STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225482	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Norwell Nursing & Rehabilitation Center LLC	329 Washington Street Norwell, MA 02061

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were provided care in accordance with professional standards of practice for three Residents (#40, #13, #21), out of a total sample of 20 residents. Specifically, the facility failed:1. For Resident #40, to administer medications per physician's orders and crushing guidelines. Specifically, measure an accurate dose of MiraLAX per physician's order, administer Depakote DR per physician's order, and administer Seroquel and Zyprexa tablets per medication guidelines;2. For Resident #13, to ensure expired Lansoprazole (liquid compound for gastro-esophageal reflux disease (GERD)) was taken out of use/destroyed and not used for daily administration for 24 days after the use by date;3. For Resident #13, to ensure the Resident was administered the prescribed enteral water bolus (form of hydration that is delivered into the digestive system) via a gastrostomy tube (G-tube - a tube inserted into the stomach through which hydration and nutrition is provided); and4. For Resident #21, to verify a physician's order for a continuous glucose monitoring device and accurately document implementation of the order for 11 months. Findings include:1. Review of the Lippincott Manual of Nursing Practice, 11th Ed. (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. Review of the facility's policy titled Crushing Medications, dated as last revised May 2025, indicated but was not limited to the following: -Medications should be crushed in accordance with standards of practice for safety and accuracy in medication administration. -Liquids and other alternative forms of medication shall be considered before crushing a medication. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Medications that typically should not be crushed include, but are not limited to Enteric-Coated medications, Sustained Release or Extended Release medications. Resident #40 was admitted to the facility in March 2025 with diagnoses which include anxiety, schizophrenia, and depressive disorder with psychotic features. Review of the Minimum Data Set (MDS) assessment, dated 11/20/25, indicated he/she score 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. Additionally, the MDS indicated he/she took antipsychotic, anti-anxiety, and antidepressant medications. Review of the Physician's Orders indicated but were not limited to the following: -Guardianship in place. -May crush medications or open caps per medication guidelines. -Polyethylene Glycol 3350 Oral Powder (MiraLAX-for constipation) 17Gram (GM)/Scoop give one scoop by mouth in the morning for constipation. -Depakote Delayed Release (DR) (anticonvulsant and used as a mood stabilizer) 250 milligram (mg) give two tablets by mouth one time a day for mood stabilizer. -Seroquel Tablet (antipsychotic) 25mg give three tablets by mouth two times a day for agitation. -Zyprexa Tablet (antipsychotic) 10mg give one tablet by mouth two times a day for Schizophrenia. On 11/25/25 between 8:27 A.M. and 8:38 A.M., the surveyor observed Nurse #2 administer medications as follows: -Nurse #2 poured Resident #40's morning medications including three Seroquel 25mg tablets and one Zyprexa 10mg tablet. -Nurse #2 was unable to locate the Depakote DR tablets, the medication was omitted and left unsigned on the Medication Administration Record (MAR). -Nurse #2 poured some MiraLAX powder from the bottle into a small clear plastic medication cup to approximately the 20ml line. -Nurse #2 proceeded to crush all the poured medications together and mix with applesauce. -Nurse #2 poured the MiraLAX powder from the medication cup into a small cup with approximately four to five ounces of water. The Surveyor reconciled the medications administered with the physician's orders and the MAR. Nurse #2 had left the Depakote DR unsigned during the medication pass and it was now signed as administered. Review of Drugs.com instructions for use indicated Seroquel tablets are coated, should be swallowed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	whole, with or without food, and do not crush, chew, or break it. Review of Drugs.com instructions for use indicate Zyprexa tablets should be taken exactly as prescribed. Tablets are coated and should be swallowed whole, with or without food. Review of the MiraLAX instructions for use label indicated the bottle top is a measuring cap marked to contain 17 grams of powder when filled to the indicated line (white section in cap). Stir and dissolve in any four to eight ounces of beverage (cold, hot or room temperature), then drink. Review of Resident #40's profile and special instructions in the medical record indicated he/she took their medications whole with thin liquids. During an interview on 11/25/25 at 12:32 P.M., while standing at the medication cart with the surveyor, Nurse #2 said she crushed the pills because her report sheet says the Resident takes them crushed. She said she was unsure if the Seroquel or Zyprexa should be administered as whole tablets, she just crushed them because that's what the paper