STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225445	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Affinity Healthcare	1102 Washington Street Braintree, MA 02184

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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 interviews, the facility failed to ensure a person-centered comprehensive care plan was developed and/or implemented for three Residents (#21, #90, and #9), out of a total sample of 25 residents. Specifically, the facility failed:1. For Resident #21, to develop and implement a potential/at risk for skin breakdown care plan and an actual skin alteration care plan for a chronic burn/wound requiring monitoring and wound care;2. For Resident #90, to implement interventions on the Activities of Daily Living (ADL) and Fall care plans specific to transfer and ambulation status; and3. For Resident #9, to develop and implement an individualized resident centered care plan for a known history of insomnia. Findings include: Review of the facility's policy titled Resident Participation-Assessment/Care Plans, dated as last revised 8/2019, indicated but was not limited to the following: -The Care Planning process will include an assessment of the resident's strengths and his/her needs. -A comprehensive care plan will be developed within seven days of completing the resident assessment. -Right to receive the services and/or items in the care plan. 1. Resident #21 was admitted to the facility in September 2025 with diagnoses which included burn of third degree (involves all layers of skin and sometimes muscle/fat under the tissue) of left lower limb and corrosion of third degree of left lower leg (chemical/corrosive substance destroyed all skin layers). Review of the Minimum Data Set (MDS) Assessment, dated 9/15/25, indicated he/she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. Additionally, the MDS indicted he/she had a diagnosis of a third degree burn to the left lower extremity. Review of the Hospital Discharge summary, dated [DATE], indicated but was not limited to the following: -Principal diagnosis: Corrosion of third degree of left lower extremity except ankle and foot. -Procedures: multiple excisions and grafts over several months. -Skin: left inner thigh with healed graft with areas of scabbing and sliver of open area to groin fold, (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mild edema to thigh around graft. -Wound Care: Leave open to air, emphasize importance of showering and not picking wounds. Keep clean, if area opens, then apply small piece of kaltostat (alginate dressing derived from seaweed that forms a gel barrier to promote moist wound healing) with gauze and tape, change every other day, and secure with boxer briefs. All healed/scabbed areas: donor site and left thigh scar tissue apply lotion, showering 1-2 times per week is goal. -Dressing instructions: Cleanse wounds, pat dry, apply lotion, keep open to air, open areas of the wound can be covered with Kaltostat and abdominal pads. Review of the Hospital Discharge summary, dated [DATE], indicated but was not limited to the following: -Reason for hospitalization: leg swelling. -History of present illness: History of third degree burn to left thigh requiring multiple skin grafts presenting with left lower extremity swelling, erythema (redness), and discharge. -Hospital Course: found to have left lower extremity cellulitis (infection of the skin's deep layers causing redness, pain, swelling, and warmth). -Wound Care Instructions: 1. LEFT MEDIAL THIGH: EVERY OTHER DAY: -Cleanse with Vashe (antimicrobial) wound cleanser, [NAME] cream (moisturizer/skin protectant) to peri wound dry skin, one layer of xeroform (petroleum mesh dressing), then 6 x 6 coversite dressing (adhesive/waterproof dressing) times two to cover wound. Change every other day or as needed. Provide dressing product size appropriate to the wound measurement size. 2. LEFT INNER GROIN WOUND: DAILY: -Apply a thick layer of Coloplast Triad Hydrophilic Wound Paste (Order Number: 000035648) (zinc oxide-based paste to promote wound healing, helps naturally loosen dead tissue, protects surrounding skin, and adheres to wet or dry skin, ideal for tough to dress wounds) to open wounds two times daily and as needed (PRN) with skin care. NOTE: clean area gently and leave thin film of Triad paste then add more after gently cleansing. Provide dressing product size appropriate to the wound measurement size. Review of the of the active Physician's Orders indicated there were wound care orders for the Left Medial Thigh and the Left Inner Groin. Review of the Comprehensive Care Plan failed to indicate a care plan for the care and management of the burn/wounds had been developed and implemented. During an interview on 12/10/25 at 9:50 A.M., Nurse #1 said there was not a care plan in place, and she did not know who puts them in or updates them. (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 12/10/25 at 9:57 A.M., Nurse #2 said there should be a care plan in place but there was not, and she didn't know why. She said she doesn't do the care plans normally and she thought the Unit Manager (UM) did them and updated them as needed. During an interview on 12/10/25 at 10:05 A.M., UM #2 said there should be a potential/at risk skin care plan in place and one for the wound but there were not any active skin care plans. She said she wasn't sure how it was missed. Additionally, she said there were a couple resolved care plans, but they were not specific to the burn either. During an interview on 12/10/25 at 11:31 A.M., the Director of Nurses (DON) said there should be a potential for skin breakdown and an actual skin alteration care plan for the