STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225440	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observations and interviews, the facility failed to ensure Resident protected health information (PHI) was secure and not visible to others on two of three nursing units.Findings include:Review of the facility policy titled Electronic Medical Records dated revised 8/1/23, indicated that the facility will make reasonable efforts to limit the use or disclosure of protected health information to only the minimum necessary to accomplish the intended purpose of the use or disclosure. On 2/4/26 at 5:00 P.M. the surveyor and the Director of Nursing (DON) observed a medication cart to have the computer screen displaying a resident's personal medical information in the hallway. The surveyor and DON also observed other residents in the hallway with access to the information. The surveyor and DON also observed the nurse not to be within eyesight of the computer screen. On 2/5/26 at 2:21 P.M. the surveyor and the DON observed a medication cart to have the computer screen displaying a resident's personal medical information in the hallway. The surveyor and DON also observed other residents in the hallway with access to the information. The surveyor and DON also observed the nurse not to be within eyesight of the computer screen. During an interview on 2/5/26 at 2:21 P.M. the DON said that the computer screen should not be displaying a resident's medical information for other residents and staff to see. During an interview on 2/5/26 at 2:21 P.M. Nurse #3 said that the computer screen should not be displaying a resident's medical information for other residents and staff to see.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to develop and implement a comprehensive person-centered plan of care for six Residents (#61, #15, #71, #74, #51, #105) out of a total sample of 30 residents.Specifically:For Resident #61 the facility failed to float both heels at all times as indicated in the Resident's plan of care.For Resident #15 the facility a). failed to place floor mats on each side of the bed and b). failed to obtain weights as ordered.For Resident #71 the facility failed to develop an activities of daily living (ADLs) care plan.For Resident #74 the facility failed to develop a comprehensive person-centered care plan for a pacemaker.For Resident #51 the facility failed to develop a comprehensive person-centered care plan for a pacemaker.For Resident #105 the facility failed to develop a comprehensive person-centered care plan for a pacemaker. Findings include:Review of the facility policy titled Care Plans, Comprehensive Person-Centered dated revised 8/1/23, indicated that the comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. 1. Resident #61 was admitted to the facility in December 2025 with diagnoses including Parkinson's disease, altered mental status and deep tissue injury of the left heel. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #61 is severely cognitively impaired. Further review indicated that Resident #61 is totally dependent on staff for all activities of daily living. Review of the current care plan indicated a focus of: Actual skin breakdown. Resident has actual skin breakdown - L -heel DTI (deep tissue injury). Further review indicated an intervention of: Pillow to float heels. Review of the physician orders dated February 2025 indicated the following order: use pillow to float heels while in bed and in Geri-chairevery shift for wound care/protection On 2/5/26 at 7:03 A.M., the surveyor observed Resident #61 sitting across from the nurse's station, in a Geri-chair (recliner), with both heels directly on the footrest. On 2/5/26 at 8:13 A.M., the surveyor observed Resident #61 sitting across from the nurse's station, in a Geri-chair, with both heels directly on the footrest. Resident #61 was being fed by staff. On 12/5/26 at 10:05 A.M., and 12:12 P.M., the surveyor observed Resident #61 in the dining room sitting in a Geri-chair with both heels directly on the footrest. During an interview on 2/5/26 at 1:55 P.M., Certified Nurse's Aide (CNA) #3 said that she was responsible for Resident #61's care today. When asked about off-loading Resident #61's heels, she was not able to respond. When asked if the Resident was supposed to have a pillow placed under the calves to float the heels, she was unable to respond. On 2/5/26 1:59 P.M. the surveyor and Nurse #3 observed Resident #61 reclined in a Geri- chair in the hallway without both heels being offloaded. Nurse #3 then said that if the physician orders and or care plan guide the staff to off-load the Resident's heels then they should be off-loaded. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/6/26 at 8:43 A.M. and 9:42 A.M., the surveyor observed Resident #61 reclined in a Geri- chair in the hallway without both heels being offloaded. On 2/9/26 at 8:23 A.M., the surveyor and Nurse #3 observed Resident #61 sitting in a Geri-chair with both feet directly on the floor. During an interview on 2/9/26 at 8:25 A.M, Nurse #3 said that Resident #61 was just fed, and the staff member must have forgotten to float Resident #61's heels. 2a. Resident #15 was admitted to the facility in July 2025 with diagnoses including dementia, bipolar disorder and kidney disease. Review of the Minimum Data Set assessment dated [DATE], indicated Resident #15 is severely cognitively impaired, scoring a 6 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #15 requires assistance with all activities of daily living. Further review indicated Resident #15 has a history of falls. Review of the care plan indicated a focus for falls with an intervention for floor mats on the floor next to the bed. On 2/4/26 at 10:45 A.M. and 2:30 P.M., the surveyor observed Resident #15 in bed with a floor mat on one side of the bed, in between bed A and bed B. On 2/5/26 at 7:08 and 8:49 A.M. the surveyor observed Resident #15 in bed with a floor mat on one side of the bed. On 2/9/25 at 8:20 A.M. the surveyor and Nurse #3 observed Resident #15 in bed with two floor mats leaning against the wall on the far side of the room and no mats on the floor next to the Resident's bed. On 2/9/26 at 8:20 A.M., Nurse #3 said that the mats should be on the floor on both sides of the bed. 2b. Review of the facility policy titled Weight Assessment and Intervention dated revised 8/1/23 indicated that weights are recorded in each unit's weight record chart and in the individual's medical record. Review of the weight record for Resident #15 indicated that the last weight was obtained 10/31/25. Review of the physician's orders dated December 2025 indicated the following order: Monthly weights to be completed on the 10th of every month. Review of the Treatment Administration Record (TAR) dated December 2025 indicated that a weight was obtained on the 8th, 9th and 10th. Review of the TAR Dated January 2026 indicated that a weight was obtained on the 8th, 9th and 10th. Review of the progress notes dated 1/8/26, 1/9/26 and 1/10/26 failed to indicate that Resident #15 refused to be weighed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/5/26 at 9:33 A.M., Nurse #3 said that when a weight is obtained it is put in the weights section of the electronic medical record on the date it was obtained. Nurse #3 then said that there is no separate weight book that weights are alternately entered into on the unit. Nurse #3 also said that if a nurse documents that a weight has been obtained then the weight should be also documented in the medical record. During an interview on 2/9/26 at 10:54 A.M., the Dietician said she reviews weights weekly. The Dietician said that if she can't find a weight, she lets nursing know. The Dietician said that she doesn't know why the Resident hasn't had a weight since October 2025. 3. Resident #71 was admitted to the facility in May 2025 with diagnoses that included cerebral infarction, hemiplegia affecting the right dominant side, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease and muscle weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition. The MDS further indicated that the Resident required supervision or touching assistance for meals. On 2/5/26 at 8:10 A.M., and 8:20 A.M., the surveyor observed Resident #71 eating breakfast alone in his/her room. The privacy curtain was pulled around the Resident's bed, and the Resident was not visible from the hallway. Review of the Resident Kardex (a document that indicates the level of assistance needed for various tasks and activities of daily living) failed to indicate the level of assistance required by Resident #71 for eating. Review of Resident #71's care plan failed to indicate an activity of daily living (ADL) care plan indicating the assistance required for assistance with meals and other ADLs. During an interview on 2/6/26 at 8:19 A.M. Certified Nurse's Aide #2 said they utilize the Kardex (a document that indicates the level of assistance a resident requires for care) that triggers from the care plan to determine the level of assistance a resident requires. During an interview on 2/9/26 at 9:41 A.M., Unit Manager #2 said that everyone should have an ADL care plan so that staff are aware of the level assistance required by a resident. He reviewed Resident #71's medical record and said that he/she did not have a care plan indicating the level of assistance needed for ADLs, but they should have. During an interview on 2/9/2026 at 10:10 A.M., the Director of Nurses said that everyone in the facility should have an ADL care plan in place, which triggers onto the Kardex for staff, indicating the level of assistance required by the resident for various tasks. 