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	12/30/2025

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents, (Resident #1), who was readmitted to the Facility after a hospitalization and who required follow up appointments one week post discharge with Cardiology and Gastrointestinal providers, the Facility failed to ensure he/she was provided services that met professional standards of practice when arraignments for the follow-up appointments were not made or scheduled by nursing.Findings Include:Resident #1 was admitted to the Facility in October 2025, diagnoses included gastrointestinal hemorrhage, anemia, atrial fibrillation (irregular heartbeat), hypertension, anoxic brain damage, and seizure disorder. Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated that Resident #1 was hospitalized for Upper Gastrointestinal (GI) Bleed and was noted with a new onset of Atrial Fibrillation with Rapid Ventricular Response (RVR). The Summary further indicated that Resident #1's discharge instructions included the following: - Upper Gastrointestinal (GI) Bleed; follow up with Gastrointestinal within one week-Atrial Fibrillation with RVR; follow up with Cardiology within one weekDuring an interview on 12/29/25 at 1:48 P.M., Family Member #1 said Resident #1 was supposed to have follow-up appointments with a Cardiologist and Gastroenterologist within one week after his/her discharge from the hospital. Family Member #1 said the Facility did not schedule Resident #1's follow-up appointments within a week and said after he/she was discharged from the Facility (after being readmitted for two weeks) the staff at his/her residential home made the appointments for him/her.During an interview on 01/05/26 at 11:40 A.M., the Unit Manager said on 10/22/25 she worked on the dayshift and reviewed Resident #1's Hospital Discharge Summary upon his/her readmission to the Facility. The Unit Manager said she verified Resident #1's orders with the Physician but could not recall seeing the Summary's instructions for follow-up appointments and that she must have missed them.Review of Resident #1's Physician Interim/Telephone Orders, dated 10/24/25, (written by the Nurse Practitioner) indicated to schedule follow-up with Cardiology and Gastrointestinal (GI).During an interview on 01/05/26 at 12:34 P.M., the Nurse Practitioner (NP) said she saw Resident #1 on 10/24/25 for a follow-up hospital readmission (two days after his/her readmission). The NP said that follow up appointments are sometimes scheduled by the hospital but Resident #1's had not been. The NP said on 10/24/25 she wrote an order for Resident #1 to follow up with Cardiology and GI, flagged the order in his/her chart and said she told the nurse (exact name unknown) who was assigned to Resident #1, there were new orders.During an interview on 12/30/25 at 2:41 P.M., Nurse #1 said she worked the 7:00 A.M. to 3:00 P.M. shift on 10/24/25 and was assigned to Resident #1. Nurse #1 said she was not aware and had not seen that Resident #1 had orders for follow-up appointments with Cardiology and GI.Review of Resident #1's medical record indicated there was no documentation to support that follow-up appointments with Cardiology and Gastrointestinal had been scheduled, per his/her Hospital Discharge Summary instructions.During an in-person interview on 12/30/25 at 4:08 P.M. and a telephone interview on 01/07/26 at 11:02 A.M., the Director of Nursing (DON) said she was not aware that Resident #1 was supposed to have follow-up appointments with Cardiology and GI. The DON said she was not sure if Resident #1's follow-up appointments were made, and that she would have to look in the Appointment Book on the unit.The DON reviewed the Appointment Book from the East Unit during the interview and said there were no follow-up appointments scheduled for Resident #1 during his/her readmission.The DON said it is her expectation that nurses fully review residents' hospital discharge summaries, follow the Facility's process and not miss any orders for follow-up appointments.