer care. During an interview on 3/3/26 at 9:38 A.M., the ADON said that Resident #77 requires an air mattress for his/her left heel pressure ulcer and MASD on the buttocks. The ADON said she was not aware Resident #77 was not using the air mattress. On 3/3/36 at 9:40 A.M., the surveyor and the ADON observed Resident #77 in bed on a (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	regular mattress. Review of the Treatment Administration Record, dated 2/19/26 through 3/2/26, indicated nursing documented yes that there was an air mattress for Resident #77 35 shifts. Further review indicated Nurse #3 document yes on 14 shifts and Nurse #2 documented yes 9 shifts.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Wakefield	One Bathol Street Wakefield, MA 01880

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure for one Resident (#4), out of a total sample 23 residents, that informed consent, including risk and benefits, was obtained from Resident #1's legal guardian prior to administering antipsychotic medication. Findings include: Review of the facility's policy titled, Subject: Psychotropic Medication, revised 2/2025, indicated: Guidelines 1. Obtain physician's order. Note: A physician's order and appropriate diagnosis is required for all psychoactive medications. Note: An informed consent from the resident (or legally authorized individual in the case of resident incompetence) is required for administration of psychoactive medication.Resident #4 was admitted to the facility in February 2026 with diagnoses including, but not limited to, aphasia (a language disorder) following cerebral infarction (stroke), major depressive disorder, recurrent and moderate, unspecified dementia with unspecified severity and with agitation, and history of suicidal ideation.Review of the Minimum Data Set assessment dated [DATE] indicated Resident #4 scored 2 out of 15 on the Brief Interview for Mental Status exam, indicating severely impaired cognition. Further, the MDS indicated Resident #4 is dependent on staff for all care activities including bathing, dressing and eating. The MDS indicated Resident #4 was administered antipsychotic medication with indication for use.Review of Resident #4's care plans indicated the following:- focus cognition, revision date 2/15/26, Resident benefits form a secured unit with a structured daily flow is necessary form of treatment due to cognitive loss/dementia/communication deficit with poor decision-making ability and decreased safety awareness. [SIC]- focus, Advanced Directives: Resident has a guardian, (named) with [NAME] (a court ordered treatment plan for the administration of antipsychotic medication). revision on 2/23/26, goal Guardian and Resident will engage in the decision making of his/her medical and mental health needs, target date 3/3/26. Interventions include allow opportunity to participate in decisions regarding care, date initiated 2/9/26On 2/25/26 at 8:04 A.M, Resident #4 was in bed and made eye contact when greeted but did not continue to participate in further conversation with the surveyor. Review of the physician's orders for Resident #4 indicated the following: Zyprexa (an antipsychotic medication) Oral tablet 5MG (milligrams) (Olanzapine) Give 2.5 mg by mouth two times a day for psychosis, order date 2/17/26, start date 2/18/26. Review of the progress notes indicated a note dated 2/17/26 documented by the Nurse Practitioner, Nursing reporting he/she is agitated during morning care, found to have injured a staff member. Adding Zyprexa BID for paranoia related to care. Review of Resident #4's medical record failed to indicate that an informed consent including the risk and benefits of the use of the Zyprexa was documented as occurring with Resident #4's guardian. During an interview on 3/2/26 at 2:34 P.M., Nurse #11 said Resident #4 is dependent on staff for all care, wakes up early and has behaviors of screaming and once he/she is up after breakfast he/she will be fine. Nurse #11 said Resident #4 recently started on Zyprexa 2.5 mg 2 times a day for his/her behaviors. Nurse #11 said the Resident's guardian would need to give consent prior to administering the medication. Nurse #11 said the nurse who enters the order should confirm there is consent for the medication. Nurse #11 and Nurse #5 looked in Resident #4's medical record and only found consents obtained on admission and not for the use of Zyprexa ordered 2/17/26.During an interview on 3/3/26 at 7:58 A.M., Social Worker #1 said there was no consent for Resident's #4 for the administration of the Zyprexa and there should have been. During an interview on 3/3/26 at 9:47 A.M. via telephone Resident #4's legal guardian said she was not informed of the order to be administer Zyprexa, dated 2/17/26, for Resident #4 until she was called by a nurse yesterday (3/2/26). The guardian said she gave consent because the medication was already started and that she would like to have a discussion with the provider because this is Resident #4's third prescribed antipsychotic.