4. Review of facility policy titled Pacemaker, Care of a Resident with, dated as updated 8/1/23, indicated the following: -The purpose of this procedure is to provide information about the guidance for the care of a resident with a pacemaker. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Documentation: For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: -a. The name, address, and telephone number of the cardiologist; -b. Type of pacemaker; -c. Type of Leads; -d. Manufacturer and model; -e. Serial number; -f. Date of implant; and -g. Paced rate. -When the resident's pacemaker is monitored by a Physician, document the date and results of the pacemaker surveillance. Resident #74 was admitted to the facility in December 2021 with diagnoses that included syncope and collapse and atrial fibrillation. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 7 out of a possible 15, indicating moderate cognitive impairment. On 2/4/26 at 10:57 A.M., the surveyor observed the Resident in his/her room. There was a pacemaker monitor on the bureau in the room. Review of the physician's progress note, dated 1/15/26, indicated in part: -Afib (atrial fibrillation) s/p (status post) pacemaker. Review of the active care plan failed to indicate a plan of care around the management of a pacemaker Review of Resident #74's active physician's orders failed to indicate monitoring orders for pacemaker. During an interview on 2/9/26 at 8:07 A.M., Nurse #2 said that when a resident has a pacemaker there should be a plan of care in place documenting any information about the pacemaker that is relevant to the resident's care. She said they should know who the cardiologist is and when the next appointment is. During an interview on 2/9/26 at 9:18 A.M., Unit Manager #2 said that residents with pacemakers either follow up in the cardiologist's office, or wirelessly for pacemaker checks. He said that there should be a comprehensive care plan in place indicating the type of pacemaker, the serial number, paced rate and cardiologist. He said the plan of care should also include the type of pacemaker checks the resident has. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/9/26 at 10:07 A.M., the Director of Nurses said that residents with a pacemaker have all pertinent information available in a care plan including the serial number, cardiologist and paced rate. 5. Resident #51 was admitted to the facility in March 2024 with diagnoses that included hypertension and atherosclerotic heart disease. Review of the most recent Minimum Data Set assessment, dated 12/12/25, indicated a Brief Interview for Mental Status score (BIMS) of 11 out of a possible 15, indicating moderate cognitive impairment. On 2/4/26 at 10:49 A.M., the surveyor observed the resident sitting up in a wheelchair in his/her room. There was a cardiac pacemaker monitor at the bedside. Review of 1/26/26 physician's progress note indicated, in part: -Surgical History: pacemaker, coronary stents Surgical History Verified. Review of active resident care plans failed to indicate a plan of care around a pacemaker. Review of physician's orders failed to indicate orders around the pacemaker and the care of the pacemaker. Review of active diagnoses failed to indicate the presence of a pacemaker. Review of the medical record failed to indicate pacemaker information regarding serial # device type or paced rate of the pacemaker. During an interview on 2/9/26 at 8:07 A.M., Nurse #2 said that when a resident has a pacemaker there should be a plan of care in place documenting any information about the pacemaker that is relevant to the resident's care. She said they should know who the cardiologist is and when the next appointment is. During an interview on 2/9/26 at 9:18 A.M., Unit Manager #2 said that residents with pacemakers either follow up in the cardiologist's office, or wirelessly for pacemaker checks. He said that there should be a comprehensive care plan in place indicating the type of pacemaker, the serial number, paced rate and cardiologist. He said the plan of care should also include the type of pacemaker checks the resident has. During an interview on 2/9/26 at 10:07 A.M., the Director of Nurses said that residents with a pacemaker have all pertinent information available in a care plan including the serial number, cardiologist and paced rate. 6. Resident #105 was admitted to the facility in March 2022 with diagnoses including Atrial Fibrillation and presence of a cardiac pacemaker. Resident #105 does not have any Minimum Data Set (MDS) information. A review of Resident #105's February physician's orders indicated the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Pacemaker. Order date 3/4/22. Further review of the Pacemaker care plan indicated the following: -Focus-I have a pacemaker in place r/t (related to) Atrial fibrillation, SSS (Sick, Sinus,Syndrome), hx (history) of syncope. [Sic] Date Initiated: 03/12/2022, Revision on: 04/25/2025. -Goal-I will remain free of complications r/t altered cardiac output through review date. [Sic] Date Initiated: 03/12/2022, Revision on: 01/14/2024, Target Date: 05/07/2026. Interventions/Tasks-Monitor/document/report PRN any s/sx, (signs and symptoms) of altered cardiac output or pacemaker malfunction: dizziness, syncope, difficulty breathing (Dyspnea), pulse rate lower than programmed rate, lower than baseline B/P (blood pressure). [Sic} Date Initiated: 03/12/2022. During an interview and record review on 2/6/26 at 9:03 A.M., Unit Manager #1 reviewed the medical record and said the resident is currently on hospice, and his/her pacemaker is being monitored externally therefore the care plan does not need to be person centered with the pacemaker's serial number. During an interview and record review on 2/9/26 at 8:39 A.M., the Director of Nurses said Resident #105's care plan and physicians orders should include the pacemaker's serial number even if the pacemaker is being monitored externally. The DON said he could not locate the pacemaker's serial number in the medical record; he said this information should have been obtained from the Resident's cardiologist and added to the care plan when the Resident was admitted but wasn't.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, record review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs) for three Residents (#9, #51 and #71) out of a total sample of 30 residents. Specifically:1. For Residents #9, who has a history of difficulty swallowing, the facility failed to provide supervision during meals.2. For Resident #51 the facility failed to provide supervision with meals as indicated in the plan of care.3. for Resident #71 the facility failed to provide supervision with meals as indicated in speech therapy notes. Findings include:1. Resident #9 was admitted to the facility in October 2025 with diagnoses including dysphagia (difficulty swallowing), dementia and heart disease. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #9 is moderately cognitively impaired, scoring a 12 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #9 complained of having difficulty swallowing and is observed to be holding food in his/her mouth/cheeks or residual food in his/her mouth after meals. Review of the care plan indicated a focus for ADL (activities of daily living) with an intervention of supervision while eating, related to a diagnosis of dysphagia. On 2/4/26 at approximately 12:10 P.M., the surveyor observed Resident #9 alone in his/her room, eating lunch. The surveyor also observed that the privacy curtain was partially pulled closed and Resident #9 was not visible from the hallway. The surveyor also observed Resident #9 to be coughing after swallowing. On 2/5/26 at 8:09 A.M., the surveyor observed Resident #9 alone in his/her room, eating breakfast. The surveyor also observed that the privacy curtain was partially pulled closed and Resident #9 was not visible from the hallway. The surveyor also observed Resident #9 to be coughing after swallowing. On 2/9/26 at 8:15 A.M., the surveyor observed Resident #9 alone in his/her room, eating breakfast. The surveyor also observed that the privacy curtain was partially pulled closed and Resident #9 was not visible from the hallway. The surveyor also observed Resident #9 to be coughing after swallowing. During an interview on 2/9/26 at 8:31 A.M., Nurse #3 said that staff should follow the care plan and if the care plan is not accurate then it should be changed. 2. Resident #51 was admitted to the facility in March 2024 with diagnoses that included hypertension and atherosclerotic heart disease. Review of the most recent Minimum Data Set assessment, dated 12/12/25, indicated a Brief Interview for Mental Status score (BIMS) of 11 out of a possible 15, indicating moderate cognitive impairment. The MDS further indicated that the Resident required supervision or touching assistance for meals. On 2/5/26 at 8:18 A.M., the surveyor observed Resident #51 eating alone in his/her room. The privacy curtain was partially pulled, and the Resident was not visible from the hallway. The surveyor entered the room and observed the Resident in bed with the head of the bed elevated to approximately a 45-degree angle. The over bed table was on the right side of the bed, and the Resident was leaning to the right eating from his/her tray that was placed off to the side. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/26 at 8:14 A.M., the surveyor observed the Resident sitting on the side of the bed eating breakfast alone. The curtain was pulled around the Resident, and he/she was not visible from the hallway Review of Resident 51's active activities of daily living (ADL) care plan indicated to assist/supervise resident with meals, dated as revised 8/29/24. Review of Resident #51's Kardex (a document that indicate the level of assistance required to care for the resident) indicated to assist/ supervise resident with meals. During an interview on 2/6/26 at 8:19 A.M., Certified Nurse Aide (CNA) #1 said that the staff utilize the kardex for each resident to determine the level of assistance required and said that staff follow what the kardex says when providing care. During an interview on 2/6/26 at 10:46 A.M., Nurse #2 said that if a resident's care plan says to assist or supervise with meals, then staff should be in the room with the resident. During an interview on 2/6/26 at 11:12 A.M., Unit Manager #2 said that CNAs and nurses should be following what is indicated in the care plan or kardex when providing assistance to residents. 2/6/26 at 10:49 A.M., the Director of Nurses said that if a resident's care plan or kardex indicates supervision or assistance with meals then the resident should not be outside of the line of vision for staff. He further said staff should be following the active care plan and kardex. 3. Resident #71 was admitted to the facility in May 2025 with diagnoses that included cerebral infarction, hemiplegia affecting the right dominant side, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease and muscle weakness. Review of the Minimum Data Set (MDS) assessment, dated 11/21/25 indicated a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition. The MDS further indicated that the Resident required supervision or touching assistance for meals. On 2/5/26 at 8:10 A.M., and 8:20 A.M., the surveyor observed Resident #71 eating breakfast alone in his/her room. The privacy curtain was pulled around the Resident's bed, and the Resident was not visible from the hallway. On 2/6/26 from 8:16 A.M. to 8:23 A.M., the surveyor observed Resident #71 eating breakfast alone in his/her room. The privacy curtain was pulled around the Resident's bed, and the Resident was not visible from the hallway. Review of the Speech Therapy Discharge summary, dated [DATE], indicated the following: -Patient was seen for 6 days for a swallowing evaluation for dysphagia (difficulty swallowing). -Comments: Patient continues to aspirate on thin liquids. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Results of a Modified Barium Swallow Study indicated that the patient continues to aspirate on thin liquids and is judged to be at moderate risk for developing aspiration pneumonia. Patient noted to have inefficient cough reflex with thin liquids. -Discharge status and recommendations: Supervision for oral intake= close supervision. Review of the Resident Kardex (a document that indicates the level of assistance needed for various tasks and activities of daily living) failed to indicate the level of assistance required by Resident #71 for eating. Review of Resident #71's care plan failed to indicate an activity of daily living care plan indicating the assistance required for meals and other ADLs. During an interview on 2/6/26 at 11:12 A.M., Unit Manager #2 said that CNAs and nurses should be providing supervision to the residents who require it. During an interview on 2/6/26 at 10:49 A.M., the Director of Nurses said that if a resident requires supervision with meals, staff should be providing supervision and a resident in their room with the curtain pulled is not being supervised.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for three Residents (#71, #66, and #1) out of sample of 30 residents. Specifically, For Resident #71 the facility failed to obtain orders for suctioning and failed to store suction equipment consistent with professional and infection control standards of practice.For Resident #66 the facility failed to maintain a clean filter on the oxygen concentrator.For Resident #1, the facility failed to provide oxygen as indicated in physician's orders, obtain a physician's order for CPAP (Continuous Positive Airway Pressure), and label and date the CPAP supplies.Findings include: 1. Resident #71 was admitted to the facility in May 2025 with diagnoses that included cerebral infarction, hemiplegia affecting the right dominant side, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease and muscle weakness. Review of the Minimum Data Set (MDS) assessment, dated 11/21/25, indicated a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition. On 2/4/26 at 10:06 A.M., the surveyor observed Resident #71 sleeping in bed. On the bedside table was a suction set up. There was no date on any of the equipment. There was a liquid in the suction canister and a yankauer (a ridged plastic suction catheter used for oral suctioning) catheter was stored in a plastic cup wrapped in a napkin. On 2/05/26 at 8:11 A.M., the surveyor observed a suction set up on the bedside table. There was no date on any of the equipment. There was a liquid in the suction canister and a yankauer suction catheter on the table, with the tip resting on the cover to a plastic bottle. On 2/6/26 at 7:21 A.M., the surveyor observed a suction set up on the bedside table. There was no date on any of the equipment. There was a liquid in the suction canister and a yankauer suction catheter on the table, with the tip resting on the cover to a plastic bottle. On 2/9/26 at 8:15 A.M., the surveyor observed a suction set up on the bedside table. There was no date on any of the equipment. There was a liquid in the suction canister and a yankauer suction catheter on the table, with the tip resting on the cover to a plastic bottle. Review of physician's orders failed to indicate orders around suctioning the Resident or the maintenance of the suction equipment. During an interview on 2/6/26 at 10:36 A.M., Unit Manager #2 said that the staff do not use the suction equipment, but the family does when they help the Resident brush his/her teeth. Unit Manager #2 said there should still be orders for the suctioning and the facility should be maintaining the equipment. He said without maintaining the equipment appropriately there is a potential for bacteria growth within the equipment. He did not know when the equipment was last changed out. During an interview on 2/9/26 at 10:11 A.M., the Director of Nurses said that the storage of Resident #71's suction equipment was not okay. He said there is a risk for bacteria growth when not changed out or stored correctly. The Director of Nurses further said that regardless of who is performing the suctioning procedure there should be physician's orders for suctioning. (continued on next page)

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Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of facility policy titled Oxygen Concentrators, dated as updated 8/1/23, indicated the following: -The facility will maintain oxygen concentrators functioning correctly at all times. -Nursing should ensure concentrator has not visible soilage on it. [sic] -Filters for concentrators need to be cleaned weekly. Resident #66 was admitted to the facility in December 2025 with diagnoses that included COPD (chronic obstructive pulmonary disease) and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/14/26, indicated a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15, indicating that the Resident is cognitively intact. The MDS further indicated that the Resident received continuous oxygen therapy. On 2/4/26 at 11:08 A.M., the surveyor observed the Resident receiving oxygen via nasal cannula from an oxygen concentrator. The filter on the concentrator was covered with a thick layer of dust. On 2/5/26 at 8:16 A.M., the surveyor observed the Resident receiving oxygen via nasal cannula from an oxygen concentrator. The filter on the concentrator was covered with a thick layer of dust. On 2/6/26 at 7:05 A.M., the surveyor observed the Resident receiving oxygen via nasal cannula from an oxygen concentrator. The filter on the concentrator was covered with a thick layer of dust. Review of physician's orders indicated the following: -Administer Oxygen continuously at 2L/LPM via nasal cannula to maintain O2 sats >88%, dated 12/19/25. Review of physician's orders failed to indicate orders for management of or cleaning of the filter in the concentrator. Review of Resident #66's active care plan, dated 12/19/25, indicated the following: -COPD: Resident is at risk for complications due to COPD with interventions that included apply O2 (oxygen) via nasal cannula as needed. During an interview on 2/6/26 at 7:06 A.M., Nurse #2 said that the night shift nurses check the filters for the oxygen concentrators daily. The surveyor and Nurse #2 observed the filter on the concentrator to be covered in a thick layer of dust. Nurse #2 said she is not sure who is responsible for cleaning or changing the filter, but that it should not be covered in a thick layer of dust. During an interview on 2/6/26 at 10:35 A.M., Unit Manager #2 said that he was under the impression that the oxygen company was managing the filters in the oxygen concentrators. He observed the layer of dust on the filter and said it should not be like that. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/6/26 at 10:49 A.M., The Director of Nurses said that oxygen filters should be cleaned and maintained on a weekly basis. He said that there was not a process in place currently to do this. He said that filters covered in a layer of dust places the Resident at risk for not receiving the ordered liter flow of oxygen. 3. Review of the facility policy titled 'Oxygen Administration', updated 8/1/23, indicated the following: -The purpose of this procedure is to provide guidelines for safe oxygen administration. -Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review of the facility policy titled 'CPAP/BiPAP support', updated 8/1/23, indicated the following: -To promote the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen. -CPAP may be appropriate for improving arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea or restrictive/obstructive lung disease. -There are general guidelines for cleaning, specific cleaning instructions are obtained from the manufacturer's guidelines. Resident #1 was admitted to the facility in November 2025 with diagnoses including COPD (Chronic Obstructive Pulmonary Disease) and obstructive sleep apnea. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/4/25, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 indicating intact cognition. Review of Resident #1's February 2026 physician's orders indicated the following: -Administer Oxygen continuously at 3L/LPM (liters per minute) via nasal cannula to maintain O2 (oxygen) sats >88% every shift, dated as an active order from 8/2/25 through 2/6/26. Further review of the physician's failed to indicate an order for the use of CPAP. On 2/4/26 at 11:28 A.M., the Surveyor observed Resident #1 in bed wearing a nasal cannula, his/her oxygen was set at 2 Liters, the CPAP was not labeled or dated. On 2/5/26 at 8:15 A.M., the Surveyor observed Resident #1 in bed wearing a nasal cannula, his/her oxygen was set at 2 Liters, the CPAP was not labeled or dated. During an interview on 2/5/26 at 8:16 A.M., Resident #1 said he/she wears the CPAP every night to help him/her sleep. He/she said he/she cannot sleep without the CPAP. During an interview and observation on 2/6/26 at 7:35 A.M., the Surveyor and Nurse #1 observed the Resident in bed wearing a nasal cannula, the oxygen was set at 2 Liters. Nurse #1 said the oxygen should be set at 3 Liters as indicated in the physician's orders. Nurse #1 observed the CPAP in the Resident's drawer unlabeled and undated. Nurse #1 said the CPAP should have a label with a date on (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it to indicate when it was last cleaned. During an interview and observation on 2/6/26 at 7:37 A.M., the Unit Manager #1 said the Resident's oxygen should be set at 3 Liters per the physician's orders, the Unit manager said the CPAP is not the responsibility of the facility since it belongs to the Resident. The Unit Manager said the Resident's family is responsible for its maintenance. During an interview on 2/6/26 at 8:04 A.M., the Nurse Practitioner said she had just changed the Resident's oxygen orders from 3 Liters to 2 Liters and wrote an order for the use of CPAP since there was not one in place previously. During an interview on 2/9/26 at 8:55 A.M., the Director of Nurses (DON) said CPAP orders should be in place and that the facility is responsible for the CPAP maintenance even though the CPAP belongs to the Resident. The DON said the CPAP should be cleaned per the manufacturer's guidelines, and the CPAP should be labeled and dated so staff can track when it was last cleaned. The DON said oxygen should be provided to the Resident as indicated in physician's orders. The CPAP manufacturers' guidelines were requested during the survey. The guidelines were not provided. 4. Resident #86 was admitted to the facility in March 2024 with diagnoses including chronic obstructive pulmonary disease, obstructive sleep apnea and major depression. Review of the Minimum Data Set assessment, dated 11/14/25, indicated that Resident #86 had moderate cognitive impairment, scoring an 8 out of 15 on the Brief Interview for Mental Status exam. Further review indicated Resident #86 is dependent on staff for most activities of daily living and also receives oxygen therapy. Review of the physician orders dated February 2026 indicated the following order for oxygen: 02 at 2 liters via NC (nasal cannula) on at HS (hour of sleep) and off in AM (morning), two times a day for On at Bedtime and off in AM. On 2/4/26 at 10:20 A.M., the surveyor observed Resident #86 to be sitting in a wheelchair. The surveyor also observed an oxygen concentrator next to the bed with the tubing and nasal cannula, dated 2/2/26, on the floor. The surveyor also observed that there was no container present to store the cannula when not in use to help prevent contamination. On 2/5/26 at 8:24 A.M., the surveyor observed Resident #86 to be sitting in a wheelchair. The surveyor also observed an oxygen concentrator next to the bed with the tubing and nasal cannula, dated 2/2/26, on the floor. The surveyor also observed that there was no container present to store the cannula when not in use to help prevent contamination. Review of the Medication Administration Record (MAR) dated February 2026 indicated that on 2/4/26 and 2/5/26 Resident #86 received oxygen via NC. Further review indicated that the oxygen tubing and cannula was not changed until 2/6/26. During an interview on 2/9/26 at 8:30 A.M. Nurse #3 said that oxygen tubing should be stored in a plastic bag tied to the concentrator for infection control.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, record review and interview, the facility failed to provide care and services consistent with professional standards of practice for one Resident (#85) who required renal dialysis (a life sustaining treatment that helps the body remove extra fluids and waste products from the blood when the kidneys are not able to) out of one applicable Resident. Specifically, the facility failed toObtain orders to monitor and assess the Resident's dialysis access site; and Maintain communication with the dialysis center.Findings include:Review of facility policy, titled End-Stage Renal Disease, Care of a Resident with, dated as updated 8/1/23, indicated the following:-Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care.-Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents.-Education and training of staff includes, specifically: the care of grafts and fistulas.-Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: communication on labs, weights and other potential medical issues between facilities. Best practice is to have a communication binder that staff can review.-The resident's comprehensive care plan will reflect the resident's needs related to ESRD/ dialysis care. 1. Resident #85 was admitted to the facility in May 2025 with diagnoses that included end stage renal disease and dependence on renal dialysis. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 11/7/25, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating that the Resident was cognitively intact. The MDS further indicated that the Resident received dialysis treatment. Review of Resident #85's active physician's orders indicated the following:-Nurse to give resident [his/her] Monday, Wednesday and Friday morning meds to take with him/her to dialysis, dated 5/10/25.-Resident goes to dialysis on Monday, Wednesday and Friday at 10AM. Asks not to be given meds on those days., dated 5/4/25. Review of physician's orders failed to indicate the location and type of dialysis access the Resident has and monitoring orders for the access. Review of the medical record failed to indicate where the Resident goes outside of the facility to receive dialysis. Review of the Resident's care plan for dialysis, dated as created 5/13/25 indicated the following:-DIALYSIS: Resident is at risk for complication due to hemodialysis treatment. -goal: Resident will have positive bruit and thrill x 90 days.-interventions: Provide dialysis communication book as needed and assess resident's dialysis access site for signs of bruit and thrill every shift and notify MD/NP if absent. Review of care plan fails to indicate the location of the dialysis access. Review of progress notes from 9/1/25 through 2/5/26 failed to indicate an assessment of the dialysis site to indicate positive bruit or thrill were present. During an interview on 2/6/26 at 7:26 A.M., Nurse #4 said that Resident #85 has a fistula, but she is not sure what side it is on. She said that nursing should be assessing the fistula for bruit and thrill and that the assessment of the fistula should be documented in the medical record. During an interview on 2/6/26 at 8:06 A.M., Unit Manager #2 said that there should be an order for assessing the dialysis access and documenting the findings in the medical record, but there was not. He said that the medical record did not hold any evidence that assessment of the dialysis site was happening. During an interview on 2/9/26 at 10:16 A.M., the Director of Nurses said that any resident on dialysis should have orders to monitor their dialysis access site in order to intervene on any complications related to the access. 