STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225459	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Nursing Center, LLC	359 Jones Rd Falmouth, MA 02540

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents, (Resident #1), the facility failed to ensure that upon admission, nursing developed and implemented a baseline care plan with interventions, treatments, goals and outcomes that addressed the residents' overall immediate care needs.Findings include:Review of the Facility Policy titled Baseline Care Plans, dated as revised May 2023, indicated that a baseline care plan will be developed for each resident within 48-hours of admission to assure the resident's immediate care needs are met and maintained.The Policy further indicated the baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan. The baseline care plan is updated as needed to meet the residents' needs until the comprehensive care plan is developed.Resident #1 was admitted to the Facility in June 2025, diagnoses included hepatic encephalopathy, severe sepsis with septic shock, alcoholic cirrhosis of liver without ascites, type 2 diabetes mellitus, anemia in chronic kidney disease stage 2, opioid dependence, chronic pain syndrome, hereditary and idiopathic neuropathy, idiopathic gout, obstructive sleep apnea, lumbar region radiculopathy and primary hypertension.Review of Resident #1's Acute Rehabilitation Discharge summary, dated [DATE], indicated his/her immediate care needs were identified as followed;-fall, generalized weakness;-cirrhosis - hepatic encephalopathy;-pneumonia - vs- pulmonary edema;-Group G strep bacteremia;-chronic kidney disease;-chronic anemia;-heart failure;-chronic pain;-obstructive sleep apneaReview of Resident #1's Medical Record indicated there was no documentation to support that Baseline Care Plans were developed and implemented, or that Comprehensive Care Plans that addressed these areas of concern were in place within 48 hours of his/her admission or prior to 09/10/25 (day of survey). During an interview on 09/10/25 at 3:35 P.M., the Unit Manager said that the Minimum Data Set (MDS) Nurse was responsible for creating the Baseline Care Plans for the residents within 48 hours after admission. The Unit Manager said that she was not aware that the baseline care plans for Resident #1 had not been completed.During an interview on 09/10/25 at 4:10 P.M., the Assistant Director of Nurses (ADON) said that the MDS Nurse was responsible for creating the resident's baseline care plans within 48 hours after admission. The ADON said that she was not aware that the baseline care plans for Resident #1 had not been completed.During an interview on 09/10/25 at 4:35 P.M., the Director of Nurses (DON) said that it was her expectation that every resident has a baseline care plan completed within 48 hours after admission and said she was not aware that Resident #1's baseline care plans were not completed.

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
	225459	A. Building B. Wing	09/10/2025

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents, (Resident #1), who was newly admitted to the facility and whose Physician's orders included PRN (as needed) pain medication to manage chronic pain, the Facility failed to ensure that his/her pain was adequately treated and effectively managed.Findings include:Review of the Facility's Policy titled, Pain Management, dated as revised May 2025, indicated the following:-The Facility must ensure that pain management is provided to residents who require such services consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences;-chronic pain refers to pain that typically lasts greater than 3 months and can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation or unknown cause;-opioid use disorder refers to a problematic pattern of opioid use leading to clinically significant impairment or distress;-The Facility will utilize a systematic approach for recognition, assessment, treatment and monitoring of pain;-manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences;Review of the Facility's Policy titled, Controlled Substances Administration and Accountability, dated as revised March 2025, indicated the following:- it is the policy of the facility to promote safe, high quality patient care, compliant with State and Federal regulations regarding monitoring the use of controlled substances;- ordering and receiving controlled substances, the pharmacy maintains the supply of controlled substances in automated dispensing system;Resident #1 was admitted to the Facility in June 2025, diagnoses included hepatic encephalopathy, severe sepsis with septic shock, alcoholic cirrhosis of liver without ascites, type 2 diabetes mellitus, anemia in chronic kidney disease stage 2, opioid dependence, chronic pain syndrome, hereditary and idiopathic neuropathy, idiopathic gout, obstructive sleep apnea, lumbar region radiculopathy and primary hypertension.Review of a Hospital Discharge summary, dated [DATE], indicated that Resident #1 had chronic pain and discharge medications included Oxycodone (opioid analgesic used for moderate to severe pain) IR (immediate release) 10 milligrams (mg) by mouth PRN (as needed) for severe pain (pain score 7 - 10) and further indicated that Resident #1's spouse stated that Resident #1 takes up to 50 mg of Oxycodone a day.Review of the Report submitted via the Health Care Facility Reporting System (HSCFRS), dated 7/03/25, (on behalf of Resident #1) indicated that on 6/29/25, Resident #1 told Family Member #1 that he/she was in terrible pain and that he/she had not received any pain medication. The Report indicated that Family Member #1 asked the nurse when Resident #1's pain medication would be available, and Family Member #1 was told by 2:00 P.M. The Report indicated that Resident #1 told Family Member #1 that he/she did not get his/her pain medication until 4:45 P.M.Review of Resident #1's Physician's Order Summary Report, dated 06/28/25, indicated his/her orders included Oxycodone IR 10 mg tablet by mouth every six hours PRN as needed for severe pain (pain score 7-10) and Acetaminophen tablet 325 mg, give two tablets by mouth every four hours as needed for pain.Review of Resident #1's Clinical Admission, dated 6/28/25, (completed by Nurse #2), indicated he/she had no indicators of pain, the pain level and pain scale were left blank.During an interview on 9/10/25 at 3:05 P.M., Nurse #2 said on the day of admission, Resident #1 was admitted to the facility from the hospital at approximately 4:30 P.M. Nurse #2 said that she sent all of Resident #1's hospital physician's orders to the on-call service provider (Third Eye) for verification. Nurse #2 said that Resident #1 requested pain medication upon arrival to the facility and said she told Resident #1 that the only medication she could give him/her was Acetaminophen. Nurse #2 said that she told Resident #1 that it was not easy to get oxycodone from the pharmacy and it would take some time to get the oxycodone.Nurse #2 said that she called the on-call provider to request that a prescription for oxycodone be faxed to the pharmacy for authorization for her to obtain the oxycodone from the Cubex (emergency medication kit). Nurse #2 said that once she got the authorization to obtain the oxycodone from the Cubex, she gave Resident #1 the oxycodone. Nurse #2 could not recall if she gave Resident #1 any Acetaminophen to Resident #1 prior to the oxycodone. Nurse #2 said that she gave Resident #1 one oxycodone 5 mg tablet and said that was all that was dispensed from the Cubex. Nurse #2 said that the Cubex only dispensed one oxycodone 5 mg tablet and said Resident #1's physician's orders were oxycodone 10 mg tablet. Nurse #2 said she could not explain why she did not notify the on-call provider or pharmacy that only one oxycodone 5 mg tablet was available. Nurse #2 said she could not recall exactly what time she administered the oxycodone to Resident #1 and said it was shortly