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure a homelike environment was maintained on one of three units. Specifically, on the [NAME] Unit, the facility failed to ensure that the unit refrigerator that was on the unit in a resident space was kept in a manner that was consistent of a reasonable homelike environment as evidenced by a brown, rusted color that was stained across the entire bottom part of the front of the refrigerator.Findings include:Review of the facility policy titled Resident Home, dated and revised April 2022, indicated the following: - Residents are provided with a safe, clean, comfortable and homelike environment.On 2/26/26 at 9:14 A.M., on the [NAME] Unit, the surveyor observed the unit refrigerator in the hallway which was a part of the Resident's shared space. The entire bottom part of the refrigerator was stained with a brown substance that resembled rust that did not rub off.Throughout the survey period, multiple residents would pass by the refrigerator as they enter and exit the shared dining room space.During an interview on 2/26/26 at 7:02 A.M., two residents who reside on the unit told the surveyor they wished the refrigerator looked better since we live here and it bothers them.During an interview on 2/27/26 at 8:06 A.M., Nurse #5 said the refrigerator looks nasty and the facility should buy a new one.During an interview on 2/27/26 at 7:48 A.M., a staff member told the surveyor that the refrigerator has looked this way for years and it is gross and we would love to have a new one.During an interview on 2/27/26 at 12:03 P.M., another resident who resides on the unit told the surveyor that he/she wishes it looked nicer.During an interview on 3/2/26 at 9:15 A.M., the Housekeeping Manager said she has tried cleaning the refrigerator and the brown stains do not come off.During an interview on 3/2/26 at 10:35 A.M., the Assistant Director of Nursing said she is aware of the state of the refrigerator, and the facility is ordering a new one.Review of the facility's reviews online indicated a review dated 3 months ago with a photo of the unit refrigerator with the entire bottom part of the refrigerator resembling the same observations the surveyor made during the survey period.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to assess the use of a potential restraint for one Resident (#34) out of a total sample of 23 Residents. Specifically, for Resident #34, the facility failed to assess the use of a scoop mattress as a potential restraint. Findings include:Review of the facility policy titled Use of Restraints, dated and revised April 2022, indicated the following:- Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions that may improve the symptoms.- Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative.Resident #34 was admitted to the facility in June 2020 with diagnoses including paranoid schizophrenia and chronic kidney disease. Review of Resident #34's most recent Minimum Data Set assessment dated [DATE] indicated that the Resident had a Brief Interview for Mental status score of 15 out of 15 indicating the Resident is cognitively intact. Further review of the MDS indicated that the resident requires substantial/maximum assistance with all transfers and does not use restraints. During an interview on 2/25/26 at 7:50 A.M., Resident #34 told the surveyor that he/she recently was getting out of bed and slipped off the side of it. The surveyor then observed that Resident #34's mattress was a scoop mattress.During observations on 2/26/26 at 6:53 A.M. and 2/27/26 at 6:53 A.M., Resident #34 was sleeping in his/her bed with a scoop mattress in place, his/her wheelchair was within arm's reach of the bed.Review of Resident #34's Unwitnessed Fall Incident Report, dated 12/29/25 at 9:45 P.M., indicated the following:- Incident Description: Call light was on in room, this writer went for assistance and noticed the resident was in sitting position on the floor. Resident explained that he/she was trying to reach over for something then slid off the bed.- Notes: 12/30/25 - Intervention: Scoop mattress to prevent slipping out of the bed.Review of Resident #34's most recent fall risk evaluation dated 1/6/24 indicated that the resident scored a13 indicating that he/she is at risk for falls. Review of Resident #34's physician's orders failed to indicate an order for the use of a scoop mattress.Review of Resident #34's care plans, including his/her falls care plan, failed to indicate an intervention for the use of a scoop mattress.Review of Resident #34's medical record failed to indicate that the facility completed an assessment for the use of a scoop mattress as a potential restraint prior to use.Review of Resident #34's mobility care plan, dated and revised 11/19/23 indicated that the Resident requires substantial/maximum assistance from staff for lying-to-sitting on the side of bed, rolling left and right as well as sitting to lying and standing.During an interview