2. On 2/6/25 at 7:35 A.M., the surveyor asked staff if there was a dialysis communication book to review for Resident #85. Unit Manager #2 said there was no communication book. He further said that he has not had any communication with the dialysis facility in regard to Resident #85's dialysis treatment. He said he has not received communication regarding lab results, weights or vital signs. He said the facility has also not communicated with the dialysis facility. During an interview on 2/6/26 7:36 A.M., Nurse #2 said that she cares for Resident #85 and that there is no communication book that goes back and forth between the facility and the dialysis facility. During an interview on 2/9/26 at 10:16 A.M., the Director of Nurses said that all residents on (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dialysis should have a communication book to ensure proper communication with the dialysis center regarding any changes in the plan of care for the resident.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for three Residents (#22, #35 and #71) out of 30 sampled residents, the facility failed to implement Enhanced Barrier Precautions (EBP) as indicated. Specifically,For Resident #22, who has a PICC (Peripherally Inserted Central Catheter) line, the facility did not implement EBP.For Resident #35 who has wounds, the facility did not implement EBP.For Resident #71 who has a gastrostomy tube (a surgically placed tube that delivers nutrition, fluids, or medication directly into the stomach for individuals who cannot eat enough by mouth), the facility did not implement EBP.Findings include:Review of the Centers for Disease Control (CDC) website indicated the following, dated June 28, 2024:-Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). 1. Resident #22 was admitted to the facility in January 2026 with diagnoses that included infection following a procedure and fracture of the upper end of the left humerus. Review of the most recent Minimum Data Set (MDS) Assessment, dated 2/1/26, indicted a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15 indicating moderate cognitive impairment. Review of physician's orders indicated the following:-Meropenem Solution (an antibiotic), 1 gram intravenously every 12 hours for a bacterial infection for 36 days, dated as started 1/16/26.-Change PICC Dressing and document measurement evert shift every Friday. Notify MD NP (Doctor or Nurse Practitioner) with any discrepancies and as needed for soiled/ loose/ missing dressing, dated 1/16/26. On 2/4/26 at 10:30 A.M., the surveyor observed Resident #22 awake in bed. Resident #22 had a PICC line in his/her right arm. There was no signage on the doorway to indicate that the Resident was on Enhanced Barrier Precautions (EBP). There was no Personal Protective Equipment (PPE) readily available for use surrounding the Resident room. On 2/5/26 at 10:00 A.M., the surveyor observed a staff member providing activities of daily living (ADL) care to the Resident. The staff member was wearing gloves but was not utilizing a gown. On 2/6/26 at 9:34 A.M., the surveyor observed a staff member enter Resident #22's room and tell the Resident that she was going to get him/her washed and dressed for the day. The staff member entered the room and applied gloves but did not apply a gown to assist the Resident with ADL care. During an interview on 2/6/26 at 9:44 A.M., Certified Nurse Aide (CNA) #2 said she was familiar with enhanced barrier precautions and only one resident on the unit is on enhanced barrier precautions, who has a foley catheter. She said no one else requires them on the unit. During an interview on 2/6/26 at 10:30 A.M., Unit Manager #2 said that any resident with a urinary catheter requires enhanced barrier precautions. He said there is only one Resident on his unit that requires enhanced barrier precautions. He said Resident #22 has a PICC line and is not on enhanced barrier precautions. During an interview on 2/6/26 at 10:49 A.M. the Director of Nurses said that any resident with open areas or indwelling medical devices such as urinary catheters, PICC lines or gastrostomy tubes, should be on enhanced barrier precautions in order to decrease the risk of spreading infection to these higher risk residents. 2. Resident #35 was admitted to the facility in November 2025 with diagnoses that included altered mental status and reduced mobility. Review of the Minimum Data Set (MDS) assessment, dated 12/9/25, indicated a Brief Interview for Mental Status score of 15 out of a possible 15, indicating that the Resident was cognitively intact. Further review of the MDS indicated that the Resident had one or more unhealed pressure injury. The MDS indicated one unstageable pressure injury presenting as a deep tissue injury that was present on admission. On 2/05/26 at 8:13 A.M., the surveyor observed Resident #35 sleeping in bed. There was no signage on the Resident's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	doorway to indicate the need for EBP, and there was no readily available PPE outside the Resident's room. On 2/6/26 at 9:30 A.M., the surveyor observed two staff members in the room providing ADL care to the resident. Both staff members were wearing only gloves, neither of the staff members were wearing gowns while providing care to the Resident. Review of Resident #35's physician's orders indicated the following:-For R.(right) heel wound, Wash with NS (normal saline), pat dry, xeroform and apply foam dressing till healed, one time a day, dated 12/20/25-2/5/26.-For R. heel wound, Wash with NS, pat dry, gauze soaked in silver gel into wound and cover w/ foam dressing, dated 2/5/26.-NS, pat dry, silver hydrogel, xeroform and foam dressing daily to R butt cheek Stage 3 wound, dated 11/27/25. Review of the most recent weekly skin assessment, dated 2/2/26 indicated the following:-right heel: DTI (deep tissue injury) treatment in place-coccyx: wound treatment in place During an interview on 2/6/26 at 9:44 A.M., Certified Nurse Aide (CNA) #2 said she was familiar with enhanced barrier precautions and only one resident on the unit is on enhanced barrier precautions, who has a foley catheter. She said no one else requires them on the unit. She further said that she had just provided ADL care to Resident #35 and did not utilize enhanced barrier precautions with the use of a gown. During an interview on 2/6/26 at 10:30 A.M., Unit Manager #2 said that any resident with a urinary catheter requires enhanced barrier precautions. He said there is only one Resident on his unit that requires enhanced barrier precautions. He said Resident #35 has wounds and is not on enhanced barrier precautions. During an interview on 2/6/26 at 10:49 A.M. the Director of Nurses said that any resident with open areas or indwelling medical devices such as urinary catheters, PICC lines or gastrostomy tubes, should be on enhanced barrier precautions in order to decrease the risk of spreading infection to these higher risk residents. 3. Resident #71 was admitted to the facility in May 2025 with diagnoses that included cerebral infarction, hemiplegia affecting the right dominant side, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease and muscle weakness. Review of the Minimum Data Set (MDS) assessment, dated 11/21/25 indicated a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition. The MDS further indicated that the Resident utilized a feeding tube. On 2/4/26 at 10:06 A.M., the surveyor observed the Resident sleeping in bed. There was no signage on the Resident's doorway to indicate the need for EBP, and there was no readily available PPE outside the Resident's room. Review of physician's orders indicated the following:-G-tube (gastrostomy) site- wash with NS (normal saline), pat dry, change dressing daily and PRN, dated 7/24/25.-Monitor G tube site for signs and symptoms of infection every shift, dated 5/21/25.During an interview on 2/6/26 at 10:30 A.M., Unit Manager #2 said that any resident with a urinary catheter requires enhanced barrier precautions. He said there is only one Resident on his unit that requires enhanced barrier precautions. He said Resident #71 has a gastrostomy tube and is not on enhanced barrier precautions. During an interview on 2/6/26 at 10:49 A.M. the Director of Nurses said that any resident with open areas or indwelling medical devices such as urinary catheters, PICC lines or gastrostomy tubes, should be on enhanced barrier precautions in order to decrease the risk of spreading infection to these higher risk residents.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review, policy review and interview, the facility failed to provide education regarding vaccine refusals, assess for eligibility, and offer Pneumococcal Vaccinations per the Centers for Disease Control and Prevention (CDC) recommendations for four out of five resident records reviewed. Findings include: Review of four out of five resident immunization records failed to indicate pneumococcal immunizations were offered and/or administered. During an interview on 2/9/26 at 10:35 A.M., the Director of Nursing (DON) said that he could not locate documentation in four out of the five resident's medical records reviewed that the pneumococcal immunization was offered or administered. The DON also said that he could not find any documentation that the residents were educated on the risks and benefits of receiving the vaccine or that the residents refused the vaccine.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews and interviews, the facility failed to ensure two Residents (#2 and #65) out of 30 sampled residents were free from unnecessary psychotropic medications by ensuring a stop date on a PRN (as needed) psychotropic medication. Specifically, for Resident #2 and Resident #65 the facility failed to ensure that as needed orders for Trazodone (an antidepressant medication) had a stop date.Findings include:Review of facility policy titled Psychotropic Medication Use, dated as updated 8/1/23, indicated the following:-Residents will not receive medications that are not clinically indicated to treat a specific condition.-Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications:-b. anti-depressants-13. Psychotropic medications are not prescribed or given on a PRN (as needed) basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record.-a. PRN orders for psychotropic medications are limited to 14 days.-(1) For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond the 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. 1a. Resident #2 was admitted to the facility in November 2025 with diagnoses that included depression and muscle weakness. Review of Resident #2's most recent Minimum Data Set (MDS) assessment, dated 12/24/25 indicated a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15, indicating moderate cognitive impairment. The MDS further indicated the use of antidepressant medications. Review of Resident #2's active physician's orders indicated the following:Trazodone (an antidepressant medication) 50 mg, give 0.5 tablet every 24 hours as needed for insomnia, give at bedtime, dated 11/6/25. Further review of physician's orders failed to indicate a stop date for as needed Trazodone and indicated it had been an active order since 11/6/25. During an interview on 2/9/26 at 9:20 A.M., Unit Manager #2 said that initially the PRN order for Trazodone should have had a 14 day stop date, then could have been extended by the provider, but it should have a stop date, and it does not. During an interview on 2/6/26 at 11:00 A.M., the Director of Nurses said that all as needed psychotropic medications require an initial 14- day stop date and then an evaluation in person by the provider to determine if the medication should be extended, but it would still require a stop date. 1b. Resident #65 was admitted to the facility in February 2022 with diagnoses that included Alzheimer's disease and depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/2/26, indicated a Brief Interview for Mental Status (BIMS) score of 2 out of a possible 15, indicating severe cognitive impairment. Further review of the MDS indicated the use of antidepressant medications. Review of active physician's orders indicated the following:-Trazodone (an antidepressant medication), give 50 mg by mouth every 24 hours as needed for agitation 50mg PO daily as needed for agitation, dated 1/6/26 Review of the January Treatment Administration Record indicated that the Resident received PRN trazodone on the following dates:-1/9, 1/12, 1/21, 1/25, 1/29. Review of nursing progress notes, dated 1/6/26 indicated the following:-Resident is alert and confused. Did not sleep last night once more and refused to stay in room this morning. ADL's (activities of daily living) done and brought to the nursing station where he/she dosed (sic) off throughout the shift. He/She ate breakfast and lunch at 60-70% of each meal. This writer updated NP (Nurse Practitioner) on resident status. New order to increase bedtime Trazodone from 75M and 50mg PO (by mouth) daily as needed for 14 days, melatonin changed to 6 mg PO at bedtime. Will continue to monitor. [sic] Review of the medical record failed to indicate that the 14 day stop date was implemented, and the active order had been in place for 30 days at the time of review by the surveyor. During an interview on 2/9/26 at 9:20 A.M., Unit Manager #2 said that initially the PRN order for Trazodone should have had a 14 day stop date, then could have been extended by the provider, but it should have a stop date, and it does not. During an interview on 2/6/26 at 11:00 A.M., the Director of (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurses said that all as needed psychotropic medications require an initial 14- day stop date and then an evaluation in person by the provider to determine if the medication should be extended, but it would still require a stop date. Refer to 756

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review and interview, the facility failed to ensure the comprehensive care plan was revised by the interdisciplinary team for one Resident (#71) out of a total sample of 30 residents, after each assessment, including the quarterly review assessment. Specifically, the facility failed to review and revise the care plan after a quarterly assessment was completed to reflect the current status of the Resident.Findings include:Resident #71 was admitted to the facility in May 2025 with diagnoses that included cerebral infarction, hemiplegia affecting the right dominant side, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease and muscle weakness. Review of the Minimum Data Set (MDS) assessment, dated 11/21/25 indicated a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition. Review of the Resident's active care plan indicated that the Resident is positive for Covid- 19, dated as 11/7/25. The active care plan indicated the following focus statements:-PRECAUTIONS: Resident on isolation/contact precautions for covid-19.-COVID-19: Resident is at risk for complication due to positive COVID-19 or COVID-19 likely status. On 2/5/26 at 9:47 A.M., the surveyor observed the Resident room. There is no indication that the Resident is on precautions or is positive for Covid-19. Review of a Physician's progress note, dated 11/14/25 indicated the following:-He/she tested positive for COVID-19 on 11-7, he/she was treated and tested negative on 11-12. [sic] During an interview on 2/9/26 at 10:10 A.M., the Director of Nurses said that care plans should be revised and updated with quarterly assessments to reflect the accurate and current status of the residents. The Director of Nurses said the Covid-19 care plans for Resident #71's should have been resolved following the quarterly assessment in November 2025, and upon testing negative for Covid-19.

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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 observations, interviews, and record review, the facility to ensure that services provided met professional standards of practice for three Residents (#15, #61 and #71) out of a total sample of 30 Residents. Specifically,For Resident #15 the facility failed to ensure that monthly weights were obtained as indicated in physician's orders.For Resident #61 the facility failed to ensure that monthly weights were obtained as indicated in physician's orders.For Resident #71 the facility failed to ensure that weekly skin checks were completed as indicated in physician's orders. Findings include: 1. Resident #15 was admitted to the facility in July 2025 with diagnoses including dementia, bipolar disorder and kidney disease. Review of the Minimum Data Set assessment dated [DATE], indicated Resident #15 is severely cognitively impaired, scoring a 6 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #15 requires assistance with all activities of daily living. Review of the weight record for Resident #15 indicated that the last weight was obtained 10/31/25. Review of the physician's orders dated December 2025 indicated the following order: Monthly weights to be completed on the 10th of every month. Review of the Treatment Administration Record (TAR) dated December 2025 indicated that a weight was obtained on the 8th, 9th and 10th. Review of the TAR Dated January 2026 indicated that a weight was obtained on the 8th, 9th and 10th. Review of the progress notes dated 1/8/26, 1/9/26 and 1/10/26 failed to indicate that Resident #15 refused to be weighed. During an interview on 2/9/26 at 10:54 A.M., the Dietician said she reviews weights weekly. The Dietician said that if she can't find a weight, she lets nursing know. The Dietician said that she doesn't know why the Resident hasn't had a weight since October 2025. 2. Resident #61 was admitted to the facility in December 2025 with diagnoses including Parkinson's disease, altered mental status and deep tissue injury of the left heel. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #61 is severely cognitively impaired. Further review indicated that Resident #61 is totally dependent on staff for all activities of daily living. Review of the physician's orders dated January 2026 indicated the following order: Monthly weights to be completed on the 10th of every month. Review of the weight record failed to indicate a weight was obtained in January 2026. Further review indicated that the last weight was obtained 12/17/25. Review of the Treatment Administration Record Dated January 2026 indicated that a weight was obtained on the 8th, 9th and 10th. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes dated 1/8/26, 1/9/26 and 1/10/26 failed to indicate that Resident #61 refused to be weighed. During an interview on 2/5/26 at 9:33 A.M., Nurse #3 said that when a weight is obtained it is put in the weights section of the electronic medical record on the date it was obtained. Nurse #3 then said that there is no separate weight book that weights are alternately entered into on the unit. Nurse #3 also said that if a nurse documents that a weight has been obtained then the weight should be also documented in the medical record. 