STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225403	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alliance Health at Coleman	112 West Main Street Northborough, MA 01532

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure proper treatment was provided to maintain hearing abilities for two Residents (#4 and #18) out of a total sample of 17 residents, increasing the risk of both Residents for impaired communication abilities.Specifically, the facility failed to:1.Follow-up with Resident #4's Physician relative to the Audiologist's recommendation for ear wax removal, so that the Resident's hearing could be adequately assessed when the Resident exhibited decreased responsiveness.2.Obtain a hearing device for Resident #18 when the Audiologist recommended replacement of the right hearing aid, after the Resident's right hearing aid was lost during a hospitalization. Findings include:1.Resident #4 was admitted to the facility in December 2020 with diagnoses including age-related cognitive decline. Review of Resident #4's Physician orders initiated 12/4/20, indicated: Audiology Consult as needed. Review of the Minimum Data Set (MDS) Assessment, dated 12/22/24, indicated Resident #4: -was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15 total possible points. -had adequate hearing abilities without the use of a hearing device. -was able to understand others. Review of Resident #4's Audiological Services Referral Form, signed and dated by the Physician on 1/4/25, indicated: -The Resident exhibited new signs/symptoms requiring Audiological testing. -The new signs/symptoms included family/staff noticed recent decreased patient responsiveness. Review of Resident #4's Audiology Consult, dated 1/21/25, indicated: -The Resident was referred for evaluation due to family/staff noticing recent decreased patient responsiveness. -The Resident had a medical history for hard of hearing. -Clinical findings indicated hearing loss could not be established bilaterally. -A large amount of wax was removed, and deep wax could not be removed. (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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Unable to complete pure tone testing due to visibly occluded cerumen. -Right ear wax removal needed. -Please contact Physician for wax removal orders. -Plan to re-evaluate patient after wax removal. Review of Resident #4's Nursing Progress Note, dated 1/29/25, indicated: -The Resident was seen by Audiology on 1/21/25. -The Audiologist recommended contacting the Physician for wax removal orders for the Resident's right ears. On 9/3/25 at 8:42 A.M., the surveyor observed Resident #4 sitting in a wheelchair in the hallway, eating breakfast. The surveyor approached the Resident at this time and greeted the Resident whose eyes were open. The Resident did not respond to the surveyor. On 9/3/25 at 9:00 A.M., the surveyor observed a staff member speak to Resident #4 and repetitively ask the Resident if he/she wanted to drink his/her milk. The surveyor observed Resident #4 tell the staff member that he/she could not understand what the staff member was saying. During an interview on 9/4/25 t 3:30 P.M., the Unit Manager (UM) said she reviewed Resident #4's clinical record on 9/4/25 and saw the Audiologist's recommendation for ear wax removal. The UM said that the Audiologist's recommendation had not been followed up on and that orders for ear wax removal had not been obtained. The UM said that facility staff should have obtained orders for ear wax removal the same day of the Audiologist's recommendation in January 2025, so that the Resident's ear wax could be removed and the Resident's hearing could be adequately assessed by the Audiologist. 2. Resident #18 was admitted to the facility in March 2023, with diagnoses including Type 2 diabetes mellitus, hyperlipidemia, and heart failure. Review of Resident #18's active Physician's Orders indicated for the Resident to have an Audiology Consult as needed, initiated 3/9/23. Review of Resident #18's Hearing Deficit Care Plan, initiated 3/20/23 and last revised 6/24/25, indicated the following: -Resident was at risk for impaired communication, social isolation, and injury due to hearing deficit. -Resident was hard of hearing. -Interventions: Resident will use hearing aid, hearing aid will be maintained in working condition, and Resident will be referred to audiology as needed. Review of Resident #18's Audiology Consult Report, dated 2/23/24, indicated the following: (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Reason for referral: Family or staff noticed recent decrease in Resident responsiveness. -Resident had history of noise exposure. -Right ear hearing aid: Resident reported lost in the hospital. -Degree of hearing loss: Severe to profound sensorineural hearing loss of right ear. -Ear impressions were made of Resident's ears. -Recommendations for Attending Physician or nursing staff: Hearing aid is recommended to both ears, and Medical Consult needed to obtain medical clearance for hearing aid. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #18: -was cognitively intact as evidenced by a score of 15 out of a possible 15 on a Brief Interview for Mental Status (BIMS). -had minimal difficulty (difficulty in some environments) with use of hearing aids. -understood verbal content with use of hearing aids. During an interview on 9/3/25 at 9:18 A.M., Resident #18 said he/she lost his/her right hearing aid a was a while ago when he/she was in the hospital. Resident #18 said he/she could hear okay unless the speaker was soft spoken. Resident #18 said he/she had difficulty hearing the surveyor as evidenced by the surveyor's need to repeat words and speak loudly enough for the Resident to hear. Resident #18 said he/she had been waiting to see the Audiologist and the staff were aware that he/she was missing his/her hearing aid. Resident #18 said the staff tell him/her month after month that he/she would see the Audiologist the following month. During an interview on 9/9/25 at 9:34 A.M., Unit Manager (UM) #1 said she was not aware the Resident had lost his/her hearing aid in the hospital. During an interview on 9/9/25 at 12:45 P.M., UM #1 said Resident #18 was last seen by the Audiologist on 2/23/24, and the Audiologist recommended replacement of the right hearing aid, requiring completion of a Medical Consult for medical clearance. UM #1 said the facility did not receive the replacement hearing aid as of 9/9/25, and the facility did not follow-up with the Audiologist's office in an attempt to obtain the replacement hearing aid. During an interview on 9/9/25 at 3:18 P.M., UM #1 said she could not locate evidence that the facility completed the Medical Consult and corresponding form required for Resident #18 to receive his/her replacement hearing aid for the right ear.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide trauma-informed care for one Resident (#33) out of a total sample of 17 residents.Specifically, the facility failed to recognize Resident #33's past history of sexual abuse and identify triggers (psychological stimuli that prompt recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening), placing the Resident at risk for re-traumatization. Findings include:Review of the facility policy titled Trauma Informed Care Program effective 11/21/19 and revised 8/1/25, indicated but was not limited to the following:-Policy:>To provide holistic, culturally sensitive, trauma-informed care in accordance with professional standards to our residents who are trauma survivors.>To account for the resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident and optimize psychosocial well-being.-Purpose: To ensure the delivery of care and services, which meet professional standards and are delivered using approaches while are culturally competent, account for individual experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization.-Procedures:>Residents will be screened for past trauma and for signs/symptoms of traumatic stress upon admission, and as needed.>The interdisciplinary team, in collaboration with the resident and with the approved resident's representative(s), will create a culturally sensitive plan of care to help prevent re-traumatization and to optimize quality of life. Individualized resident triggers will be identified as able.-These care plans shall include the identified trigger(s), prevention, intervention, and treatment services that address traumatic stress. Resident #33 was admitted to the facility in July 2024, with diagnoses including vascular Dementia, major depressive disorder, adjustment disorder with mixed anxiety and depressed mood, Parkinson's Disease (a movement disorder of the nervous system), constipation, and restlessness and agitation. Review of Resident #33's active Physician's orders indicated:-Behavioral Health Consult as needed, initiated 7/12/24.-Monitoring for refusal of care, increased anxiety, distressing delusions, and insomnia every shift, initiated 3/27/25. Review of Resident #33's Comprehensive Care Plan initiated 7/12/24, indicated:-Resident's Behavior Symptoms Care Plan relative to socially inappropriate behavior, initiated 8/26/25 and last revised 8/26/25, indicated the Resident exhibited socially inappropriate behavior, as evidenced by exhibiting public display of affection, and intrusive behavior with a particular companion.-Resident's Behavior Symptoms Care Plan relative to verbal abuse, initiated 7/22/24 and last revised 9/8/25, indicated the Resident exhibited verbally abusive behavior and demanding and accusatory behavior towards staff, as evidenced by becoming increasingly restless and agitated with staff surrounding his/her care needs.Further review of the Comprehensive Care Plan failed to indicate any care plan had been developed for trauma-informed care. Review of Resident #33's Trauma Informed Care assessment dated [DATE], indicated the Resident did not have a traumatic experience that had lasting effects on him/her. Review of Resident #33's Behavioral Health Psychiatric Assessment and Progress Note written by the Psychiatric Nurse Practitioner and dated 8/12/24, indicated:-The Resident was seen for his/her initial assessment performed by the Behavioral Health Psychiatric Nurse Practitioner on 8/12/24.-The Resident had a history of sexual abuse as a child. Review of Resident #33's Minimum Data Set (MDS) assessment dated [DATE], indicated:-Resident was moderately cognitively impaired as evidenced by a score of 8 out of a possible 15 on a Brief Interview for Mental Status (BIMS).