on 2/26/26 at 1:16 A.M., Nurse #6 said Resident #34 is a partial assistance for care activities of daily living staff and he/she can sometimes get out of bed on his/her own if his/her wheelchair is next to the bed. Nurse #6 then said Resident #34 has a scoop mattress to prevent him/her from falling out of bed but she is not sure when the Resident received the scoop mattress.Shortly after the Surveyor interviewed Nurse #6, Nurse #6 proceeded to input a physician's order and update Resident #34's care plan for the use of a scoop mattress.During an interview on 2/27/26 at 6:54 A.M., Nurse #7 said Resident #34 uses a scoop mattress to keep herself/himself in bed and the Resident sometimes gets out of bed on his/her own at nighttime. Nurse #7 said he believes that Resident #34 received the scoop mattress about one month ago and Resident #34 told Nurse #7 that he/she did not like the scoop mattress at first because he/she said he/she cannot get out of bed.During an interview on 2/27/26 at 8:08 A.M., Nurse #5 said Resident #34 sometimes get out of bed on his/her own. Nurse #5 then said she thinks Resident #34 received the scoop mattress after his/her fall in December. Nurse #5 said if a Resident is on a scoop mattress there needs to be a physician's order and care plan as well a restraint assessment to determine if the device is a restraint or not.During a follow up (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 2/27/26 at 8:54 A.M., Resident #34 said he/she believes that he/she received the scoop mattress about six weeks ago.During an interview on 2/27/26 at 9:54 A.M., the Maintenance Director said he has been filling in as the Maintenance Director for four months. He said he was never made aware of Resident #34 receiving a scoop mattress and he does not remember any maintenance requests for a scoop mattress.During an interview on 3/2/26 at 10:22 A.M., the Assistant Director of Nursing (ADON) said Resident #34 can sometimes get out of bed on his/her own and she does not remember the last time the Resident had a fall. The ADON then said after a Resident has a fall, the facility will conduct an investigation, and any new interventions will need a physician's order, and the care plan will be updated. The ADON then said if a resident needs a scoop mattress, then the facility must first determine why it is necessary and then put in an order and care plan for it as well as make sure a restraint assessment is completed prior to its use. The ADON said she was not aware Resident #34's scoop mattress was implemented from the 12/29/25 fall and said that an order, care plan, and restraint assessment should have been completed.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure for one Resident (#1), out of a total sample of 23 residents, that recommended services were implemented in accordance with the Pre-admission Screening and Resident Review (PASRR) Level II Evaluation Determination Summary. Specifically, Resident #1 was screened to meet PASRR criteria for SMI (serious mental illness) with recommended behavioral health services, individual psychotherapy. Findings include: Review of the facility's policy subject; Preadmission Screening and Resident Review (PASARR), dated revised 5/2022 indicated: It is the policy of the facility to comply and state PASARR requirements to ensure that individuals with Serious Mental Illness (SMI), Intellectual Disability (ID), or Related conditions receive appropriate screening, placement, and specialized services prior to and during admission to the facility. Further, review of the policy indicated if Level 1 is positive a level II evaluation must be completed and approved prior to admission unless an allowable hospital exemption applies. 2. Level II Evaluation Conducted by the state-designated authority, Determines: Appropriateness for nursing facility placement. Need for specialized mental health or developmental disability services. The facility must: Await Level II determination prior to admission. Implement all recommended specialized services upon admission. Resident #1 was admitted to the facility in November 2025 and has diagnoses that include, but are not limited to, chronic obstructive pulmonary disease, adult failure to thrive, dysphagia, delusional disorder, major depressive disorder recurrent severe with psychotic symptoms, anxiety disorder, post-traumatic disorder, borderline personality disorder. Review of the most recent Minimum Data Set assessment dated [DATE] indicated Resident #1 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating Resident #1 as cognitively intact. Review of Resident #1's clinical record indicated the following:-A Pre-admission Screening and Resident Review (PASRR) level II Evaluation Determination Summary, dated 11/19/25, which indicated Resident #1 meets the PASRR criteria for a SMI (serious mental illness) and nursing facility services are appropriate up to 90 days. Recommended behavioral health services including Individual Psychotherapy. -An active