| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225459 | A. Building<br>B. Wing | 12/18/2025 |

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

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observations, interviews, and meal test tray results, the facility failed to serve meals that were palatable and at appetizing temperatures on one (Vineyard Sound) of three units.Using the reasonable person concept, a person would not find the food temperatures palatable and appetizing.Findings include:Review of the facility's Matrix (used to identify pertinent care categories for residents) provided to surveyors by the Director of Nursing on 12/16/25 indicated 36 out of 40 residents residing on the Vineyard Sound Unit had a diagnosis of Alzheimer's disease or dementia. On 12/17/25 at 8:13 A.M., the surveyor made the following observations on the Vineyard Sound Unit:-At 8:13 A.M., the first breakfast truck arrived on the unit.-At 8:23 A.M., the first tray is served to residents in the dining area from the first truck.-At 8:27 A.M., the second truck arrives on the unit.-At 8:33 A.M., the first tray is served to residents in the dining area from the second truck.-Staff continue to serve residents off the first truck.-At 8:54 A.M., the final breakfast tray is removed off the first breakfast truck, 41 minutes after the first meal truck was delivered on the unit.-Staff continue to serve residents from the second truck.-At 9:27 A.M., the final breakfast tray is removed from the second breakfast truck, 60 minutes after the second meal truck was delivered on the unit.-Meals were observed delivered directly to residents and not heated prior to delivery. On 12/18/25 at 8:17 A.M., the surveyor made the following observations on the Vineyard Sound Unit:-At 8:17 A.M., the first breakfast truck arrived on the unit.-At 8:21 A.M., the first tray is served to residents in the dining area from the first truck.-At 8:29 A.M., the second truck arrives on the unit.-Staff continue to serve residents off the first truck.-At 8:33 A.M., the first tray is served to residents in the dining area from the second truck.-At 8:41 A.M., the final breakfast tray is removed off the second breakfast truck, 8 minutes after the second meal truck was delivered on the unit.-Staff continue to serve residents from the first truck.-At 8:49 A.M., the final breakfast tray is removed from the first breakfast truck, 32 minutes after the first meal truck was delivered on the unit.-Meals were observed delivered directly to residents and not heated prior to delivery. On 12/17/25 at 8:55 A.M., a test tray from the first breakfast truck was conducted with Nurse #5 observing and confirming temperatures (in degrees Fahrenheit (F)). The results were as follows:-Scrambled Eggs: 105 F, cold to taste-Ham Slices: 96.3 F, lukewarm to taste-Biscuit: 102.2 F, lukewarm to taste-Oatmeal 120 F, warm to taste in the middle of the bowl but lukewarm on the sides of the bowl-Orange Juice 67.3 F, warm to touch/taste-Milk 59.9 F, warm to touch/tasteDuring an interview on 12/17/25 at 8:59 A.M., Nurse #5 said the eggs were cold, the biscuit was supposed to be hot, and it was not, the oatmeal could have been warmer, and the milk and orange juice could have been colder. On 12/17/25 at 9:28 A.M., a test tray from the second breakfast truck was conducted with Nurse #5 observing and confirming temperatures. The results were as follows:-Ham Slices: 94.8 F, lukewarm to taste-Biscuit: 96.2 F, lukewarm to taste-Orange Juice 63.9 F, warm to touch/taste-Milk 62.9 F, warm to touch/tasteOn 12/17/25 at 9:32 A.M., Nurse #5 said she liked her milk cold and if this was her breakfast tray she would send it back and get a new one. On 12/18/25 at 8:50 A.M., a test tray from the first breakfast truck was conducted with the Food Service Manager (FSM) observing and confirming temperatures. The results were as follows:-Scrambled Eggs: 110 F, lukewarm to taste-Muffin: 100.6 F, not warm to taste-Oatmeal: 118 F, warm to taste in the middle of the bowl but lukewarm on the sides of the bowlDuring an interview<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | on 12/18/25 at 8:53 A.M., the FSM said the eggs, oatmeal, and muffin should be warmer. The FSM said when meal carts come up from the kitchen they should not be sitting for an extended time. The trays should be passed out in 10 minutes. The FSD said his expectation was for food to be served at the appropriate temperatures. During an interview on 12/17/25 at 11:06 A.M., Certified Nursing Assistant #2 said most of the residents on the Vineyard Sound unit eat breakfast in the dining room. She said the 11:00 P.M. to 7:00 A.M. shift had a list of residents to get out of bed and the 7:00 A.M to 3:00 P.M. shift would get the rest of the residents up and bring them to breakfast. During an interview on 12/18/25 at 10:58 A.M., the District