-Resident had a presence of verbal behavioral symptoms directed toward others (Examples: Threatening others, screaming at others, cursing at others), occurring four to six days during the assessment period.-Resident had a presence of other behavioral symptoms not directed toward others (Examples: Physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming/disruptive sounds.), occurring four to six days during the assessment (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	period.-Resident felt down, depressed, or hopeless over the last two weeks, for two to six days. During an interview on 9/4/25 at 3:16 P.M., Resident #33 was crying and said he/she was sexually abused as a child. Resident #33 said the (unspecified) Doctor gave him/her advice regarding the history of sexual abuse, and the Resident said that he/she would like to speak with a Therapist regarding the history of sexual abuse. During an interview on 9/9/25 at 12:59 P.M., the Psychiatric Nurse Practitioner said it was important to identify whether a resident had a history of trauma so that the resident could be treated appropriately, including being prescribed medications and implementing behavioral interventions. The Psychiatric Nurse Practitioner said that the expectation was that any Behavioral Health notes would be provided to Resident #33's Physician by the facility for review. The Psychiatric Nurse Practitioner said Resident #33 informed her of the Resident's history of sexual abuse and she believed that the Resident disclosed this history during his/her initial assessment. The Psychiatric Nurse Practitioner said she referred the Resident to therapy for further exploration of this history of sexual abuse. During an interview on 9/9/25 at 12:08 P.M., Social Worker (SW) #1 said it was important to screen a resident for a history of trauma in order to develop a care plan that acknowledged the resident's traumatic experience that occurred in the past because that experience may be affecting the resident to this day. SW #1 said that a resident was screened for a history of trauma upon admission and as needed, such as when there was a change in the resident's behavior, if the resident was voicing something, and when there was a change in the resident's mood. SW #1 said it was important to develop and implement a trauma-informed care plan for a resident with a history of trauma to ensure staff were aware of the resident's triggers and other things that may bother the resident. SW #1 said that she would develop a trauma-informed care plan for a resident even if the resident said the trauma occurred, but it was not affecting the resident at that time, as the trauma could resurface at a later time. SW #1 said she was not aware that Resident #33 had a history of sexual abuse. During an interview on 9/9/25 at 2:45 P.M., Unit Manager (UM) #1 said that Behavioral Health Progress Notes were printed by either UM #1 or the Director of Nursing (DON) and were placed in the Provider's (Physician or Nurse Practitioner's) folder for review. UM #1 said that she would update the facility Social Worker when the Psychiatric Nurse Practitioner wrote in the progress note that the facility Social Worker should be updated. UM #1 said the interdisciplinary team was not notified each time there was a Behavioral Health encounter with Resident #33.

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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, interviews, and record reviews, the facility failed to ensure that two Residents (#35 and #38) out of a total sample of 17 residents were free from physical restraint. Specifically, the facility failed to ensure Resident #35's and #38's wheelchair brakes were not locked when both Residents required the use of a wheelchair for mobility and were attempting to move, resulting in the Resident's freedom of movement or activity being inhibited.Findings include:Review of the facility's policy titled Physical Restraint Policy, undated, indicated the following:-It was the facility's policy that physical restraint would only be utilized when they are required to treat a resident's medical symptoms.-Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. a. Resident #38 was admitted to the facility in January 2025 with diagnoses including Dementia, weakness, and restlessness and agitation. Review of Resident #38's Cognitive Deficit Care Plan, initiated 1/31/25, indicated:-The Resident had Dementia . as evidenced by altered cognition and confusion. -Verbal cues and redirection as needed. Review of Resident #38's Behavior Care Plan, initiated 1/31/25, indicated the Resident exhibited . restlessness and agitation. Review of the Minimum Data Set (MDS) Assessment, dated 7/13/25, indicated Resident #38:-was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of four out of 15 total possible points.-wandered daily.-required the use of a wheelchair. Review of Resident #38's Occupational Therapy (OT) Evaluation, dated 7/21/25, indicated:-was referred for evaluation to assess the Resident's wheelchair positioning and mobility.