physician order, dated 11/26/25, Behavioral health contracted provider to evaluate and treat for psychiatric and psychological health -A document signed by Resident #1, dated 11/26/25 titled ?authorization to screen, evaluate and treat for behavioral health services dated 11/26/25 During an interview on 2/26/26 at 9:03 A.M., Resident #1 said since admission to the facility he/she has talked with his/her physical therapists and doctor and has not been seen by a psychotherapist and would like to be able to talk with someone. During an interview on 2/26/26 at 11:33 A.M., Nurse #8 said Resident #1 will report he/she is anxious but may not be specific about what he/she is anxious about. Nurse #8 said she was not sure if Resident #1 was receiving behavioral health services. Nurse #8 reviewed the notes under miscellaneous in the medical record and said she did not see any behavioral health notes and would need to check further. During an interview on 2/26/26 at 9:25 A.M., the contracted behavioral health Nurse Practitioner (NP) said she provides medication review services, and that talk therapy is provided by a clinician via telehealth on Thursdays. The NP said she is not familiar with Level II PASRR determinations, but for a resident to be seen by behavioral health a physician's order and consent is needed. During an interview on 2/26/26 at 1:11 P.M., the behavioral health NP said Resident #1 was referred today for services and had not been seen by the talk therapist since admission. During an interview on 2/26/26 at approximately 1:00 P.M., Social Worker (SW) #1 said she is the regional SW and is currently covering the facility. SW #1 said the facility social worker would be responsible to review a resident's PASSR Level II determination letter. SW #1 said the facility SW would coordinate the recommendations from the [NAME] II determination by developing a care plan to include the recommended services to continue support a resident's behavioral health needs. SW #1 said behavioral health services, (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including psychotherapy therapy, should have been put in place for Resident #1 before now and that the admitting SW did not implement the recommended PASSR Level II services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, record review and interviews, the facility failed to ensure standards of professional nursing practice for one Resident (#1) out of a total sample of 23 residents. Specifically, the nursing staff documented in Resident #1's medical record that 1:1 supervision was being provided during meals when it was not provided in accordance with the physician's orders. Findings include: 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 the following:Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Resident #1 was admitted to the facility in November 2025 and has diagnoses that include but are not limited to chronic obstructive pulmonary disease, adult failure to thrive, delusional disorder, major depressive disorder, recurrent and severe, with psychotic symptoms, and dysphagia (a swallowing disorder). Review of the most recent Minimum Data Set assessment dated [DATE] indicated Resident #1 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating Resident #1 is cognitively intact. Review of Resident #1's medical record indicated the following physician's order:-1:1 supervision/feed with meals for Aspiration precaution (sic), start date 1/21/26. During the survey the following the surveyor made the following observations: -On 2/25/26 at 12:57 P.M., Resident #1 was eating in the dining room with other residents. Resident #1 was eating a meal that consisted of a hot dog in a bun with a cup of beans and condiments. Resident #1 was sitting at a table with 2 other residents, a total of 16 residents in the room with 2 staff present. No staff was observed providing 1:1 supervision to Resident #1 while he/she ate his/her meal. The Speech Language Pathologist did sit near Resident #1 after most of his/her meal was consumed. -On 2/25/26 at 4:27 P.M., Resident #1 was provided with crackers by staff in his/her room. The staff exited the room and Resident #1 was behind the curtain eating crackers, while resting in bed, not sitting up. -On 2/26/26 at 9:05 A.M., Resident #1 was in the dining room, sitting at a table alone. Nine other residents were present, and one staff member was sitting at a table feeding a resident. At 9:19 A.M., Resident #1 remained eating his/her breakfast meal. At 9:31 A.M., staff approached Resident # 1 and removed his/her breakfast tray. At no time during the observation did staff provide 1:1 supervision during the observation. During an interview on 2/26/26 at 7:18 A.M., Resident #1 said he/she had pneumonia not too long ago. Resident #1 said I can swallow now but I had a problem swallowing before. During an interview on 2/26/26 at 12:12 P.M., Certified Nursing Assistant (CNA #4) said Resident #1 is independent with eating his/her meals and will ask for food