Food Service Manager said the expectation was for meal trays to be passed in a timely manner and foods should be served at appropriate temperatures. During an interview on 12/18/25 at 11:46 A.M., Unit Manager #3 said most residents on the Vineyard Sound Unit eat in the dining room. She said housekeeping goes in first thing in the morning and vacuums the dining room floor. She said then the staff start to bring residents into the floor dining room as they are getting up and they get their meal trays as soon as they come to the dining room. She said food should be served at appropriate temperatures. During an interview on 12/18/25 at 12:01 P.M., the Director of Nursing and the Administrator said mealtimes are posted and the expectation would be for residents to be in the dining room and for staff members to be ready to help pass out meal trays. They said food should be served at appetizing temperatures. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards for one Resident (#4), out of a total sample of 20 residents. Specifically, the facility failed to implement physician's orders for air mattress settings. Findings include:Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following:-The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice.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 prescribers 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.Review of the facility's policy titled Medication and Treatment Orders, dated 2/2024, indicated, but was not limited to, the following:-Orders for medications and treatments will be consistent with principles of safe and effective order writing.Resident #4 was admitted to the facility in September 2009 with diagnoses including dementia.Review of Resident #4's Minimum Data Set (MDS) assessment, dated 11/14/25, indicated the Resident was cognitively impaired, as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Further review of the MDS assessment indicated the Resident had one stage 3 pressure ulcer, not present on admission, and had a pressure reducing device for his/her bed.Review of Resident #4's Physician's Orders indicated, but was not limited to, the following:-Air Mattress - Pressure set per resident's most recent weight; +/- 10 lbs. Document weight. Check placement and function every shift. (order date 12/4/25)Review of Resident #4's medical record indicated that he/she weighed 162.5 pounds on 12/2/25.During the course of the survey, the surveyor made the following observations:-On 12/16/25 at 3:03 P.M., Resident #4 was lying in bed, and his/her air mattress was on and set to 72 kilograms (or 158.7 pounds).-On 12/17/25 at 8:08 A.M., Resident #4 was lying in bed, and his/her air mattress was on and set to 143 kilograms (or 315.3 pounds).-On 12/17/25 at 1:47 P.M., Resident #4 was lying in bed, and his/her air mattress was on and set to 143 kilograms (or 315.3 pounds).-On 12/18/25 at 7:47 A.M., Resident #4 was lying in bed, and his/her air mattress was on and set to 143 kilograms (or 315.3 pounds).During an interview on 12/17/25 at 4:21 P.M., Nurse #3 said Resident #4's air mattress should be set for his/her body weight, which was most recently documented at 162.5 pounds.During an interview on 12/18/25 at 7:52 A.M., Unit Manager #2 said Resident #4's air mattress should be set at about 72 kilograms, not 143 kilograms. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on record review and interviews, the facility failed to ensure staff provided residents an environment free from accident hazards for one Resident (#17), out of a total sample of 20 residents. Specifically, the facility failed to implement fall prevention interventions to prevent future falls for Resident #17.Findings include:Review of the facility's policy titled Fall Prevention Program, last revised May 2025, included but was not limited to:-Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.-A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g. resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere.-Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk.-The nurse will indicate on the resident's care plan in the resident's medical record the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk.-Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care.Resident #17 was admitted to the facility in July 2025 and had diagnoses including fusion of the spine cervical region, history of falling, muscle weakness, and ataxia (a neurological condition characterized by poor muscle control that leads to clumsy movements).Review of the Minimum Data Set (MDS) assessment, dated 7/21/25, indicated Resident #17 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15 and required partial to moderate assistance with transfers from bed to chair.Review of the initial Fall Risk Evaluation, dated 7/15/25, indicated Resident #17 had a fall risk score of 14 (at risk).Review of the medical record indicated Resident #17 had multiple falls from July 2025 to October 2025.Review of the fall investigations indicated:-7/27/25 at 9:40 A.M., Resident #17 had an unwitnessed fall without injury and was found sitting on the floor in his/her room. The Resident reported that he/she was done using the bathroom and did not use the call light, got up to walk and did not realize that his/her underwear was around his/her ankles. Immediate action taken: Range of motion, vitals and assessment.A care plan for falls was developed on 7/28/25 as follows:Focus: I am at risk for falls as evidenced by scoring tool (7/28/25)Interventions: Anticipate and meet the resident's needs; Assist resident with ambulation and transfers when therapy recommendations are made; Be sure the resident's call light is within reach and encourage the resident to use it for assistance to all requests; Determine the resident's ability to transfer; Educate on importance of maintaining a safe environment, free of potential fall hazards (7/28/25)Goal: I will not sustain serious injury through the review date; I will be free of minor injury through the review date; I will be free of falls through the review date (7/28/25, Target date: 1/22/26)-8/17/25 at 12:00 P.M., Resident #17 was transferring from a shower chair with a Certified Nursing Assistant (CNA), stood up and immediately fell to the floor. Resident is usually an assist of one. Immediate action taken: Use two staff members to transfer Resident until cleared by therapy. This fall intervention was added to the care plan on 8/17/25. Review of the medical record, including but not limited to Physical Therapy and Occupational Therapy notes, failed to indicate Resident #17 was cleared by therapy.-9/2/25 at 2:00 P.M., Resident #17 was self-transferring to bed from a wheelchair and fell to the floor. The fall was witnessed by the Resident's visitor. The investigation found the wheels on the Resident's bed were not locked at the time of the fall. Immediate action taken: Bed put in locked position. This fall intervention was added to the care plan on 9/3/25.Review of the Kardex (quick reference summary of a resident's care plan, orders, history, and needs utilized by care providers) indicated Resident #17 required moderate assistance of two staff members for transfers with a rolling walker.-10/1/25 at 7:30 A.M., Resident #17 sustained a fall in his/her bedroom while being assisted to the bathroom. The CNA reported to the<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | nurse that the Resident attempted to get his/her walker when the CNA opened the bathroom door and he/she fell to floor face down and was bleeding from the lip. The Resident was assessed by the nurse and found to have abrasions to the left side of his/her lip and bilateral knees. The investigation revealed that at the time of the fall, Resident #17 was assisted by one staff member and not two as indicated on the fall care plan. Immediate action taken: bilateral floor mats on both sides of the bed. This fall intervention was added to the care plan on 10/1/25.-10/2/25 at 10:00 A.M., Resident #17 sustained a fall during a transfer from his/her bed to wheelchair. The investigation revealed that at the time of the fall, Resident #17 was assisted by one staff member and not two as indicated on the fall care plan. Immediate action taken: Resident was assessed with no noted injury; orders to follow facility protocol. The fall risk care plan was updated on 10/3/25 to indicate staff are to utilize sit to stand lift (a mobility device used to safely move someone with limited strength from a seated position (like a wheelchair or bed) to a standing position and back again, or transfer between surfaces) until cleared by therapy.Review of a Health Status Note, dated 10/1/25 and written by Nurse #1, indicated Resident #17 sustained a fall in his/her bedroom while being assisted by one CNA. Nurse #1 indicated Resident #17 was an assist of two.During an interview on 12/17/25 at 12:54 P.M., Nurse #1 reviewed the Resident's medical record and said at the time of the falls on 10/1/25 and 10/2/25, two staff members should have been assisting the Resident but was not.During an interview on 12/17/25 at 1:39 P.M., CNA #1 said she works on all units in the facility and usually receives information about residents on her assignment from the previous shift, or by reviewing their Kardex. She said Resident #17 was on her assignment on 10/2/25 and remembers assisting him/her with a transfer. She said his/her legs got weak and fell onto his/her butt. She said she was not told about the Resident's fall the previous day, did not review the Kardex prior to providing care to Resident #17 and was not aware he/she was an assist of two.During an interview on 12/18/25 at 11:25 A.M., the Director of Nursing (DON) reviewed Resident #17's medical record and fall incident reports. She said Resident #17 is a fall risk and the care plan and Kardex indicated Resident #17 was an assist of two at the time of the falls on 10/1/25 and 10/2/25. She said Resident #17 should have been assisted/transferred by two CNAs on 10/1/25 and 10/2/25 and not one. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and document review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed:1. For Resident #4,a. to perform hand hygiene as indicated during a dressing change, andb. to doff (remove) personal protective equipment (PPE) as indicated for a resident on Enhanced Barrier Precautions (EBP); and2. To disinfect shared vital signs equipment after use.Findings include1. Review of the facility's policy titled Hand Hygiene, revised 12/2024, indicated, but was not limited to, the following:-Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.-The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.Review of the facility's policy titled Enhanced Barrier Precautions, revised 12/2024, indicated, but was not limited to, the following:-Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.-High-contact resident care activities include wound care.-Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room.Review of the Centers for Disease Control and Prevention (CDC) document titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrugresistant Organisms (MDROs), updated 7/2022, indicated, but was not limited to, the following:-Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs.-Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room)-Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same roomResident #4 was admitted to the facility in September 2009 with diagnoses including dementia.Review of Resident #4's Minimum Data Set (MDS) assessment, dated 11/14/25, indicated the Resident was cognitively impaired, as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Further review of the MDS assessment indicated the Resident had one stage 3 pressure ulcer.Review of Resident #4's Physician's Orders indicated, but was not limited to, the following:- Staff to maintain Enhanced barrier precautions related to G-tube (gastrostomy tube, a tube inserted through the abdomen that provides direct access to the stomach for nutrition) and wounds (order date: 8/14/25)a. On 12/17/25 at 1:47 P.M., the surveyor observed Nurse #4 perform a dressing change to Resident #4's sacral pressure ulcer and gastrostomy tube insertion site. The surveyor observed Nurse #4 remove her gloves after removing the Resident's soiled gastrostomy tube dressing and don (apply) new gloves without performing hand hygiene. The surveyor then observed Nurse #4 remove her gloves after removing the Resident's soiled sacrum dressing and don new gloves without performing hand hygiene. During a telephonic interview on 12/18/25 at 11:42 A.M., Nurse #4 said she should have sanitized or washed her hands every time she removed her gloves.During an interview on 12/18/25 at 10:48 A.M., the Infection Prevention Nurse/Assistant Director of Nursing said it was her expectation that staff perform hand hygiene after removing gloves.b. On 12/17/25 at 2:05 P.M., the surveyor observed Nurse #4 remove her gloves, perform hand hygiene, and leave Resident #4's room to retrieve additional dressing supplies from the treatment cart out in the hallway. Nurse #4 failed to remove her gown before exiting Resident #4's room. Nurse #4 returned to the room at 2:06 P.M. with the same gown on.During an interview on 12/18/25 at 10:48 A.M., the Infection Prevention Nurse/Assistant Director<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | of Nursing said it was her expectation that staff remove all PPE when exiting the room for a resident on Enhanced Barrier Precautions.2. Review of a facility document titled [Corporate Health Group], undated, indicated, but was not limited to, the following:-Standard Precaution:Properly handle and properly clean and disinfect patient care equipment and instruments/devices. On 12/17/25 at 9:36 A.M., the surveyor observed Nurse #4 retrieve a portable vital signs machine from the unit's sitting room and use it to obtain Resident #67's blood pressure. After obtaining the Resident's blood pressure, Nurse #4 returned the vital signs machine to the sitting room but failed to disinfect the shared vital signs machine after it was used. During an interview on 12/17/25 at 4:27 P.M., Unit Manager #2 said Nurse #4 should have disinfected the vital signs machine after using it.During a telephonic interview on 12/18/25 at 11:42 A.M., Nurse #4 said she should have disinfected the blood pressure cuff after she used it.During an interview on 12/18/25 at 10:48 A.M., the Infection Prevention Nurse/Assistant Director of Nursing said it was her expectation that staff disinfect shared equipment after it is used. |