burn/wound care in place and there is not. She said they were not in the active care plans, and the history showed a couple of resolved care plans that were skin related, but none were specific to the burn/wound care. 2. Resident #90 was admitted to the facility in June 2025 with diagnoses which include unsteadiness on feet, anoxic brain injury, dementia, and muscle wasting and atrophy. Review of the MDS Assessment, dated 10/21/25, indicated he/she scored 5 out of 15 on the BIMS indicating he/she had severe cognitive impairment. Additionally, Resident #90 was dependent on staff for activities of daily living (ADLs) and ambulated with assistance from staff without a device. Review of the medical record indicated Resident #90 had one fall in June 2025 and two falls in November 2025. Review of the Comprehensive Care Plan indicated but was not limited to the following: ADLs: Resident has an ADL deficit as evidenced by needs assistance. -Transfers: contact guard (CGA-touching) with transfers. (2/13/25) -Mobility: Stand by Assist (SBA) with ambulation. (2/13/25) -Mobility: [NAME] (6/28/22) FALLS: Resident is at risk for injuries related to fall history, decreased mobility, impaired balance, and poor safety awareness. -Staff to supervise Resident #90 when ambulating in the hallway. (11/24/25) -CGA for ambulation when the hallway is crowded. (meals, groups etc.) (11/28/25) Review of the Fall incident Report and Investigations indicated but were not limited to the following: 6/10/25 at 2:40 A.M. -Resident #90 ambulates independently on the unit without assistance. He/she was observed entering the dining room from his/her bedroom with a small amount of blood on their face. He/she can recover from the floor independently. After assessment resident was transferred to the hospital for evaluation, returning with three staples to the laceration. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An intervention related to toileting was added to the care plan. 11/20/25 at 8:30 P.M. -Witnessed fall in hallway. Resident #90 tripped while ambulating independently and fell forward to the floor. He/she said they lost their balance and fell. Small abrasion on right upper forearm. Nurse witnessed the fall and approached him/her after they fell to assess. No other staff member witnessed the fall. -The intervention added to the care plan after the fall was for staff to supervise Resident #90 when ambulating in the hallway. (11/24/25) 11/27/25 at 8:15 A.M. -It was reported Resident #90 was walking through a congested area and was witnessed losing their balance and falling to their right knee. -The intervention added to the care plan was for CGA for ambulation when the hallway is crowded. (meals, groups etc.) (11/28/25) The facility failed to implement the transfer and ambulation interventions on the care plan at the time of each fall. Specifically, Resident #90 should have had CGA with transfers, SBA with ambulation, and a walker in use at the time of the three falls and they did not. During an interview on 12/10/25 at 9:50 A.M., Nurse #1 said it was her first day at the facility and based on the care plan she did not know what Resident #90s ambulation status was or if they used a walker and would have to ask someone who knows the Resident since the care plan had conflicting information. During an interview on 12/10/25 at 9:57 A.M., Nurse #2 said she was not sure who updates the care plans because she has never done it at this facility. During an interview on 12/10/25 at 10:05 A.M., UM #2 said the care plans should be updated after a fall to reflect the most current status. She said CGA is contact guard assistance which means handheld assistance and SBA is stand by assist which means being within arm's length walking with the resident. She said adding supervision doesn't make sense because someone should have been walking next to him/her at the time of the falls and they were not. She said Resident #90 is very impulsive and just gets up, so we are constantly chasing him/her to walk with them. Additionally, she said Resident #90 does not use a walker. During an interview on 12/10/25 at 11:31 A.M., the DON said the care plan should reflect the most current transfer and ambulation status. She said they should be accurate and updated as needed. Additionally, she said adding supervision in the hallway does not make sense because the care plan already indicated SBA which is being right next to the resident but not touching them and Resident #90 does not use a walker and hasn't for a while. She said they were not following the care plan, and it will need to be reviewed. 3. Resident #9 was admitted to the facility in December 2024 with diagnoses which included insomnia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS Assessment, dated 9/6/25, indicated he/she scored 15 out of 15 on the BIMS indicating his/her mental cognition was intact. Review of the PHQ-9 evaluation (patient health questionnaire indicates concerns over a prior two-week period), dated 12/02/25, indicated, but was not limited to, Resident #9 was having trouble falling or staying asleep or sleeping too much; symptom frequency of 7-11 days. Feeling tired or having little energy answer indicated yes with a frequency of 7-11 days over the last two weeks. Review of the medical record failed to indicate a care plan was developed for the Resident's diagnosed insomnia. Review of the active Physician's Orders indicated but was not limited to the following: -diphenhydramine HCL 50mg, one tablet at bedtime for insomnia (8/20/25). -melatonin 3mg, one tablet by mouth at bedtime for insomnia (3/20/25). -mirtazapine 7.5mg tablet at bedtime for insomnia (10/29/25). -document hours of sleep every night shift for