items that he/she wants. During an interview on 2/26/26 at 12:46 P.M., the Speech Language Pathologist (SLP) said Resident #1 is on SLP services and his/her diet has been upgraded to a regular diet. The SLP reviewed the orders and said the Resident does have a 1:1 supervision order for meals and that it was not discontinued and could be. Review of the Medication Administration Record (MAR) dated February 2026 indicated from 2/1/26 through the 1230 (12:30 P.M.) meal on 2/25/26 indicated that all three meals were documented by nursing staff as provided per the order 1:1 supervision/feed with meals for aspiration precautions was being provided. The documentation on 2/25/26 meal at 1700 (5:00 P.M.) and 8300 (8:30 A.M.) conflicts with the surveyor's observations. During an interview on 2/26/26 at 2:15 P.M., Nurse #10 said Resident #1 was in the hospital sometime in January and came back, was on rehabilitation and was at risk for aspiration. Nurse #10 said staff observes and supervises Resident #1 during meals, but nursing staff is not (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	providing 1:1 supervision as the order reads. Nurse #10 said she documented the MAR on 2/24/26 for all three meals. Nurse #10 said by checking off the MAR means the order was completed as written. Nurse #10 said nurses should not be checking off something they did not provide. During an interview on 3/2/26 at 10:42 A.M., the Assistant Director of Nursing said nursing staff should not sign off on an order that they did not provide or validate.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure one Resident (#77) received treatment and care in accordance with professional standards of practice, out of total sample of 23 residents. Specifically for Resident #77 who had surgery on 1/22/26, the facility failed to send the Resident #77 to his/her orthopedic follow up appointment on 2/4/26 for suture removal and the sutures were not removed until 2/24/26, 35 days after surgery, potentially placing the resident at risk for complications. Findings include:Resident #77 admitted to the facility in January 2026 with diagnosis including diabetes, disorders of bone density, obesity, heart failure, and periprosthetic fracture around internal prosthetic left knee joint. Review of Resident #77's most recent Minimum Data Set assessment, dated 2/2/26, indicated the Resident had a moderate cognitive impairment as evidenced by a Brief interview of mental status score of 12 of 15. Resident #77 did not reject care, and he/she was coded as experiencing pain as almost constantly: which impacted sleep, therapy activities, and day to day activities. Resident #77 experienced functional range of motion on the lower extremity on one side and he/she was dependent on facility staff for lower body dressing and putting on and taking off footwear. The MDS assessment indicated Resident #77 had a surgical wound. Review of the hospital after visit summary orthopedic Discharge summary, dated [DATE] through 1/27/26, indicated but was not limited to the following:You were admitted to the hospital for a fracture of your left knee; you underwent surgery on 1/22/26.1. Activity/Restrictions - Weight bearing as tolerated 2. Wound Care - Keep dressing clean dry and intact, monitor daily for saturation. If dressing remains dry keep intact until follow up visit. If saturated remove immediately. 3. DVT Prophylaxis: Lovenox 40 milligrams (mg), one daily for 4 weeks.4. Follow Up: 2/4/26. Review of Resident #77's physician's orders, dated 1/28/26, indicated: - Monitor dressing with wound to left femur related to status post-surgery. Keep dressing dry and intact. If become saturated remove immediately and apply dry sterile dressing and monitor for continued drainage every shift for status post (S/P) surgery.- Do not shower. Do not get dressing wet. every shift for S/P surgery. Review of Resident #77's plan of care related to is at risk of complications related to fractured hip [SIC], dated as initiated 1/28/26, indicated:- Dressing as ordered. On 2/25/26 at 10:08 A.M., Resident #77 said I am in so much pain, you need to get someone for me, I have an appointment I cannot miss, I haven't seen my orthopedic yet, I am supposed to go to the hospital at 11:00 A.M., to get my sutures removed!. The surveyor observed a dressing on Resident #77's knee area that was peeling, there were two occlusive dressings, covered by ABD pads, and wrapped coban (a lightweight, breathable, and water-resistant bandage). Review of Resident #77's progress note, dated 2/25/26, indicated: -Patient back from Post-op appointment. Per progress note from Surgeon: Suture were removed this day. Pt (patient) can get incisions wet and pat dry. Avoid fully submerging. Continue current pain management. WBAT with left lower extremity (LLE) using assistive device. Can continue with Physical therapy. Follow up in 5 weeks. 