says. Additionally, she said you are supposed to use the cap of the MiraLAX bottle to measure the dose, but then you would have to leave it uncovered, so she just pours some into the med cup and then into a plastic cup when she is ready to give it. She said the order doesn't have an amount of liquid to mix in, but this cup is enough (holding a four-to-six-ounce plastic cup). Nurse #2 said she was unable to find the Depakote earlier and that was why she did not give it during the med pass. When asked why it was signed off now, she said she got it from the other nurse. She said, sometimes things end up in the wrong med cart. During an interview on 11/25/25 at 12:35 P.M., Nurse #3 said she did not give Nurse #2 a card of Depakote this morning. Nurse #2 was still standing at her medication cart with the surveyor and was asked to provide the surveyor with the card of Depakote used to administer the dose this morning (Depakote DR 250mg two tablets). Nurse #2 opened the second drawer of the medication cart (the drawer where the active cards for medication administration were kept) and was unable to locate the card of Depakote. Nurse #2 then opened and closed the third drawer and finally opened the fourth/bottom drawer. Nurse #2 started to look through all the over stock medication cards in the bottom drawer looking for the Depakote card. After several minutes, a card of Depakote DR was located. The card had one tablet punched out of the card. Nurse #2 proceeded to punch two tablets out of the card allowing them to fall into the bottom of the medication cart. The Surveyor observed this action, heard the foil pop, and the pills hit the bottom of the metal cart. Nurse #2 immediately said she was not popping the pills right now. Nurse #2 then started to stand up with the card of Depakote DR that now had three pills punched from the card. The surveyor asked Nurse #2 to remove the cards and retrieve the pills from the bottom of the medication cart. Nurse #2 picked up the other medication cards where the Depakote DR card was and removed two Depakote DR pills from the bottom of the medication cart. There were no other loose pills in the bottom of the medication cart. During a follow up interview on 11/25/25 at 12:37 P.M., Nurse #2 said this was the card of Depakote and she again said she did not just pop those pills. She said she administered the Depakote whole because they cannot be crushed. When asked what she administered to Resident #40 she opened the MAR and said he/she gets two in the morning. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/25/25 at 2:27 P.M., the Director of Nurses (DON) said MiraLAX should always be measured with the cap of the bottle up to the line on the cap, Seroquel and Zyprexa cannot be crushed, and the Depakote should have been marked as not given, a note written, and physician notified if the medication was not available. Additionally, she said medication should be administered per the physician's orders and the resident profile and report sheet should match indicating if medication is to be crushed or not and anything that should not be crushed would need a specific order to crush it of an alternative was not available. 2. Resident #13 was admitted to the facility in March 2025 with diagnoses which include gastroesophageal reflux disease (GERD). Review of the facility's policy titled Storage of Medications, undated, indicated but was not limited to the following: -Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Review of the Physician's orders indicated but were not limited to the following: -Lansoprazole Oral Suspension 3mg/milliliter (ml) give 10ml via G-Tube (feeding tube inserted directly into the stomach) one time a day for GERD (10/20/25) On 11/25/25 at 12:15 P.M., the surveyor observed one bottle of Lansoprazole Suspension in the North Unit Medication Fridge with a Beyond Use Date of 11/1/25 written on the label from the Pharmacy. Review of the Medication Administration Record indicated Resident #13 had been administered the Lansoprazole daily as ordered. Review of the National Library of Medicine (NIH.gov) website indicated Lansoprazole Suspension should not be used beyond the Use By date indicated by the pharmacy. During an interview on 11/25/25 at 12:15 P.M., Nurse #3 said that was the only bottle they had and they have been using it. She said she did not realize it was expired and would have to call the pharmacy for a new one. During an interview on 11/25/25 at 2:27 P.M., the DON said the Lansoprazole Suspension has a short shelf life and it should not have been administered after 11/1/25, since it was expired. 