monitoring (12/20/24). Further review of the medical record indicated Resident #9 had a previous order for: -zolpidem tartrate tablet 5mg (a hypnotic), one tablet by mouth as needed for difficulty sleeping at bedtime from 8/25/25 to 8/31/25. During an interview on 12/10/25 at 3:37 P.M., Certified Nursing Assistant (CNA) #2 said she does not know what time the Resident goes to sleep, and when she does rounds at night, the Resident is sometimes sleeping. CNA #2 said she is not aware of any sleeping issues the Resident may have because the Resident is independent and they do not offer him/her anything in the evening unless the Resident requests something. During an interview on 12/10/25 at 3:42 P.M., CNA #3 said Resident #9 will comes out of his/her room in the evening between 7:00 P.M. and 8:00 P.M. to ask for a snack before returning to his/her room. CNA #3 said they do not provide any care to the Resident or bother the Resident unless the Resident calls for something, so he is unsure if the Resident sleeps on the 3:00 P.M. to 11:00 P.M. shift. During an interview on 12/10/25 at 5:11 P.M., the surveyor reviewed Resident #9's record with UM #3. UM #3 said Resident #9 did not have a care plan for their insomnia, but they should have a care plan that includes interventions and goals to reduce the impact of insomnia for the Resident. During an interview on 12/10/25 at 5:09 P.M., the Director of Social Services said she would think they would have a care plan for sleep if they had a diagnosis of insomnia, are experiencing symptoms of poor sleep, and Resident #9's PHQ-9 assessment did indicate trouble sleeping most days and feeling tired. The Director of Social Services said we should have identified it as a problem, have goals and interventions. There is not a care plan but there should be one to address his/her sleep disturbances and sleep. During an interview on 12/11/25 at 4:41 P.M., Physician #2 said Resident #9's insomnia is long (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and interview, the facility failed to ensure individualized comprehensive care plans were reviewed and revised to accurately reflect care needs for one Resident (#90), out of a total sample of 25 residents. Specifically, the facility failed to ensure the comprehensive care plan was reviewed and revised after a significant change in October 2025. Findings include:Review of the facility's policy titled Change in a Resident's Condition of Status, undated, indicated but was not limited to the following:-A Significant Change of condition is a major decline or improvement in the resident's status that:a. will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions; b. impacts more than one area of the resident's health status; andc. requires interdisciplinary review to the care plan. Resident #90 was admitted to the facility in June 2025 with diagnoses which include unsteadiness on feet, anoxic brain injury, dementia, and muscle wasting and atrophy. Review of the medical record indicated Resident #90 had a significant change Minimum Dat Set (MDS) Assessment completed on 10/21/25. Review of the nursing progress notes indicated he/she had a significant change due to decline in Activities of Daily Living (ADLs), cognitive status, and increased behaviors. Review of the MDS Assessment, dated 10/21/25, indicated he/she scored 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had severe cognitive impairment. Additionally, Resident #90 was dependent on staff for ADLs and ambulated with assistance from staff without a device. Review of the Comprehensive Care Plan indicated but was not limited to the following:ADLs: Resident has an ADL deficit as evidenced by needs assistance.-Bathing: assist-Dressing: assist-Transfers: contact guard (CGA) with transfers-Eating: independent-Mobility: stand and by assist (SBA) with ambulation. -Toileting: independent; assist with occasional bladder incontinence-Mobility: [NAME] Review of the ADL flow sheets indicated Resident #90 was dependent on staff for ADLs, including bathing, dressing, and toileting. He/she was incontinent of bladder, had variable assistance with transfers and ambulation ranging from independent to minimal assistance, and was supervised with eating. During an interview on 12/10/25 at 11:10 A.M., Certified Nursing Assistant (CNA) #1 said if she does not know a resident's status, she usually asks another aide or the nurse. During an interview on 12/10/25 at 9:50 A.M., Nurse #1 said it was her first day at the facility and she would have to ask someone who knows the Resident because she was unsure of his/her actual status. Additionally, she said she does not know who updates the care plans. During an interview on 12/10/25 at 9:57 A.M., Nurse #2 said she was not sure who updates the care plans because she has never done it at this facility. During an interview on 12/10/25 at 10:05 A.M., Unit Manager (UM) #2 said the care plans should be updated on admission, quarterly, with a significant change, and as needed, like after a fall to reflect the most current status. She said the ADL care plan was not updated after the significant change in October and does not accurately reflect his/her needs. She said Resident #90 requires staff to perform ADLs, cannot toilet themselves, and does not use a walker. During an interview on 12/10/25 at 11:31 A.M., the Director of Nurses (DON) said the care plan should reflect the most current status and it does not. She said they should be accurate and updated on admission, quarterly, with a significant change, and as needed. She said Resident #90 needs staff to provide care, does walk with minimal assistance but does not use a walker and hasn't for a while. The DON said she was unsure why the care