4/1/26 at 12:45pm.Review of Resident #77's department of orthopedic surgery form, dated 2/25/26, indicated: -Sutures were removed today. Can get incisions wet and pat dry. Avoid fully submerging. During an interview on 2/25/26 at 3:59 P.M., Resident #77 said he/she just returned from the orthopedic appointment, and he/she said the orthopedic doctor was not happy that I still had my original dressing, and I missed my follow up. The surveyor observed Resident #77's left knee area which was open to air, there were steri-strips across the surgical wounds. On 2/26/26 at 2:00 P.M., the surveyor requested Resident #77's ortho follow up paperwork from the Unit Manger. The paperwork was not located in the medical record or at the nursing station. During an interview on 2/27/26 at 7:16 A.M., the Unit Manager said she couldn't find Resident #77's paperwork from ortho. During a subsequent interview on 2/27/26 at 10:29 A.M., the Unit Manager said she is still unable to find the follow-up paperwork from the visit on 2/25/26, and she was not sure why Resident #77 did not go on her ortho follow up appointment on 2/4/26. She said she would follow (continued on next page)

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	225400	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Wakefield	One Bathol Street Wakefield, MA 01880

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up with the receptionist to find out why. The Unit Manager said that the process for follow-up appointments is for the admitting nurse to write down the appointment in the appointment book, make a copy of the appointment, and fill out the transport request form and provide this information to the receptionist to book the transport. Unit Manager #1 said that the night nurses are supposed to review the appointment book on the night shift and fill out paperwork for every appointment. During a subsequent interview on 2/27/26 at 11:48 A.M., the Unit Manager #1 said Resident #77's initial dressing indicated not to remove until the ortho follow up. The Unit Manager said that she had no excuse for why the appointment on 2/4/26 was missed. The Unit Manager said the next available ortho appointment was on 2/11/26 and the resident wasn't ready when the ride came and the ride came and went and didn't wait and left for the resident to get ready. The Unit Manager said that the Receptionist rebooked the ride for 2/18/26 with receptionist, and the company brought in a wheelchair not a stretcher and the Resident wasn't tolerating being up for too long, so the facility had to rebook that day for 2/25/26. The Unit Manager said that the initial surgical dressing was not to be removed and for them to ensure the dressing remained dry and intact. The Unit Manager said that the facility Nurse Practitioner removed the dressing one day since Resident #77 was having issues. The Unit Manager said that she did not contact the ortho place to obtain orders for dressings changes after the dressing was removed. During an interview on 2/27/26 at 12:04 P.M., the orthopedic office said that Resident #77 was supposed to have a follow up appointment to have his/her sutures removed on 2/4/26. The Orthopedic Office said Resident #77 did not show up for appointments on 2/4/26, 2/11/26, and 2/18/26. Review of Resident #77's Nurse Practitioner note, dated 2/10/26, indicated:Chief Complaint: Reporting decreased sensation in distal lower extremities. He/she is feeling hopeless about his/her back pain and future ambulating.Review of systems: Bilateral Lower Extremity leg, decreased mobility.Skin: Surgical incision with sutures intact.Plan: Surgical Incision Open to Air with approximated with sutures. Review of Resident #77's Nurse Practitioner note, dated 2/11/26, indicated:-Chief Complaint: Pain in the left lower extremity, guarding with palpation.-Review of systems: Bilateral Lower Extremity pain, decreased mobility, and anxiety.-Assessment/Plan: Fracture - reporting pain on palpation, adding ultrasound to assess for deep vein thrombosis. Review of Resident #77's Nurse Practitioner note, dated 2/17/26, indicated:Chief Complaint: Reporting nerve pain with numbness and tingling. During an interview on 2/27/26 at 10:52 A.M., the Nurse Practitioner said she had evaluated Resident #77 multiple times during his/her admission to the facility. The NP said that Resident had pain in the left lower leg and Resident #77 was admitted after a fall with surgical repair. The NP said that Resident #77 had a surgical incision and a dressing on his/her left leg and that dressing was supposed to be removed at the orthopedic follow up on 2/4/26, which the appointment was missed. The NP said she was not supposed to take the dressing off Resident #77's leg, but on 2/10/26 Resident #77 had begun to complain about numbness in the left lower foot and he/she had increased edema. The NP said on 2/10/26 she removed the ace wrap and gauze layers from Resident #77's left leg, and she said she left the initial surgical dressing intact. The NP said it was very important for Resident #77 to have his/her orthopedic follow up for suture removal 14 days post