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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 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. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews for one of three sampled residents, (Resident #1), the facility failed to ensure they maintained complete and accurate medical record when nursing documentation in Resident #1's Medication Administration Record (MAR) and documentation in the Controlled Substance Register (record/log book used by the facility for maintaining accurate records of narcotics ordered and administered to each resident) related to the administration of Oxycodone conflicted, and therefore making on of them accurate.Findings include:Review of the facility's policy titled, Administering Medication, undated, indicated the following:- medications are administered in a safe and timely manner, as prescribed;-medications administration times are determined by resident need and benefit, not staff convenience;- the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication;-as required for a medication the individual administering the medication records in the resident's medical record: the date and time the medication was administered, the dosage, the rout of administration, any complaints or symptoms for which the drug was administered, any results achieved and when those results were observed and the signature and title of the person administering the drug;Review of the facility's policy titled, Charting and Documentation, dated May 2023, indicated the following:- All services provided to the resident, progress toward the care plan goals or changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record;- medications administered shall be documented in the resident medical record.Review of the facility's policy titled, Control Substance Administration and Accountability, dated as revised March 2025, indicated the following:-all controlled substances are recorded on the designated usage form;-in all cases, the dose noted on the usage form must match the dose recorded on the MAR, Controlled Drug Record, or other facility specified form and placed in the patient's medical record;-the Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration;-the Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source form documenting any patient-specific narcotic dispensed from the pharmacy.Resident #1 was admitted to the Facility in June 2025, diagnoses included hepatic encephalopathy, severe sepsis with septic shock, alcoholic cirrhosis of liver without ascites, type 2 diabetes mellitus, anemia in chronic kidney disease stage 2, opioid dependence, chronic pain syndrome, hereditary and idiopathic neuropathy, idiopathic gout, obstructive sleep apnea, lumbar region radiculopathy and primary hypertension.Review of Resident #1's Physician's Order Summary Report, dated 06/28/25, indicated his/her orders included Oxycodone (opioid analgesic used for moderate to severe pain) 10 milligrams (mg) immediate release (IR) tablet by mouth every six hours PRN (as needed) for severe pain (pain score 7-10) and Acetaminophen tablet 325 mg, give two tablets by mouth every four hours as needed for pain.Review of the MAR, dated 7/01/25, indicated that Resident #1 received Oxycodone IR 10 mg at 2:26 A.M. for pain level of 7. Review of a Controlled Substance Register page specific to Resident #1's medications indicated that on 6/29/25, Resident #1 was administered Oxycodone IR 10 mg at 4:04 A.M., and on 7/01/25 he/she received Oxycodone 10 mg at 4:00 A.M.Review of Resident #1's Medical Record indicated there was no documentation to support that Nurse #2 administered a PRN dose of Oxycodone IR 5 mg to Resident #1 on 6/29/25 at 12:35 A.M. The Record further indicated that on 7/01/25 at 8:00 A.M., Resident #1 requested oxycodone, Nurse informed him/her that oxycodone was last administered at 4:00 A. M. and medication is ordered every six hours as needed and that medication is not due until 10:00 A.M. However, per Resident #1's MAR he/she had received Oxycodone at 2:26 A.M., and therefore could have been administered the medication again, at the time of his/her request. During an interview on 9/10/25 at 3:35 P.M., the Unit Manager said that Nurse #2 did not document in Resident #1's Medical Record the administration of Oxycodone IR 5 mg to him/her on 6/29/25 at 12:36 A.M. and said it was her expectation that nurses document all medications administered to residents in the Medical Record.The Unit Manager said that on 7/01/25, Resident #1 requested Oxycodone IR 10 mg PRN at 8:00 A.M. and said when the nurse looked at Resident #1's Controlled Substance Register page it indicated that Resident #1 had received Oxycodone IR 10 mg at 4:00 A.M. and was not due for Oxycodone until 10:00 A.M. The Unit Manager said that when she reviewed Resident #1's MAR, it indicated that Resident received Oxycodone IR 10 mg at 2:26 A.M. and he/she could have received the medication at 8:26 A.M. not 10:00 A.M., which was why it was necessary for nurses to accurately document administration times of medications within the Medical Record. During an interview on 9/10/25 at 4:35 P.M., the Director of Nurses (DON) said that it is her expectation that