plan was not updated and it would need to be reviewed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure one Resident (#21), out of a total sample of 25 residents, received necessary treatment and services to promote healing of an alteration in skin integrity related to a burn of third degree (involves all layers of skin and sometime muscle/fat under the tissue) of left lower limb. Specifically, the facility failed to accurately transcribe and implement wound care orders per the hospital discharge summary and physician's orders for two months. Findings include: Review of the facility's policy titled Medication and Treatment Orders, dated as last revised 4/2018, indicated but was not limited to the following:-Orders for medications and treatments will be consistent with regulatory standards. Review of the Lippincott Manual of Nursing Practice, 11th Edition (2019) indicated: Scope of Practice, Licensure, and Certification: The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. The National Council of State Boards of Nursing and the National League of Nursing have developed standards that guide each State Board in the development of their licensure requirements and scope of practice rules. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated:-Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error.-In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. Resident #21 was admitted to the facility in September 2025 with diagnoses which included burn of third degree of left lower limb and corrosion of third degree of left lower leg (chemical/corrosive substance destroyed all skin layers). Review of the Minimum Data Set (MDS) Assessment, dated 9/15/25, indicated he/she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. Additionally, the MDS indicted he/she had a diagnosis of a third degree burn to the left lower extremity. Review of the Hospital Discharge summary, dated [DATE], indicated but was not limited to the following: -Reason for hospitalization: leg swelling.-History of present illness: History of third degree burn to left thigh requiring multiple skin grafts presenting with left lower extremity swelling, erythema (redness), and discharge. -Hospital Course: found to have left lower extremity cellulitis (infection of the skins deep layers causing redness, pain, swelling, and warmth).-Wound Care Instructions: 1. LEFT MEDIAL THIGH: EVERY OTHER DAY: -Cleanse with Vashe (antimicrobial) wound cleanser, [NAME] cream (moisturizer/skin protectant) to peri wound dry skin, one layer of xeroform (petroleum mesh dressing), then 6 x 6 coversite dressing (adhesive/waterproof dressing) times two to cover wound. Change every other day or as needed. Provide dressing product size appropriate to the wound measurement size. 2. LEFT INNER GROIN WOUND: DAILY: -Apply a thick layer of Coloplast Triad Hydrophilic Wound Paste (Order Number: 000035648) (zinc oxide-based paste to promote wound healing, helps naturally loosen dead tissue, protects surrounding skin, and adheres to wet or dry skin, ideal for tough to dress wounds) to open wounds two times daily and as needed (PRN) with skin care. NOTE: clean area gently and leave thin film of Triad paste then add more after gently cleansing. Provide dressing product size appropriate to the wound measurement size. Review of the of the active Physician's Orders indicated but were not limited to the following: -LEFT MEDIAL THIGH: EVERY OTHER DAY: Cleanse with Vashe wound cleanser, [NAME] cream to peri wound dry skin, one layer of xeroform, then 6 x 6 coversite dressing times two to cover wound. Change every other day or as needed. Provide dressing product size appropriate to the wound measurement size. (10/3/25)-LEFT INNER GROIN WOUND: DAILY: Apply a thick layer of Coloplast Triad Hydrophilic (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wound Paste (Order Number: 000035648) to open wounds two times daily and PRN with skin care. NOTE: clean area gently and leave thin film of Triad paste then add more after gently cleansing. Provide dressing product size appropriate to the wound measurement size. (10/3/25) Review of the Treatment Administration Records (TAR) for October, November, and December 2025 failed to indicate the treatment to the LEFT INNER GROIN WOUND was scheduled twice daily per the physician's order and the treatment was not administered as ordered. The physician's order was only scheduled PRN in the electronic medical record. Review of the Comprehensive Care Plan failed to indicate a care plan for the care and management of the burn/wounds had been developed and implemented. The surveyor was unable to observe wound care as it is done at bedtime when he/she is in bed lying down and Resident #21 declined to have it done during the day. During an interview on 12/10/25 at 9:57 A.M., Nurse #2 said the treatment is done at night and she hadn't seen his/her leg or groin in a while. She said on Admission/readmission she thinks the Unit Manager (UM) enters the physician orders in the computer. She said, in reading the order, the treatment to the groin was supposed to be done twice a day and PRN. She said the twice a day schedule was never added to the order, so it never populated for anyone to do it. She said it only had a PRN schedule. During an interview on 12/10/25 at 10:05 A.M., UM #2 said the order was transcribed wrong when they returned from the hospital. She said the order should have been scheduled twice daily and PRN and it was not. She said the directions are in the order, but they never linked a schedule to it. She said she will have to see what the provider wants to do because it has been a couple months and the treatment was never done. She said the provider is coming in today and she will have him look at the area. During an interview on 12/10/25 at 11:31 A.M., the Director of Nurses (DON) said the order is missing the twice a day schedule. She said the admission/readmission orders should be double checked for accuracy and it was missed. She said the directions are in the body of the order, but they didn't link the schedule to it, so it was never done.