3. Review of the facility's policy titled Assisted Nutrition and Hydration – Enteral Feeding, dated as revised January 2025, indicated but was not limited to the following: -Residents within the facility will maintain adequate parameters of nutritional and hydration status, to the extent possible, to ensure each resident is able to maintain the highest practicable level of well-being. -The facility will ensure each resident is offered sufficient fluid intake to maintain proper hydration and health -The physician will be responsible for ordering the appropriate enteral feeding (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13 was admitted to the facility in March 2025 with diagnoses including traumatic brain injury and dysphagia (difficulty swallowing liquid or food). Review of the Minimum Data Set (MDS) assessment, dated 11/12/25, indicated Resident #13 had a feeding tube and the portion of the total calories the Resident received through a feeding tube was 51% or more. Review of the care plans indicated Resident #13 was dependent on the G-tube including but not limited to the following interventions: -Administer water flushes as ordered -Diet NPO (nothing by mouth) Review of the Physician's Orders indicated Resident #13 had the following orders related to the feeding tube: -Diet NPO (11/18/25) -Give 200 milliliters (ml) water bolus 4 times a day (11/13/25) -For nutritional supplement give 80 ml/hr (hour) Jevity 1.5 (liquid meal replacement) from 6:00 PM to 6:00AM (8/26/25) On 11/25/25 at 12:02 P.M. the surveyor observed the following: -Nurse #2 and the surveyor entered Resident #13's room and observed a graduated container (used to measure the volume of liquid) with 200ml of water on Resident #13's bedside table. There was a 60ml piston syringe (type of syringe with a plunger that pushes fluid of the barrel or draws fluid into it) placed inside the container. Resident #13's feeding tube was exposed and there was a towel placed underneath it. Clinical Coordinator #1 was in the room, standing at Resident #13's bedside. She said she would like to observe Nurse #2 administer the water bolus to Resident #13. -Nurse #2 raised the height of Resident #13's bed, took the piston syringe and drew 60ml of water into the syringe. -Nurse #2 placed the syringe into Resident #13 feeding tube and administered the water by depressing the plunger of the syringe. -Nurse #2 removed the syringe from the feeding tube and placed it inside the container and drew 60ml of water into the syringe. -Nurse #2 placed the syringe into Resident #13's feeding tube and administered the water by depressing the plunger of the syringe. -Nurse #2 removed the syringe, placed it back into the container, removed the towel from under the feeding tube, covered Resident #13 with a sheet, lowered the bed to the floor, and said she had completed the administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nurse #2 went to exit the room and Clinical Coordinator #1 asked if she could intervene because Nurse #2 did not administer the correct amount of water. Clinical Coordinator made Nurse #2 aware of the error, reviewed proper administration technique and had Nurse #2 administer the remaining 80ml of water to Resident #13. During an interview on 11/25/25 at 12:09 P.M., Nurse #2 said she only administered 120ml of water and the Resident was supposed to receive 200ml. Nurse #2 said she did not realize the syringe only held 60ml of water. During an interview on 11/25/25 at 12:14 P.M., Clinical Coordinator #1 said she had to intervene because the Resident did not receive the proper amount of water. She said Nurse #2 should have placed the syringe into the feeding tube without the plunger and poured the measured amount of water into the syringe in the feeding tube to ensure the Resident received the prescribed amount. Review of Nurse #2's G-Tube/Enteral Feeding Competency Evaluation completed on 10/16/25, indicated she demonstrated proper administration of medications via a G-tube. During an interview on 11/25/25 at 3:09 P.M., the DON said Nurse #2 should have administered the amount of water the physician ordered. She said it is essential that the proper amount of water is administered because this is his/her only source of hydration and is unable to eat or drink anything by mouth. 4. Review of Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of registered nurse and practical nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered nurse and Practical nurse respectively. The regulations stipulate that both the registered nurse and practical nurse bear full responsibility for systematically assessing health status and recording the related health data. Resident #21 was admitted to the facility in July 2020 and has diagnoses including diabetes mellitus type 2. Review of the MDS assessment, dated 9/16/25, indicated Resident #21 was cognitively intact as evidenced by a BIMS score of 15 out of 15, had diabetes and received insulin daily. Review of the medical record included but was not limited to the following Physician's Order: - FreeStyle Libre 2 Sensor Miscellaneous (Continuous Glucose System Sensor) Inject 1 application subcutaneously (under the skin) one time a day every 14 days for diabetes (11/7/24) Review of [NAME] Freestyle Libre Continuous Glucose Monitoring (CGM- https://www.freestyle.