operative. During an interview on 2/27/26 at 12:07 P.M., the Wound NP said that she did not remove the left leg surgical incision dressing. The Wound NP said that the dressing needed to be removed by the orthopedic. During an interview on 3/3/26 at 7:49 A.M., the Receptionist said there are several people who book appointments for Residents', she said all appointments are booked when she receives paperwork from nursing. During an interview on 3/3/26 at 8:45 A.M., the Assistant Director of Nursing said that Resident #77 had a left leg surgical dressing and missed an appointment on 2/4/26. The ADON said the follow ups are important to follow to follow the surgeon would want to see the site itself and do a follow up imaging. The ADON said she was not aware off all the missed appointments and she said I heard about it after them the fact. She said the Unit Manager rescheduled. The ADON said negative impacts from missing the appointment would include infection of the surgical site and delay in care. On 3/3/25 at 8:50 A.M., the surveyor and the ADON reviewed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #77's medical record. Resident #77 still had active physician's orders to 1. Monitor dressing with wound to left femur related to status post-surgery. Keep dressing dry and intact. If become saturated remove immediately and apply dry sterile dressing and monitor for continued drainage. every shift for status post (S/P) surgery and 2. Do not shower. Do not get dressing wet. every shift for S/P surgery, despite the follow up recommendations on 2/25/26. The ADON said that nursing was still documenting that nursing was monitoring and assessing Resident #77's dressing and Resident #77 when these orders should have been discontinued by the Unit Manager.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and observation the facility failed to ensure medications were secure on two of three resident units. Specifically, the facility failed to:Secure a narcotic medication in the Solerna Unit medication room.a.Secure medications which were left unsupervised at the [NAME] Unit nursing station and b. secure a treatment cart on the [NAME] Unit.Findings include:1.Review of the facility policy Medication Storage, dated as revised March 2022, indicated there was no reference to the securing of narcotics in the medication room refrigerator. On 3/3/26 at 9:15 A.M., the surveyor observed the Solana dementia unit medication storage room, accompanied by Nurse #9. Nurse #9 unlocked the medication room door. Inside the room was a small, unlocked refrigerator. The surveyor opened the refrigerator and observed one large, white box and one smaller black box. The white box was locked and affixed to the shelf by nylon cable ties. The black box locked but not affixed to the refrigerator. The surveyor lifted the box out of the refrigerator and Nurse #9 unlocked the box. Inside was one unopened vial of liquid Ativan 2 milligrams/ml, a schedule IV narcotic. Nurse #9 said he did not know that the locked box containing the Ativan was required to be secured to the refrigerator. During an interview with the Assistant Director of Nurses (ADON) on 3/3/26 at 9:52 A.M, she said that refrigerated narcotics should be stored in a locked box and the box should be securely affixed to the inside of the refrigerator. The DON said that the box should be affixed to the refrigerator to prevent anyone from removing the box from the medication room and possibly diverting the narcotic medication. 2. Review of the facility policy titled, Medication Storage, dated 3/2022, indicated the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. a. On 2/25/26 at 6:55 A.M., the survey team entered the [NAME] Unit and there were no staff present. There was a resident self-propelling up and down the hallway. The surveyor observed at the nursing station the following: - two bags of medications that were sealed, - a tote box sealed with medications in it, - two blue bags with medications that indicated perishable open immediately, - one box of prescription strength lidocaine jelly, - four medication cards containing 120 tablets of fluvoxamine, an antipsychotic medication, - one medication card containing 14 tablets of quetiapine, an antipsychotic medication, - three medication cards containing 90 tablets of sevelamer, a phosphate binder, - two medication cards containing 60 tablets of levetiracetam, and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- one medication card containing 14 capsules of tamsulosin. b. On 2/25/26 at 7:12 A.M., the surveyor was able to gain access to an unlocked and unattended treatment cart on the [NAME] Unit. The surveyor observed the following: - two bottles of ketoconazole 2% shampoo, - one container of silver sulfate cream 1%, - one tube of ketoconazole crem 2%, - one tube of nystatin powder, - one tube of clobetasol propionate, and various treatment supplies including but not limited to hydrocortisone 1%, packets, medihoney, xeroform dressings, and hydrogel. On 2/25/26 