-One goal was for the Resident to be independent with wheelchair ability in his/her room and on the Unit. Review of Resident #38's OT Treatment Encounter Note, dated 8/22/25, indicated the Resident was able to maneuver his/her wheelchair independently on the Unit with cues for destination. b. Resident #35 was admitted to the facility in February 2025 with diagnoses including Dementia, unsteadiness on feet, restlessness and agitation. Review of Resident #35's Cognitive Deficit Care Pan, initiated 2/11/25, indicated:-The Resident had Dementia . as evidenced by altered cognition and confusion.-Redirection and cueing as needed. Review of Resident #35's Mood State Care Plan, initiated 2/11/25, indicated: [Resident] had an altered mood state or feelings as evidenced by . restlessness and agitation. Review of Resident #35's Communication Care Plan, initiated 2/14/25, indicated:-The Resident had impaired ability to understand language and be understood.-The Resident was unable to make his/her needs known to staff as his/her Dementia continued to progress as anticipated.-Staff to anticipate [Resident's] needs. Review of Resident #35's Physical Therapy (PT) Discharge summary, dated [DATE], indicated:-was able to wheel at least 50 feet and make two turns on level surfaces with supervision or touching assistance while seated in his/her wheelchair.-The Resident's functional status fluctuated due to Dementia. Review of the Resident #35's Minimum Data Set (MDS) Assessment, dated 7/20/25, indicated Resident #35:-was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of one out of 15 total possible points.-required the use of a wheelchair. On 9/4/25 between 8:17 A.M. and 9:03 A.M., the surveyor observed the following in the facility's Small Dining Room during the breakfast meal:-Resident #38 and Resident #35 were both seated in wheelchairs at tables that were positioned in front of the Residents.-Resident #38's and Resident #35's wheelchair brakes were locked.-Resident #38's and Resident #35's wheelchairs were equipped with anti-rollback devices.-Resident #35 used his/her hands to push forcefully against the tabletop repeatedly and grunting while pushing.-Resident #35 looked side to side and said, This is odd, then pushed against and pulled on the table repeatedly.-Resident #38 used his/her feet on the floor, forcefully pushing backward and side to side.-Resident #38 pushed the wheelchair, with his/her brakes locked, approximately 12 inches away (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the table, through forceful pushing (backward and side to side) using his/her feet.-The Assistant Director of Nursing (ADON) approached Resident #38 and said, What's the matter? then the ADON unlocked the Resident's wheelchair brakes.-Resident #38 immediately pushed his/her feet on the floor, moving his/her wheelchair backward.-The ADON was observed saying, We're going to serve breakfast.-Resident #38 was observed saying, that will never happen, and the Resident proceeded to propel the wheelchair forward using his/her feet, toward the Small Dining Room exit.-The ADON was observed saying, Okay, and assisted Resident #38 out of the Small Dining Room.-Breakfast was served to Resident #35 and his/her wheelchair brakes remained locked.-A staff member unlocked Resident #35's wheelchair brakes and assisted the Resident out of the Small Dining Room at 9:03 A.M. On 9/4/25 between 10:52 A.M. and 12:20 P.M., the surveyor observed the following on the Resident Unit:-Resident #38 was seated in a wheelchair next to the railing in the hallway across from the Small Dining Room.-The Resident was facing toward the nurses' station.-Both of the Resident's wheelchair brakes were locked and the anti-rollback device was in place on the wheelchair.-Resident #38 placed his/her right hand on the railing and used his/her feet to push backward and side to side, while pulling on the railing.-Resident #38 then used his/her feet to push backward forcefully and the Resident's front wheelchair wheels lifted slightly off the floor and then back down on the floor.-Resident #38 placed his/her left hand on the large left wheel of the wheelchair, then leaned to the left and looked down toward the wheel while his/her right hand remained on the railing. - Resident #38 continued to intermittently push/pull his/her feet against the floor and use his/her hand to pull on the railing.- The surveyor observed that Resident #38's wheelchair remained in the same place in the hallway.During this observation, the surveyor also observed:- Several staff members pass through the hallway where Resident #38 was seated. - Nurse #2 in the hallway at the medication cart with unobstructed view of Resident #38.- The lunch meal cart was observed on the Unit at 12:10 P.M.-Nurse #2 approached Resident #38 and unlocked the Resident's wheelchair brakes at 12:17 P.M.-Nurse #2 then assisted Resident #38 into the Small Dining Room and locked both of the Resident's wheelchair brakes.