[NAME]/us-en/home.html) guidelines, included but was not limited to: -the Libre CGM is a small sensor-based system that provides real-time glucose readings day and night, without fingersticks; -The sensor is applied to the back of the upper arm with a simple, disposable device called an applicator. When the sensor is applied, a small (5 millimeter) filament (needle) is inserted just under the skin and held in place with a small adhesive pad; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There is a needle (sharp) in the applicator to insert the filament in the back of your upper arm so the sensor can monitor your glucose; -The sensor lasts up to 14 days and it is recommended to rotate application site of the sensor between arms. Review of the MAR/Treatment Administration Records (TAR) from December 2024 through November 2025 indicated Resident #21 had a FreeStyle Libre2 sensor applied subcutaneously every 14 days as follows: -12/5/24, 12/19/24 -1/2/25, 1/16/25, 1/30/25 -2/13/25, 2/27/25 -3/13/25, 3/27/25 -4/10/25, 4/24/25 -5/8/25, 5/22/25 -6/5/25, 6/19/25 -7/3/25, 7/17/25, 7/31/25 -8/14/25, 8/28/25 -9/11/25, 9/25/25 -10/9/25, 10/23/25 -11/6/25, 11/20/25 On 11/24/25 at 7:51 A.M., the surveyor observed Resident #21 seated on the bed in his/her room wearing a short-sleeved shirt. The Resident's upper arms were exposed, and no continuous glucose monitoring device was observed on either of his/her arms. During an interview on 11/25/25 at 7:51 A.M., Nurse #2 reviewed the medical record and noted the active order for the FreeStyle Libre2 sensor and said she was not aware he had one and checks his/her capillary blood glucose (CBG) using a fingerstick. Nurse #2 and the surveyor went to the Resident's room. Resident #21 said he/she does not have a continuous glucose monitoring device and lifted up the short sleeves on either arm. No device was noted. During an interview on 11/25/25 at 11:17 A.M. and 12:02 P.M., the DON reviewed Resident #21's medical record. She noted the physician's order for the FreeStyle Libre2 and the MAR/TARs that indicated the device had been applied according to physician's orders. She said Resident #21 never had a Libre device because his/her insurance would not pay for it. The DON said the physician's orders are inaccurate and there should not be an order for the FreeStyle Libre2 device. She said (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing should not have signed off that the device was applied every 14 days for nearly a year when the Resident did not have the device. During an interview on 11/25/25 at 2:35 P.M., NP #1 reviewed Resident #21's medical record. He said the Resident does not have a FreeStyle Libre2 device and there should not be an order for one. He said he should have picked up on that and discontinued it.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and interviews, the facility failed to ensure drugs and biologicals were stored in accordance with State and Federal laws. Specifically, the facility failed to ensure:1. The Medication Cart remained locked when not in view and/or proximity of the nurse;2. For Resident #40, MiraLAX (medication for constipation) was not left at the bedside; and3. For Resident #50, crushed Ativan (controlled substance/anti-anxiety medication) was double locked and not crushed until administered. Findings include:Review of the facility's policy titled Storage of Medications, undated, indicated but was not limited to the following:-Unlocked medication carts are not left unattended.-Compartments (including but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use.-Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received.-Schedule II-V controlled medications are stored in separately locked compartments. Security access to controlled medication is separate from access to non-controlled substances.-Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Review of the facility's policy titled Administering Medications, undated, indicated but was not limited to the following:-Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so.-During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. Review of the facility's policy titled Crushed Medications, dated as last revised May 2025, indicated but was not limited to the following:-Crushed medication shall be administered immediately. The nurse shall verify the resident is available and ready for his/her medication prior to crushing medications. If unable to administer a medication that has been crushed, the nurse shall discard the medication. 1. The surveyor made the following observations on the locked North Unit:-11/24/25 at 3:02 P.M., Short hall medication cart unlocked and unattended in the hallway next to nurses' station.-11/25/25 from 8:04 A.M. through 8:09 A.M., Long hall medication cart was unlocked and unattended. Residents were wandering around the unit. Nurse #2 was in and out of resident rooms and the medication cart was not in view/proximity of her.-11/25/25 at 8:14 A.M., Long hall medication cart was left unlocked and unattended in the hallway near the nurses' station while Nurse #2 entered a Resident's room with her back to the hallway she then administered medications.-11/25/25 at 8:25 A.M., Long hall medication cart was unlocked and unattended in the hallway next to nurses' station.-11/25/25 at 8:38 A.M., Nurse #2 left the medication cart unlocked and unattended in the hallway and went in the medication room behind a closed door.