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interviews, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Ensure appropriate holding temperatures for time/temperature control for safety (TCS) foods;2. Handle ready-to-eat food (food which does not require cooking or further preparation prior to consumption) to prevent cross contamination; and3. Ensure kitchenettes were maintained in a clean, sanitary, and organized manner, and food was properly stored, labeled, and dated in four of four kitchenettes. Findings include:1. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated, but was not limited to:3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding.(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained:(1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54 C (130 F) or above; or(2) At 5 C (41 F) or less During an observation with interview on 12/9/25 at 7:40 A.M., the surveyor arrived in the kitchen after breakfast tray line began. Items on the tray line included scrambled eggs, pureed eggs, hard boiled eggs, sausage, French toast, and pancakes. Oatmeal and cream of wheat was also observed on the tray line pre-portioned in thermal bowls with lids and stacked in two layers inside a steam pan. The surveyor asked to see the completed temperature log (a monitoring process used to document the temperature of each food item being served) for breakfast. Dietary Staff #1 said he did not obtain food temperatures of the foods that morning and continued to plate food. Dietary Staff #2 said food temperatures should be obtained prior to service to ensure the food is safe to eat. Dietary Staff #2 temped the breakfast foods which were found to be above 135 Fahrenheit (F), with the exception of the oatmeal which was at 135 F, and the cream of wheat at 132 F, which was below the lowest acceptable value for temperature control for safety. On 12/9/25 at 8:37 A.M., the Food Service Director (FSD) said temperatures should be obtained for all food being served to ensure it is cooked and held at temperatures that ensure food safety compliance and Dietary Staff #1 should have obtained food temperatures for breakfast. 2. Review of the 2022 Food Code by the U.S. FDA indicated, but was not limited to: 3-302 Preventing food and ingredient contamination; (A) FOOD shall be protected from cross contamination by: (3) Cleaning equipment and utensils as specified under 4-602.11(A) and sanitizing as specified under S 4-703.11; Review of the facility's policy titled Steps to Prevent Foodborne Illness, undated, indicated but was not limited to:-Cross-contamination is the transfer of harmful bacteria to food from other foods, cutting boards, and utensils and it happens when they are not handled properly. On 12/8/25 at 11:50 A.M., the surveyor observed Dietary Staff #1 temp food on the tray line with a probe thermometer. The surveyor observed Dietary Staff #1 rinse the thermometer under the faucet, wipe the length of the probe with the gloved hand used to turn the faucet on and off, and return to the tray line to temp the next food item. Dietary Staff #1 did not wash or sanitize the probe between food items. On 12/8/25 at 11:50 A.M., the surveyor observed the FSD temp food on the tray line. The surveyor observed the FSD take the temperature of green beans, rinse the thermometer probe under running water, and return to the line to temp the French fries. During an interview on 12/8/25 at 1:15 P.M., the FSD said thermometers should be cleaned with soapy water and appropriate sanitizer between use/food items if no thermometer probe cleaners are available. 3. Review of the 2022 Food Code by the U.S. FDA indicated, but was not limited to: - 3-305.11 (A) Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food (1) in a clean, dry location. - 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a reduced oxygen packaging method as specified (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Affinity Healthcare	1102 Washington Street Braintree, MA 02184

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 Celsius (41 Fahrenheit) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.(B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (C) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request. - 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A food specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3- 501.17(A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A). - 4-602.11 (D) Equipment is used for storage of packaged or unpackaged food such as a reach-in refrigerator and the equipment is cleaned at a frequency necessary to preclude accumulation of soil residues. - 4-602.13 Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. - 6-501.12 (A) Physical facilities shall be cleaned as often as necessary to keep them clean. Review of the facility's policy titled Food Storage, dated 4/29/20, indicated but was not limited to: -Facility uses the Date Marking Policy in conjunction with this Food Storage Policy ensuring ready-to-eat, closed, or opened foods maintain an expiration or Use-By dating system. -Dry storage items will be required to have a date (including month/date/year) in which the product was delivered or a manufacturer's printed Best By/Use By date. -Refrigerated, ready-to-eat, potentially hazardous food opened or prepared shall be clearly marked at the time of preparation to indicate the date of preparation. Ready-to-eat items shall be discarded within 72 hours of the date opened. -Food storage, to include Dry Storage, Refrigerators, Freezers, and Chemical Rooms, shall always be clean and sanitary. On 12/4/25, the surveyor made the following observations in the unit kitchenettes: 10:10 A.M. M1 Unit-one opened Glucerna drink, no label or date;-two tuna salad sandwiches, no label or date;-six packets of Ken's salad dressing, manufacturer's expiration date 8/6/25;-one opened container of applesauce, no label or date; -six boxes of packaged cookies, located in different areas of the kitchenette, no decipherable expiration date indicated. 