3. Resident #71 was admitted to the facility in May 2025 with diagnoses that included cerebral infarction, hemiplegia affecting the right dominant side, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease and muscle weakness. Review of the Minimum Data Set (MDS) assessment, dated 11/21/25 indicated a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition. The MDS further indicated that the Resident required supervision or touching assistance for meals. Review of active physician's orders indicated the following: -Weekly skin assessment by licensed staff to be completed every Wednesday on 3-11p shift, dated 5/21/25. Review of the Norton Assessment (an assessment to determine a resident's risk for skin breakdown and the development of pressure ulcers), completed 1/8/26, indicated a risk score of 10, indicating high risk for skin breakdown. Review of the medical record indicated that between 9/30/25 and 1/8/26, no skin assessments were completed. Review of the medical record indicated that the most recent skin assessments were completed on the following dates: -9/30/25, 1/8/26, 1/15/26, 1/25/26, 2/7/26. Review of the medical record indicated that five weekly skin assessments were completed in a 19-week time period. During an interview on 2/9/26 at 8:08 A.M., Nurse #2 said that skin checks are done weekly. She said there are orders to complete it that get signed off, and an assessment in the electronic medical record is also completed with the results of the skin check. During an interview on 2/9/26 at 9:37 A.M., Unit Manager #2 said that skin checks are completed weekly, usually on the 3:00-11:00 P.M. shift or on a resident's shower day. He said that an assessment in the electronic medical record should be completed weekly as indicated in the physician's orders. During an interview on 2/9/26 at 10:15 A.M., The Director of Nurses said that his expectation is that (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weekly skin checks are completed as indicated in the physician's orders and documented in the medical record with the findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure one Resident (#72) with a history of pressure ulcers, and assessed as being at high-risk for the development of pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing, out of a total sample of 30 Residents. Specifically, the facility failed ensure the air mattress turned on while the Resident was in bed.Findings include: Review of the facility policy titled ?Support Surface Guidelines', updated 8/1/23, indicated the following:-The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown.-Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air loss or gel while lying in bed.-Use a pressure ulcer risk scale such as the Braden Scale to help determine need for and appropriate type of pressure relieving devices. Resident #72 was admitted to the facility in July 2023 with diagnoses including Dementia with agitation.Review of the Minimum Data Set (MDS) assessment, dated 1/9/26, did not indicate a Brief Interview Mental Status (BIMS) score because the Resident is rarely/never understood.Review of the [NAME] Skin Assessment (an assessment to determine a resident's risk for the development of pressure ulcers), dated 1/23/26, indicated a score of 8, indicating the Resident is at high risk for the development of pressure ulcers.Review of the February 2026 physician's orders indicated the following:-Monitor air mattress for placement and function, order date 12/10/25.-Apply an air mattress, set proper settings, monitor proper settings adjust accordingly. Report adverse findings of the heel DTI (Deep Tissue Injury) to the MD (Medical Doctor) related to pressure ulcer of right heel, stage 4. Start date 11/6/25.Further review of the wound doctor's progress notes dated 1/14/26 indicated that the stage 4 pressure wound to the right heel had resolved.On 2/4/26 at 10:46 A.M., 11:47 A.M., and 12:21 P.M., the Surveyor observed the Resident in bed, sleeping on an air mattress that was not turned on.On 2/4/26 at 12:44 P.M., the Surveyor observed a Certified Nurse's Aide deliver the Resident's lunch tray, the Resident was in bed, and the air mattress was off. The CNA delivered the lunch tray and left the room.During an observation and interview on 2/4/26 at 12:46 P.M., the Surveyor and Unit Manager #1 observed the Resident in bed on an air mattress that was turned off. The Unit Manager said the air mattress was not on because it was unplugged. The Unit Manager plugged it back in and set the air mattress as ordered per the Resident's weight. The Unit Manager said the Resident's right heel wound had resolved but the air mattress should be turned on for wound prevention purposes. During an interview on 2/9/26 at 8:53 A.M., the Director of Nurses (DON) said physician's orders should be followed at all times. The Director of Nurses said the Resident's air mattress should always be plugged in, and on, while he/she is in bed and set according to his/her weight. The DON said the Resident's heel had resolved and the air mattress is being used for wound prevention purposes because the Resident is at a high risk for developing pressure ulcers.The air mattress manufacturer's guidelines were requested during the survey. The guidelines were not provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to ensure that recommendations made by the Consultant Pharmacist during the Monthly Medication Review (MMR) were addressed for two Residents (#2 and #65) out of a total sample of 30 residents. Specifically, the facility failed to review and implement recommendations from the Consultant Pharmacist in regard to a stop date for as needed (PRN) psychotropic medications. Findings include:Review of facility policy titled Consults: Pharmacy, [named facilities consulting provider], wound MD and other outside consultants, dated as updated 8/1/23, indicated the following: -Residents who have consultants will have recommendations reviewed by attending MD/NP/PA/LIP (physician/ nurse practitioner, physician's assistant, licensed independent practitioner).-Staff will review consultation report and or recommendations with prescriber.-Prescriber will make decision on if recommendations are followed and orders obtained.-Nursing will document new orders and. will order supplies if necessary.-Nursing will document per house protocol. 1a. Resident #2 was admitted to the facility in November 2025 with diagnoses that included depression and muscle weakness. Review of Resident #2's most recent Minimum Data Set (MDS) assessment, dated 12/24/25 indicated a Brief Interview for Mental Status (BIMS) score of 121 out of 15, indicating moderate cognitive impairment. The MDS further indicated the use of antidepressant medications. Review of active physician's orders indicated the following:Trazodone (an antidepressant medication) 50 mg, give 0.5 tablet every 24 hours as needed for insomnia, give at bedtime, dated 11/6/25. Review of Monthly Medication Reviews completed for Resident #2 indicated the following:-A Note to Attending Physician/ Prescriber, dated 11/20/25, that indicated the following: The Resident has an order for a psychoactive PRN (as needed) Trazodone which has been in place without a STOP date recorded. If this medication is continued as a PRN, a stop date or evaluation date must be added to this PRN order.-A Note to Attending Physician/ Prescriber, dated 12/17/25, that indicated the following: The Resident has an order for a psychoactive PRN (as needed) Trazodone which has been in place without a STOP date recorded. If this medication is continued as a PRN, a stop date or evaluation date must be added to this PRN order.-A Note to Attending Physician/ Prescriber dated, 1/23/26, that indicated the following: The Resident has an order for a psychoactive PRN (as needed) Trazodone which has been in place without a STOP date recorded. If this medication is continued as a PRN, a stop date or evaluation date must be added to this PRN order. The Note to Attending Physician/ Prescriber dated 11/20/25 was signed as reviewed by the physician on 12/3/25 and indicated to add a stop date of 12/3/25 and an evaluation date of 12/17/25 for the Trazodone. Review of the Note to Attending Physician/ Prescriber dated 12/17/25 and 1/23/26 failed to indicate it had been reviewed by the physician or prescriber. Review of a Pharmacist progress note, dated 1/22/26, indicated, in part, the following:-MD rec (Medical Doctor recommendation): stop date PRN (as needed) Trazodone Review of the medical record failed to indicate a stop date or evaluation date was added to the PRN Trazodone order and the order had been an active, ongoing order since 11/6/25. During an interview on 2/9/26 at 9:20 A.M., Unit Manager #2 said that monthly pharmacy recommendations get printed out and put into each Unit Manager's mailbox to address. He said sometimes there are nursing recommendations that are addressed immediately and sometimes there are recommendations for physicians. He said that those recommendations are placed in communication books for the physician to review. He said that the physician will sign to agree or disagree with the recommendations and orders will be update by nursing as indicated. He said that pharmacy recommendations should be addressed within 7-10 days. During an interview on 2/6/26 at 11:00 A.M., The Director of Nursing said that the pharmacy brings the recommendations to the facility and nursing notifies the physician of any recommendations which should be addressed as soon as practically able, and it should be documented in the medical record. He said that the most recent recommendations from 1/23/26 should have been addressed by now. 1b. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #65 was admitted to the facility in February 2022 with diagnoses that included Alzheimer's disease and depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/2/26, indicated a Brief Interview for Mental Status (BIMS) score of 2 out of a possible 15, indicating severe cognitive impairment. Further review of the MDS indicated the use of antidepressant medications. Review of active physician's orders indicated the following:-Trazodone (an antidepressant medication), give 50 mg by mouth every 24 hours as needed for agitation 50mg PO daily as needed for agitation, dated 1/6/26. Review of a pharmacist progress note, dated 1/23/26 indicated in part, the following:-MD rec (medical doctor recommendation): stop date PRN (as needed) Trazodone Review of the Summary of Recommendations for DNS (Director of Nursing)/ Medical Director indicated the following recommendation, indicated as created between 1/1/26 and 1/23/26:This resident has an order for a psychoactive PRN (as needed) Trazodone which has been in place without a STOP date recorded. If this medication is continued as a PRN, a stop or evaluation date must be added to the PRN order. Review of the recommendation failed to indicate that it had been reviewed by a physician. Review of the medical record failed to indicate this recommendation had been reviewed with the physician or prescribing provider. During an interview on 2/9/26 at 9:20 A.M., Unit Manager #2 said that monthly pharmacy recommendations get printed out and put into each unit managers mailbox to address. He said sometimes there are nursing recommendations that are addressed immediately and sometimes there are recommendations for physicians. He said that those recommendations are placed in communication books for the physician to review. He said that the physician will sign to agree or disagree with the recommendations and orders will be update by nursing as indicated. He said that pharmacy recommendations should be addressed within 7-10 days. During an interview on 2/6/26 at 11:00 A.M., The Director of Nursing said that the pharmacy brings the recommendations to the facility and nursing notifies the physician of any recommendations which should be addressed as soon as practically able, and it should be documented in the medical record. He said that the most recent recommendations from 1/23/26 should have been addressed by now.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and interviews, the facility failed to ensure that medications were accurately reconciled by nursing for one Resident (#104), out of a total sample of 30 residents, to ensure he/she was free from a significant medication error. Specifically, the facility failed to ensure Cefadroxil (an antibiotic medication) was accurately transcribed in the medical record upon admission to the facility, resulting in the Resident not receiving the complete course of antibiotics. Findings include: Review of facility policy titled Administering Medications dated as updated 8/1/23, indicated the following:-Medications are administered in accordance with prescriber orders, including any required time frame. Resident #104 was admitted to the facility in January 2026 with diagnoses that included fracture of the shaft of the left tibia and encounter for orthopedic aftercare. There is no MDS information available for Resident #104. Review of admission paperwork from the referring acute care hospital indicated the following:-Start cefadroxil 500 mg (milligrams) capsule, 1 capsule by mouth every 12 hours for 7 days. [sic] Review of active physician's orders failed to indicate an order for cefadroxil. Review of completed orders indicated an order for the following:-Cefadroxil 500 mg 1 capsule twice a day for 7 administrations, dated 2/1/26. [sic] Review of the February Medication Administration Record (MAR) indicated that the medication stopped after seven administrations. Review of progress notes since admission failed to indicate that the recommendation was to change the order from seven days (and 14 administrations) to seven administrations. During an interview on 2/5/26 at 2:20 P.M., Unit Manager #2 said that the Resident was admitted after orthopedic surgery and was on antibiotics prophylactically to prevent infection. Unit Manager #2 reviewed the medical record and said that there was no active order for the medication but that it was ordered for seven administrations instead of seven days and had dropped off the administration record at this time. He said he would look into it. During a follow up interview on 2/5/26 at 3:00 P.M., Unit Manager said that the medication was transcribed incorrectly, and a medication error had occurred. During an interview on 2/6/26 at 10:55 A.M., the Director of Nurses said that a medication error had occurred for Resident #104. He further said that a transcription error had occurred on admission. He said that not receiving the full course of antibiotics places the resident at risk of developing a post-operative infection.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview the facility failed to maintain accurate medical records for two Residents (#15 and #61) out of a total sample of 30 residents. Specifically:For Resident #15 the facility documented that weights were obtained when they were not.For Resident #61 the facility documented that weights were obtained when they were not.Findings include: Review of the facility policy titled Charting and Documentation, dated revised 8/1/23, indicated that documentation in the medical record will be objective, complete and accurate. 1. Resident #15 was admitted to the facility in July 2025 with diagnoses including dementia, bipolar disorder and kidney disease. Review of the Minimum Data Set assessment, dated 10/31/25, indicated Resident #15 was severely cognitively impaired, scoring a 6 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #15 requires assistance with all activities of daily living. Review of the weight record for Resident #15 indicated that the last weight was obtained on 10/31/25. Review of the physician's orders dated December 2025 indicated the following order: Monthly weights to be completed on the 10th of every month. Review of the Treatment Administration Record (TAR) dated December 2025 indicated that a weight was obtained on the 8th, 9th and 10th. Review of the TAR Dated January 2026 indicated that a weight was obtained on the 8th, 9th and 10th. Review of the progress notes dated 1/8/26, 1/9/26 and 1/10/26 failed to indicate that a weight was obtained or that Resident #15 refused to be weighed. 2. Resident #61 was admitted to the facility in December 2025 with diagnoses including Parkinson's disease, altered mental status and deep tissue injury of the left heel. Review of the Minimum Data Set assessment, dated 12/5/25, indicated Resident #61 had severe cognitive impairment. Further review indicated that Resident #61 is totally dependent on staff for all activities of daily living. Review of the physician's orders dated January 2026 indicated the following order: Monthly weights to be completed on the 10th of every month. Review of the weight record failed to indicate a weight was obtained in January 2026. Further review indicated that the last weight was obtained 12/17/25. Review of the Treatment Administration Record Dated January 2026 indicated that a weight was obtained on the 8th, 9th and 10th. Review of the progress notes dated 1/8/26, 1/9/26 and 1/10/26 failed to indicate that a weight was obtained or that Resident #61 refused to be weighed. During an interview on 2/5/26 at 9:33 A.M., Nurse #3 said that when a weight is obtained it is put in the weights section of the electronic medical record on the date it was obtained. Nurse #3 then said that there is no separate weight book that weights are alternately entered into on the unit. Nurse #3 also said that if a nurse documents that a weight has been obtained then the weight should be also documented in the medical record. Nurse #3 also said that nurses should not be documenting that a weight was obtained if it was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225440	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview, and record review, the facility failed to ensure the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN: notice issued to a resident when a facility determines the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all his/her Medicare benefit days) were issued with the required information for two out of two applicable residents reviewed. Specifically, the facility failed to issue a complete SNF ABN notice, so the Resident/Resident Representative could decide if they wished to continue receiving skilled services that may not be paid for by Medicare and were aware of the financial responsibility they may have to assume. Findings include: The SNF ABN (CMS-10055) notice is administered to a Medicare recipient when the facility determines that the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all of the Medicare benefit days for that episode. The SNF ABN provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility.Review of two out of two applicable Advance Beneficiary Notices of Non-Coverage failed to indicate the cost of services received while the residents were covered by Medicare part A. During an interview on 2/5/26 at 2:17 P.M., the Social Service Director said that the ABN's were incomplete and should include the cost of the room as well as the cost of therapies that the resident received while on their Medicare part A benefit. During an interview on 2/5/26 at 2:25 P.M., the Director of Nursing said that the ABN's were incomplete and should include the cost of the room as well as the cost of therapies that the resident received while on their Medicare part A benefit.