- The lunch meal tray pass for the Small Dining Room began at 12:20 P.M. During an interview on 9/4/25 at 2:15 P.M. with the ADON and Director of Nursing (DON), the ADON said she had unlocked Resident #38's wheelchair brakes and assisted the Resident out of the Small Dining Room that morning because the Resident did not want to stay in the Smal Dining Room for breakfast. The ADON said locking resident wheelchair brakes was done for safety so that residents would not fall if they tied to get up and also so that they would not run into each other. During this same interview, the DON said resident wheelchair brakes should not be kept in a locked position because residents should be able to move if they want to. The DON said if a resident's wheelchair brakes were left in a locked position and the resident could not move because the brakes were locked, this would be a restraint. The DON said neither Resident #35 nor Resident #38 should have been left with their wheelchair brakes in the locked position. During an interview on 9/4/25 at 3:09 P.M., Nurse #2 said she locked Resident #38's brakes for the lunch meal that day and tat locking resident brakes at meals was a habit and was done for safety. Nurse #2 said that other than during meals, residents should not have their brakes locked by staff and that residents should be free to move. Nurse #2 said neither Resident #35 nor Resident #38 should have been left with their brakes in the locked position and that both Residents sh9uold have been free to move.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services related to activities of daily living (ADL) care for one Resident (#9), out of a total sample of 17 residents.Specifically, for Resident #9, the facility failed to:1. provide assistance to the Resident with applying his/her dentures when the Resident verbalized the need for his/her dentures before the breakfast meal, resulting in the Resident coughing and vomiting during the meal due to inability to chew his/her food.2. assist/encourage the Resident to use his/her back brace when he/she was out of bed.3. ensure that the Resident's hearing aids were in place every morning as required. Findings include: Resident #9 was admitted to the facility in February 2023 with diagnoses including Spinal Stenosis, Low Back Pain, Memory Deficit, and Conductive Hearing Loss. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #9:-was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. -required assistance from staff for ADL's (basic skills such as bathing, dressing, eating, etc.). Review of Resident #9's September 2025 Physician's orders indicated:-Resident to wear LSO brace (rigid back brace designed to stabilize and support the lower spine) when out of bed. Start date 7/29/25.-Insert bilateral hearing aids in the morning, remove in the evening. Start date 8/18/25. Review of Resident #9's September 2025 Care Plans indicated:1.Vertebral compression, pain management, initiated 5/22/25, interventions included:- -Apply LSO back brace for comfort when out of bed.2. Cognitive Deficits, initiated 2/9/24:-the Resident was alert and oriented.-He/she was his/her own decision maker.-He/she has memory deficit diagnosis and was at risk for further decline in his/her cognitive status.3. Sensory deficit - Hearing deficit- initiated 12/29/24:-Use hearing aid as ordered.4. ADL'S, initiated 3/8/23:-required assistance from one staff member for grooming and dressing. Review of Resident #9's CNA Care Card indicated that the Resident had upper and lower partial dentures. During an interview on 9/3/25 at 7:20 A.M., Resident #9 said the facility staff did not always assist him/her to wear his/her back brace. Resident #9 said he/she was having difficulty hearing without his/her hearing aids. The surveyor observed that the Resident did not have any hearing aids in place and was not wearing a back brace. Resident #9 said he/she has difficulty remembering to perform his/her daily tasks during ADL care. On 9/4/25 at 8:02 A.M., the surveyor observed Certified Nurse Aide (CNA) #1 assist Resident #9, who was seated in a wheelchair, into the dining room for breakfast. The surveyor observed Resident #9 say to CNA #1, Oh I forgot to put my teeth in, and CNA #1 failed to respond to the Resident. The surveyor observed Resident #9 did not have his/her hearing aids in place and back brace on at this time. On 9/4/25 at 8:38 A.M., the surveyor observed Resident #9 coughing and vomiting while seated at the breakfast table. During an interview at the time, Resident #9 said that this occurred because he/she was not wearing his/her dentures. During an interview on 9/4/25 at 8:44 A.M., Nurse #4 said she observed Resident #9 without his/her dentures when the Resident was brought to his/her room after he/she had vomited. Nurse #4 said the CNAs were responsible to ensure Residents had their dentures in after the CNAs provide the Residents with ADL care. Nurse #4 said the Resident should have had his/her dentures in before his/her meal. Nurse #4 further said she only worked two days a week in the facility and was not aware Resident #9 needed his/her hearing aids in the morning. Nurse #4 further said she was not aware Resident #9 needed a back brace when he/she was out of bed. During an interview on 9/4/25 at 904 A.M., the Unit Manager (UM) said the CNAs were expected to perform oral care and provide Residents with their dentures. The UM said Resident #9 should have been provided with his/her dentures, hearing aids and back brace, but was not. During an interview on 9/4/25 at 9:25 A.M., CNA #1 said she was not aware Resident #9 had dentures. CNA #1 said Resident #9 performed his/her own ADL's and she would assist if the Resident asked. CNA #1 said she did not provide Resident #9 with his/her dentures before the breakfast meal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225403	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alliance Health at Coleman	112 West Main Street Northborough, MA 01532