11:00 A.M. B1 Unit-1 peanut butter and jelly sandwich, no label or date 11:21 A.M. M2 Unit-2 drawers with food packets piled and scattered about: one with mustard, relish, jam, mayonnaise, parmesan cheese, another with jam, peanut butter, barbecue sauce, salad dressing with no dates;-one opened jar of (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	peanut butter, no date;-one opened jar of jelly, refrigerated, no date;-two Tupperware containers, refrigerated, no label or date;-one bag of frozen burritos, open to air, no label or date; -one foil-wrapped item with no label or date. 11:33 A.M. B2 Unit- one disorganized drawer with packages of cookies, cereal, jam with no dates. During an interview on 12/9/25 at 9:00 A.M., Nurse #5 said all food should be labeled and dated in the kitchenettes. If a food item is opened, it should have the date it was opened. If food is brought from outside or made in the kitchen, it should be dated and discarded after three days. During an interview on 12/9/25 at 9:15 A.M., the FSD said dietary staff visit the kitchenettes twice per day to organize, check labels and dates, and restock. Housekeeping cleans the kitchenettes. During an observation with interview on 12/9/25 at 9:00 A.M., the surveyor observed in the M1 Unit kitchenette one drawer with a punctured pack of syrup that dripped down to the drawer below, sealing it shut. The FSD was present and said kitchenettes should be maintained in a clean and sanitary condition with food stored properly which included labeling and dating and discarding food that is beyond the three-day limit, has no label or date, is expired, or the seal is compromised.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure a complete and accurate medical record was maintained for one Resident (#5), out of a total sample of 25 residents. Specifically, the facility failed to ensure the percentage of lunch consumed was accurately documented after the meal was provided and fed to Resident #5 on 17 of 35 days reviewed. Findings include: Review of the facility's policy titled Charting and Documentation, undated, indicated but was not limited to the following:-All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.-Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Resident #5 was admitted to the facility in September 2022 with diagnoses which included protein calorie malnutrition, adult failure to thrive, dysphagia (difficulty swallowing), and Huntington's Disease (HD- fatal genetic disorder causing uncontrolled movements (chorea) and cognitive decline). Review of the Minimum Data Set (MDS) Assessment, dated 11/13/25, indicated he/she was rarely/never understood, was dependent on staff for feeding, and had weight loss. Review of the Comprehensive Care Plan indicated but was not limited to the following:NUTRITION: Risk for Malnutrition related to increased nutrient/energy needs for Huntington's Disease (HD), progressive chorea, and dysphagia as evidenced by a downward trend in weight. Review of the Meal Percentage Record from 11/5/25 through 12/9/25 indicated he/she consumed 75-100% of meals daily. Further review of the Meal Percentage Record indicated on 17 of 35 days the amount consumed for lunch was documented prior to the meal being served. Specifically, the timestamped documentation was completed between 10:30 A.M. and 11:36 A.M., within minutes of the breakfast meal being documented. During an interview on 12/10/25 at 11:10 A.M., Certified Nursing Assistant (CNA) #1 said she did not know why lunch was documented before noon. She said it should be documented after lunch is over and you know how much they ate. She said she usually finishes her documentation between 1:30 P.M. and 2:30 P.M. and that is when she would document the lunch meal percentage. During an interview on 12/10/25 at 9:50 A.M., Nurse #1 said meals should be documented after the meal, but before the end of the shift. During an interview on 12/10/25 at 9:57 A.M., Nurse #2 said the meal percentage should only be documented after the meal is served and you know how much they ate. During an interview on 12/10/25 at 10:05 A.M., Unit Manager #2 said the meal percentage is documented under the task panel. She said the CNAs are supposed to complete the documentation after the meal is served or resident is fed. She said lunch should not be documented prior to 12:30 P.M. She said she can't see who did the inaccurate documentation, but they will have to investigate it because it is a lot of days. She said she is concerned that the inaccurate documentation could be with other residents too and they (CNAs) should not be guessing how much the resident will eat. During an interview on 12/10/25 at 11:31 A.M., the Director of Nurses (DON) said meal percentage should never be documented before the Resident consumes the meal. She said based on the time stamps they are documenting breakfast and lunch at the same time, which would be fine if it were later in the day, but lunch is not served until noon and the amount eaten cannot be documented prior to the resident eating.