STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225435	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colony Center for Health and Rehabilitation	277 Washington Street Abington, MA 02351

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43963 Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose Health Care Agent (HCA, Family Member #1) was very involved in his/her care, the Facility failed to ensure staff promptly notified Family Member #1 of a change in Resident #1's status, when on 04/25/25, he/she fell while working with Occupational Therapy (OT). Findings include: Review of the Facility Policy titled Change in a Resident's Condition or Status, undated, indicated that the Facility promptly notifies the resident, his/her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Resident #1 was admitted to the Facility in April 2025 diagnoses included status-post left below the knee (BKA) amputation, peripheral vascular disease, urinary retention with an indwelling urinary catheter (a tube inserted into the bladder allowing urine to flow out of the body) in place, diabetes mellitus, and depression. Review of Resident #1's Durable Power of Attorney (POA), dated 03/14/25, indicated his/her HCA's (Family Member #1) contact information was listed and available for staff. Review of Resident #1's Consent to Treat Form, dated 04/09/25, indicated he/she requested, and his/her HCA (Family Member #1) signed the form. Review of Resident #1's Side Rail Consent, dated 04/09/25, indicated he/she requested and his/her HCA (Family Member #1) signed the form. Review of Resident #1's Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST), dated 04/10/25, indicated his/her HCA (Family Member #1) signed as his/her legal representative. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 05/13/25 at 11:11 A.M., Family Member #1 (HCA) said Facility staff were well aware of how involved she was with Resident #1's care. Family Member #1 (HCA) said the Facility allowed her to sign a portion of Resident #1's admission paperwork, including the Consent to Treat and his/her MOLST. Family Member #1 (HCA) said that she would visit Resident #1 daily for hours at a time, and was always available. Family Member #1 (HCA) said that no one from the Facility called her on 4/25/25 to inform her of Resident #1's fall, that Resident #1 was the one who informed her. During a telephone interview on 05/14/25 at 1:06 P.M., Resident #1 said he/she refers to his/her HCA (Family Member #1) for everything and would have wanted her to know about the fall. During a telephone interview on 05/19/25 at 12:51 P.M., Nurse #1 said that on 04/25/25, Resident #1 was on her assignment and said she had completed the facility incident report after his/her fall. Nurse #1 said that she was unable to located a phone number for Resident #1's HCA on his/her Face Sheet and asked Resident #1 if there was anyone that he/she wanted her to call following the fall. Nurse #1 said that if Resident #1's HCA information had been on his/her Face Sheet, she would have called to notify them of his/her fall because that is protocol. During an interview on 05/14 at 3:13 P.M., the Director of Nurses (DON) said that he was unaware that Resident #1's HCA was not notified of the incident that had occurred with OT on 04/25/25. The DON said that it is the Facility's expectation that nursing notify a resident's HCA or responsible party with any fall unless the resident is against such notification.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 43963 Based on records reviewed and interviews for one of three sampled residents, (Resident #1), the facility failed to ensure that upon admission, that nursing developed and implemented baseline care plans with interventions, treatments, goals, and outcomes that addressed the residents' overall immediate care needs. Findings include: Review of the Facility Policy titled Baseline Care Plans, dated as last revised 07/26/17, indicated a Baseline Care Plan will be developed and implemented within 48 hours of admission, for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. The Policy indicated that the baseline care plan will include the minimal healthcare information necessary to properly care for a resident including but not limited to; -Initial goals based on admission orders; -Physician Orders; -Dietary Orders; -Therapy Services; -Social Services; and Preadmission Screening and Resident Review (PASRR) recommendations, if applicable. The Policy further indicated that the baseline care plan will be used until the staff can conduct the comprehensive assessment and develop a comprehensive interdisciplinary care plan. Resident #1 was admitted to the Facility in April 2025, diagnoses included status-post left below the knee (BKA) amputation, peripheral vascular disease, urinary retention with an indwelling urinary catheter (a tube inserted into the bladder to allow urine to flow out of the body) in place, diabetes mellitus, and depression. Review of Resident #1's Hospital Discharge Summary, dated 02/04/25, indicated his/her immediate care needs were identified as followed; -New surgical wound to left below the knee amputation site; -Urinary retention with an indwelling catheter in place; -Psychotropic medications in use; (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diabetes Mellitus and impaired skin with nutrition needs; and -Anticoagulation therapy. Review of Resident #1's Medical Record indicated there was no documentation to support that Baseline Care Plans were developed and implemented, or that Comprehensive Care Plans that addressed these areas of concern were in place within 48 hours of his/her admission. Review of Resident #1's Medical Record, indicated that nursing had not initiated, developed, or implemented necessary care plans for his/her surgical wound, indwelling urinary catheter, psychotropic medication use, diabetic needs, and anticoagulation therapy until 04/21/25 (12 days after admission). During an interview on 05/14/25 at 12:13 A.M., Nurse #3 said that the nurse responsible for the resident's admission is expected to begin the Baseline Care Plans for that resident and if unable to complete the baseline care plans at that time, the responsibility would get passed on to the next shift until it is completed. During a telephone interview on 05/19/25 at 12:03 P.M., the Nurse Clinical Manager said that she was not aware that Resident #1's baseline care plans had not been completed within 48 hours and said she was not certain as to who was responsible for completing the resident's baseline care plan. During an interview on 05/14/25 at 3:13 P.M., the Director of Nurses (DON) said that he was not aware that Resident #1's baseline care plans had not been completed upon admission. The DON said that it is the Facility's expectation that all residents have a complete baseline care plan in place within 48 hours after admission that allows the staff to provide care and services that each resident requires.