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide appropriate treatment and services related to an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine outside the body) for one Resident (#8), out of 2 applicable residents reviewed for catheter care, out of a total sample of 17 residents.Specifically, for Resident #8, the facility staff failed to obtain Physician orders relative to the Foley (type of indwelling urinary catheter) catheter and balloon size, putting the Resident at risk for indwelling urinary catheter complications. Findings include: Review of the facility policy titled Urinary Catheter Monitoring and Documentation, revised 9/1/16, indicated:-The Charge Nurse will inform the Director of Nursing (DON) and Quality Assurance Department of all residents in the facility who have catheters, any residents who are admitted with catheters and any new orders for catheterization.-The Quality Assurance Department will examine the charts of these residents to make sure it is well documented the catheter is clinically necessary. Review of the facility nursing assessment tool titled, Indwelling Urinary Catheter Screening, dated 8/18/25, indicated:-Order Present (if no order - contact Medical Doctor (MD) to obtain order). Resident #8 was admitted to the facility in August 2025 with diagnoses including retention of urine, BPH with lower urinary tract symptom, obstructive and reflux uropathy, Urinary Tract Infection (UTI), and unspecified Dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #8:-was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. -has an indwelling urinary catheter -was dependent on staff for activities of daily living (ADL's - basic skills such as bathing, dressing, eating, etc.). On 9/3/25 at 7:55 A.M., the surveyor observed Resident #8 lying in bed with a Foley catheter and a urinary drainage bag in a privacy bag in place. Review of Resident #8's September 2025 Physician orders failed to indicate Physician's orders for the appropriate size of the Resident's Foley catheter. Review of Resident #8's September 2025 Care Plan failed to indicate a Foley catheter size or the size of the catheter balloon. Review of the Foley Catheter Assessment completed on 8/18/25, failed to indicate a Foley catheter size or catheter balloon size. On 9/4/25 at 6:49 A.M., the surveyor and Nurse #1 observed Resident #8's Foley catheter. During an interview at the time, Nurse #1 said the Resident's Foley catheter that was in place was size 16 French (Fr) with 10 milliliters (ml) catheter balloon. On 9/4/25 at 7:37 A.M., the surveyor and Nurse #2 reviewed Resident #8's September 2025 Physician's orders. Nurse #2 said there was no order for the size of the Resident's Foley catheter and the size of the catheter balloon. Nurse #2 said the size of the Foley catheter and the size of the catheter balloon was supposed to be part of the Physician's order but was not. During an interview on 9/4/25 at 8:02 A.M., the Unit Manager (UM) said there was no Physician's order for the size of the Foley catheter and the catheter balloon size. The UM said there should have been a Physician's order for the Foley catheter size and the catheter balloon size from the Resident's admission, but there were no Physician orders.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to post on a daily basis the required nurse staffing information that included the actual hours worked by licensed and unlicensed nursing staff for three days.Specifically, the facility failed post the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift that should also reflect any staff absences on that shift due to call-outs and illness. Findings include: The surveyor observed that nurse staffing information was posted in the resident dining area on the following days:-9/3/25-9/4/25-9/5/25 Review of the nursing staffing information posted on 9/3/25, 9/4/25 and 9/5/25 indicated the name of the facility, the date, the census and the number of CNAs and LPN/RN working on each shift. The posted nurse staffing information was observed as follows:-DAY (7:00 A.M. to 3:00 P.M.) RN/LPN 3, CNA 5-EVENING (3:00 P.M. to 11:00 P.M.) RN/LPN 2, CNA 4-NIGHT (11:00 P.M. to 7:00 A.M.) RN/LPN 2, CNA 2Further review of the nurse staffing information postings failed to indicate the actual hours worked by licensed and unlicensed nursing staff. During an interview on 9/5/25 at 12:37 P.M., the Payroll Personnel (PP) responsible for posting the staffing information said she was unaware of any additional information that was needed on the posted nursing staff information. During an interview on 9/5/25 at 2:25 P.M., the Executive Director (ED) said she was unaware of any additional information that was needed on the posted nursing staff information. The ED said the actual working hours were not posted on the daily nurse staffing information. The ED said she would work with the Director of Nursing (DON) to update the nurse staffing posting to include all the necessary information.