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interviews, and record review, the facility failed, for one Resident (#9), out of a total sample of 25 residents, to notify the Resident's attending physician of a potential adverse effect from a newly started medication.Findings include: Review of the facility's policy titled Change in a Resident's Condition or Status, last revised 2/2021, indicated but was not limited to:The nurse will notify the Resident's attending physician or physician on call when there has been a (an):-adverse reaction to medicationResident #9 was admitted to the facility in December 2024 with diagnoses which include insomnia.Review of the Minimum Data Set (MDS) assessment, dated 9/6/25, indicated he/she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam indicating his/her mental cognition was intact.During an interview on 12/10/25 at 1:46 P.M., Resident #9 said he/she cannot wake up from night terrors/nightmares that he/she is having since starting the new medication mirtazapine (for insomnia). Review of Resident #9's Physician's Orders indicated but was not limited to:-Mirtazapine Tablet 7.5 milligrams (MG). Give 1 tablet by mouth at bedtime for insomnia and decreased appetite (10/29/25),-Psychiatric services as needed (12/9/24).Review of Resident #9's electronic medication administration record (eMAR) indicated Resident #9 refused mirtazapine on the following dates:-On 11/3/25 at 8:00 P.M., indicated Resident refusal because the medication causes nightmares.Further review of Resident #9's medical record failed to indicate notification of the potential side effects to the physician.During an interview on 12/10/25 at 2:15 P.M., Nurse #4 said she recalls offering Resident #9 the newly prescribed psychotropic medication, mirtazapine 7.5mg. Nurse #4 said she thinks she only documented the side effect and not the notification to the provider and will have to review the chart.During an interview on 12/10/25 at 3:32 P.M., Nurse #4 said she reviewed the medical record for Resident #9 and was unable to find any evidence that she ever notified the Nurse Practitioner (NP) or Physician (MD) of the Resident's refusal. Nurse #4 said she did not document the notification and therefore is unsure if it ever occurred.During an interview on 12/10/25 at 4:41 P.M., Physician #2 said the staff did not make him aware of Resident #9's concerns with night terrors/nightmares while using the medication as a potential side effect.During an interview on 12/11/25 at 7:41 A.M., the Director of Nursing (DON) said she was not aware that the Resident had declined the mirtazapine medication because of a potential side effect of nightmares or night terrors. The DON said the staff should have notified the physician at that time of the potential side effect.

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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. Based on observations, interviews, and record reviews, the facility failed to provide care and services consistent with professional standards for one Resident (#9), out of a total sample of 25 residents. Specifically, the facility failed to ensure psychotropic medication recommendations for Resident #9 were communicated to and addressed by the Attending Physician. Findings include: Review of the facility's policy titled Physician Services, last revised 2/2021, indicated but was not limited to the following:-The attending physician will determine the relevance of any recommended interventions from other disciplines.-Consultive services are made available from community-based consultants.Resident #9 was admitted to the facility in December 2024 with diagnoses which included insomnia, anxiety disorder, personality disorders, depression, post-traumatic stress disorder (PTSD), unspecified psychosis, and adult physical abuse.Review of the Minimum Data Set (MDS) Assessment, dated 9/6/25, indicated he/she scored 15 out of 15 on the Brief Interview for Mental status (BIMS) indicating his/her mental cognition was intact. Review of Resident's orders indicated but was not limited to:-Mirtazapine Tablet 7.5 MG. Give 1 tablet by mouth at bedtime for Insomnia and decrease appetite (10/29/25),-Psychiatric services as needed (12/9/24). Review of Resident #9's electronic medication administration record (eMAR) for November 2025 and December 2025, indicated Resident #9 received mirtazapine medication each evening, as scheduled, except for on two occasions, which the Resident declined the medication.Review of Resident #9's medical record indicated but was not limited to the following:-On 11/5/25 a consultant psychiatric Nurse Practitioner's (NP) note indicated Resident complained that the mirtazapine was causing night terrors and recommendations were provided to hold medication due to reported night terrors.-On 11/5/25 a nurse's note indicated Resident was seen by psychiatric services with no recommendations, physician was notified and no new orders were provided.Further review of Resident #9's medical record failed to indicate recommendations to hold mirtazapine medication were communicated to and addressed by the Resident's Attending Physician.During an interview on 12/10/25 at 10:31 A.M., Unit Manager #3 and the Surveyor reviewed the behavioral health recommendation process. Unit Manager #3 said the behavioral health NP reviews each resident's recommendations and provides those recommendations on paper to him. Unit Manager #3 said once he receives the recommendation he provides those recommendations to the medical provider for approval. Unit Manager #3 said he was unable to find a copy of the recommendation to hold Resident #9's mirtazapine.During an interview on 12/10/25 