at 7:10 A.M., Nurse #1 arrived at the [NAME] Unit nursing station, and he said he was not sure why there were medications left unattended at the nursing station. Nurse #1 said that mediations are usually delivered around 3:00 A.M. and 4:00 A.M., and he said the medications in the blue bags were room temperature and should have been immediately placed in the refrigerator once delivered. Nurse #1 said he would put the medications away in the medication cart. During an interview on 2/25/26 at 8:10 A.M., Nurse #2 she just returned to the facility and said she had left to get coffee and another nurse in a different Unit was covering the [NAME] Unit. Nurse #2 said that she left the medications out at the nursing station because they were supposed to go back to the pharmacy because the Residents were no longer here (conflicting with Nurse #1's interview and observation). Nurse #2 said that treatment carts should be always locked. During an interview on 3/3/26 at 8:42 A.M., the Assistant Director of Nursing (ADON) said that nursing should put the medications away upon delivery from the pharmacy, and nursing should ensure medications are secure to ensure staff and residents don't have access. The ADON said nursing should refrigerate medications immediately based on the manufacture's recommendations.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on records review, and interviews, the facility failed to obtain diagnostic services as ordered by the provider for one Resident (#77), out of a total sample of 23 residents. Specifically for Resident #77 who experienced pain in the left lower extremity the facility failed to obtain a left lower extremity ultrasound (non-invasive imaging test used to detect blood clots, evaluate venous flow, and assess venous valve function in the leg). Findings include: Review of the facility policy titled, Labs and Diagnostics, dated as revised 5/2025, indicated:Assessment and Recognition 1. The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. 2. The staff will process test requirements and arrange for tests.3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. Resident #77 admitted to the facility in January 2026 with diagnosis including diabetes, disorders of bone density, obesity, heart failure, and periprosthetic fracture around internal prosthetic left knee joint. Review of Resident #77's most recent Minimum Data Set assessment, dated 2/2/26, indicated the Resident had a moderate cognitive impairment as evidenced by a Brief interview of mental status score of 12 of 15. Resident #77 did not reject care, and he/she was coded as experiencing pain as almost constantly: which impacted sleep, therapy activities, and day to day activities. Resident #77 experienced functional range of motion on the lower extremity on one side and he/she was dependent on facility staff for lower body dressing and putting on and taking off footwear. Review of Resident #77's Nurse Practitioner note, dated 2/11/26, indicated:- Chief Complaint: Pain in the left lower extremity, guarding with palpation.- Review of systems: Bilateral Lower Extremity pain, decreased mobility, and anxiety.- Assessment/Plan: Fracture - reporting pain on palpation, adding ultrasound to assess for deep vein thrombosis. Review of Resident #77's physician's order, dated 2/11/26, indicated: - Ultrasound to left lower extremity to rule out deep vein thrombosis. Scheduled 2/11/26 duration 4 days. Review of Resident #77's laboratory and diagnostic studies tab in the electronic health record failed to include documentation to support the facility obtained the ultrasound. During an interview on 2/27/26 at 6:40 A.M., Nurse #3 said that he obtained the order to obtain an ultrasound for Resident #77 left lower extremity, Nurse #3 said he was supposed to call the vendor to order the diagnostic study, but he did not. Nurse #3 reviewed the vendor portal and said that the diagnostic test was not ordered, and he must have forgotten to schedule it. During an interview on 2/27/26 at 7:16 A.M., the Unit Manager said she was unable to locate results from Resident #77's left lower extremity ultrasound and that she would notify the Nurse Practitioner to see if she still wanted the diagnostic test completed. During an interview on 2/27/26 at 10:52 A.M., the Nurse Practitioner (NP) said that Resident #77 was experiencing increased edema and decreased sensation in his/her left lower extremity after a surgical repair. The NP said that Residents who have surgical repairs are at risk for blood clot formation and she wanted Resident #77 to have an ultrasound on the left lower extremity due to his/her symptoms. The NP said that she was not aware that nursing did not obtain the left lower extremity ultrasound until 2/27/26 (16 days after the initial order), and she said she had to reorder the exam. During an interview on 3/3/26 at 9:17 A.M., the Assistant Director of Nursing said that nursing should have ordered and obtained the left lower extremity ultrasound but they did not.