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43963 Based on records reviewed and interviews for one of three sampled residents (Resident # 1), who upon admission required a therapeutic diet in relation to diabetes mellitus, the Facility failed to ensure nursing developed and implemented a comprehensive person-centered care plan with interventions, treatment goals, and outcomes that addressed his/her person-centered nutritional needs. Findings include: Review of the Facility Policy titled Comprehensive Care Plans, dated a last revised 07/2023, indicated that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the residents' medical, nursing, emotional and psychological needs is developed for each resident within seven days of the completion of the resident's comprehensive assessment. The Policy further indicated that identifying problem areas and their causes and developing interventions that are targeted and meaningful to the residents are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making. Resident #1 was admitted to the Facility in April 2025 diagnoses included status-post left below the knee (BKA) amputation, peripheral vascular disease, urinary retention with an indwelling urinary catheter (a tube inserted into the bladder to allow urine to flow out of the body) in place, diabetes mellitus (insulin dependent), and depression. Review of Resident #1's Hospital Discharge Summary, dated 04/09/25, indicated his/her diet, according to the International Dysphagia Diet Standardization Initiative (IDDSI, framework that provides a standardized way to describe food and drink textures for people with swallowing difficulties) was IDDSI Level Six (6, known as a soft bite size with supervision dysphagia diet). Review of Resident #1's Admission Nutritional Evaluation, dated 04/14/25, indicated his/her diet was Low Calorie Sweetener (LCS), two (2) gram (g) sodium (Na), puree (blended or mashed until smooth) textures and nectar (a type of thickened liquid consistency of fruit nectars) liquids while also providing a P.M. diabetic snack. Review of Resident #1's Medical Record from 04/09/25 through 04/30/25, there is no documentation to support a Nutritional Care Plan had been developed and implemented that was person-centered to meet his/her nutritional needs. During a telephone interview on 05/15/25, the Registered Dietician (RD) said that he was not aware Resident #1 did not have a Nutritional Care Plan in place and said he is not always able to get a care plan in for all of the residents. The RD said it was his responsibility as part of the Interdisciplinary Team (IDT) to develop a nutritional care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/25 at 3:13 P.M., the Director of Nurses (DON) said that he was not aware that Resident #1 did not have a Nutritional Care Plan in place. The DON said it is the Facility's expectation that the IDT to work together and ensure all care plans, including nutrition (if needed) are person-center and in place at the time the comprehensive care plan is completed.

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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. 43963 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had been assessed as requiring nutritional interventions for wound care, the Facility failed to ensure nursing staff provided care and services that met professional standards of quality, when recommendations made by the Registered Dietician (RD) for Resident #1, were not followed up on timely by nursing. Findings include: Review of the Policy titled Consultants, undated, indicated the Facility utilizes outside resources to furnish specific services provided by the facility. The Policy further indicated Consultants provide the Administrator with written, dated, and signed reports for each consultation visit. Such reports contain the consultants; -Recommendations; -Plans for implementation of his/her recommendations; -Findings; and -Plans for continued assessment. Resident #1 was admitted to the Facility in April 2025 diagnoses included status-post left below the knee (BKA) amputation, peripheral vascular disease, urinary retention with an indwelling urinary catheter (a tube inserted into the bladder to allow urine to flow out of the body) in place, diabetes mellitus, and depression. Review of Resident #1's Admission Nutritional Evaluation, dated 04/14/25, indicated he/she was admitted with a new surgical wound related to his/her left below the knee amputation (BKA). The Evaluation further indicated that the Registered Dietician (RD) recommended to start a Multivitamin (MVI), add 30 milliliters (ml) of liquid protein, and add yogurt to breakfast. Review of Resident #1's Physician's Orders, dated 04/15/25, indicated to add yogurt daily to his/her breakfast. Review of Resident #1's Wound Monitoring Dietician Note, dated 04/28/25, indicated the RD again recommended to begin a MVI and add 30 ml of liquid protein to support wound healing. Review of Resident #1's Medical Record, from 04/14/25 through 04/30/25, indicated that there was no documentation to support that his/her physician had been notified of the RD recommendations on 04/14/25 or 04/28/25 regarding the addition of a MVI and 30 ml of liquid protein. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 05/19/25 at 12:03 P.M., the Nurse Clinical Manager said she was unaware that RD recommendations had not been communicated to Resident #1's physician. The Nurse Clinical Manager said that the RD (or any consultant) is to electronically mail (e-mail) the Director of Nurses (DON) their recommendations and the DON will then distribute the recommendations to the appropriate staff to review with the resident's physician to obtain orders as appropriate. During a telephone interview on 05/15/25 at 2:48 P.M., the Registered Dietician (RD) said he did not know the recommendations that he made for Resident #1 on 04/14/25 and 04/28/25, had never been followed up on. The RD said that at the end of the day after being in the Facility, he uploads his recommendations into a portal (used to communicate with the Facility), runs a report that includes any recommendations made, and e-mails the report to the DON. The RD said once the DON receives the report, the DON distributes his recommendation to the appropriate staff (dietary/nurse) to review with the resident's physician and obtain a physician order if agreeable. During an interview on 05/14/25 at 3:13 P.M., the DON said he was not aware Resident #1's nutritional recommendations from the RD had never been addressed. The DON said that it is the Facility's expectation that all recommendations from any provider, including nutrition, are to be sent to me by e-mail and then are given to the nurses on the unit attending to the resident and promptly followed up with the resident provider and obtained an order if approved.