at 11:30 A.M., NP #1 said the process for recommendations is to write the recommendation on paper and then provide it to the unit manager. NP #1 said recommendations are reviewed together and then the unit manager would follow up with the medical provider for approval. NP #1 said she did not know how the recommendation was missed. NP #1 said the facility should have a written recommendation.During a follow-up interview on 12/10/25 at 5:11 P.M., Unit Manager #3 said when the 24- or 72-hour reports are reviewed by him, he should have seen the NP recommendations in the late entry note the NP documented, to hold the mirtazapine, but it was overlooked.During an interview on 12/10/25 at 4:34 P.M., Physician #1 said he was not aware Resident #9 was having issues with his/her mirtazapine medication and did not receive any update or report on that from the facility since taking over the Resident's care approximately 1-2 weeks ago.During an interview on 12/10/25 at 4:41 P.M., Physician #2 said he was not notified of any recommendations to hold the mirtazapine medication for Resident #9. Physician #2 said there is no evidence of notification of the recommendation in the provider documentation and is unclear why they would not have followed such a recommendation when the goal with this Resident is to control his/her symptoms while reducing polypharmacology. During an interview on 12/11/25 at 7:41 A.M., the Director of Nursing (DON) said the process for any consultant's recommendations is for the consultant to review the recommendations with the unit manager and then those recommendations are provided to the MD/NP for approval. The DON said the recommendation was missed and we need to put something in place to ensure that does not happen again.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and document review, the facility failed to ensure staff stored drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed to ensure treatment carts were locked when not in direct supervision of the licensed nurse on one of four units observed.Findings include:Review of the facility's policy titled Medication Labeling and Storage, dated as revised February 2023, indicated but was not limited to the following:-The facility stores all medications and biologicals in locked compartments. Only authorized personnel have access to keys.-Compartments (including drawers, cabinets, rooms, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.On 12/9/25 at 7:39 A.M., the surveyor observed an unlocked treatment cart positioned in front of the nursing station on the M2 unit. There were no nursing staff in the vicinity of the unlocked cart. One resident was observed in the hallway unaccompanied at the time of the observation.On 12/09/25 at 7:43 A.M., the surveyor observed Nurse #5 walk up to his medication cart and bring it down the hallway and around the corner. The treatment cart remained unlocked and out of the line of sight of Nurse #5.On 12/09/25 at 7:47 A.M., the surveyor observed a staff member walk by the unlocked treatment cart while propelling a resident in a wheelchair.On 12/09/25 at 7:49 A.M., the surveyor observed a staff member stand next to the unlocked treatment cart carrying a bag of soiled linen.On 12/09/25 at 7:50 A.M., the surveyor observed Unit Manager (UM) #3 walk in front of the unlocked treatment cart and continue down the hallway. UM #3 did not lock the treatment cart.During an observation with interview on 12/9/25 at 7:52 A.M., the surveyor observed Staff Development Coordinator (SDC) and UM #3 walk by the unlocked treatment cart. The SDC approached the cart and locked it. The SDC said she locked the cart because it should be locked at all times when unattended. During an interview on 12/10/25 at 1:06 P.M., the Director of Nursing (DON) said her expectation is that the treatment carts are clean, organized and locked on the units. The DON said none of the biological medications stored inside should be available for the residents to have access to. She said the cart should not have been left unlocked and unattended on the unit for any amount of time.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure nurse staffing information which included the current date and actual hours worked per shift for licensed and unlicensed staff including Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nurse Aides (CNA), and the resident census was posted daily as required.Findings include:On 12/3/25 at 8:58 A.M., the surveyor did not observe any nurse staffing posting in the lobby, hallways or nursing units.On 12/4/25 at 9:22 A.M., the surveyor did not observe any nurse staffing posting in the lobby, hallways or nursing units.On 12/8/25 at 8:12 A.M., the surveyor did not observe any nurse staffing posting in the lobby, hallways or nursing units.On 12/9/25 at 9:39 A.M., the surveyor did not observe any nurse staffing posting in the lobby, hallways or nursing units.On 12/10/25 at 8:35 A.M., the surveyor did not observe any nurse staffing posting in the lobby, hallways or nursing units.During an interview on 12/10/25 at 12:01 P.M., the Scheduler said she has been managing the nursing schedule for the facility for the past year. The Scheduler said she completes a nursing schedule daily which includes all nurses and CNAs working for that day. The Scheduler said it is her job to complete and post the daily staffing numbers, but it has been busy, and it must have been overlooked.During an interview on 12/10/25 at 1:10 P.M., the Director of Nursing (DON) said the daily nursing staffing sheet with the resident census should be updated daily and posted in a highly visible area for everyone to see. The DON said it has not been posted in the facility as it should have been.