-11/25/25 at 10:15 A.M., Medication cart left unlocked and unattended next to nurses' station. A resident came by and placed a fork on the medication cart and another resident, walking slowly in hallway, was near the medication cart. At 10:18 A.M., Nurse #2 returned to her medication cart. -11/25/25 at 10:34 A.M., Long hall medication cart was unlocked, the nurse walked down the hallway, leaving it unattended. At 10:37 A.M., Nurse #2 returned to her med cart, picked up the water pitcher and walked away from the cart again, leaving it unlocked and unattended. Unlicensed staff and residents were walking around the unit. During an interview on 11/25/25 at 10:38 A.M., Nurse #2 said she usually locks it every time she walks away so the residents can't get into the medications, especially on a dementia unit. She said she has been trying but forgot. During an interview on 11/25/25 at 12:37 P.M., Nurse #2 said the medication cart should always be locked. During an interview on 11/25/25 at 2:27 P.M., the Director of Nurses (DON) said the medication cart should be locked anytime it is not in view of the nurse. 2. Resident #40 was admitted to the facility in March 2025 with diagnoses which include schizophrenia, anxiety, and major depressive disorder with psychotic symptoms. Review of the Physician's Orders indicated he/she had a Guardian in place. During the Medication Pass, the surveyor observed the following:-On 11/25/25 between 8:27 A.M. and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8:38 A.M., Nurse #2 poured the medications for Resident #40, including MiraLAX (a powdered medication mixed with water) and then entered the room for administration.-During Medication Administration, Resident #40 said they did not want the drink. With some encouragement, Resident #40 agreed to take the medication drink.-Resident #40 was administered the pill form medications crushed in applesauce. He/she took a couple small sips of the MiraLAX to swallow the mixture and handed the cup back to the nurse.-Nurse #2 placed the cup, half full of the MiraLAX medication mixture, on the breakfast tray and exited the room. During an interview on 11/25/25 at 12:35 P.M., Nurse #2 said she should not have left the medication at the bedside. She said sometimes she will leave a supplement drink at the bedside and come back to make sure they drank it, but she should not have left the MiraLAX on the table, she should have stayed while he/she drank it. During an interview on 11/25/25 at 2:27 P.M., the DON said no medication should be left at the bedside, the nurse should stay with the resident until they take the medications. 3. Resident #50 was admitted to the facility in April 2019 with diagnoses which include dementia and anxiety. Review of the Physician's Orders indicated but were not limited to the following:-Ativan 1 milligram (mg) by mouth in the morning for anxiety. The surveyor observed the following on the South Unit:-11/25/25 at 11:38 A.M., the Short Hall medication cart was in the hallway, next to the nurses' station. The Nurse was not visible at or around the nurse's station and was not in view of the medication cart.-Nurse #5 returned to the medication cart with an ice cream cup, placed the ice cream on top of the medication cart, walked away again, then returned with a cup of water.-11/25/25 at 11:40 A.M., Nurse #5 opened the top drawer of the medication cart and removed a one-ounce clear plastic medication cup with white powder in it. She took the cup, the ice cream, and the water and left the nurses' station to administer the medication. During an interview on 11/25/25 at 11:45 A.M., Nurse #5 said the cup of white powder was Resident #50's Ativan. She said she crushed it and left it in the top drawer until he/she was ready for it. She said it should not have been left in the medication cart crushed and unlabeled after it was removed from the narcotic drawer. During an interview on 11/25/25 at 2:27 P.M., the DON said medications should not be pre-poured and left in the top of the medication cart. Additionally, she said narcotics should be locked in the narcotic drawer and removed when ready to administer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225482	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Norwell Nursing & Rehabilitation Center LLC	329 Washington Street Norwell, MA 02061

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on record review and interview, 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 for two Residents (#71 and #25) out of a sample of 17 residents. Specifically, the facility failed:1. To ensure that the staff wore the indicated personal protective equipment (PPE-items such as gowns and gloves worn by staff to decrease the spread of infections) when entering the room for Resident #71 on Contact Precautions (measures using protective barrier gowns and gloves as an infection control intervention designed to reduce transmission of methicillin-resistant Staphylococcus aureus (MRSA)); and 2. For Resident #25, to provide hand hygiene prior to meals.Findings include:1. Resident #71 was admitted to the facility in April 2024 with diagnoses including venous insufficiency. Review of the Minimum Data Set (MDS) assessment, dated 9/12/25, indicated Resident #71 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment, indicating the Resident is cognitively intact. Review of Resident #71's Physician's Orders, dated 11/11/25, indicated staff maintain contact precautions related to colonized MRSA in leg wounds every shift.On 11/24/25 at 8:00 A.M., the surveyor observed a three-tiered cart containing PPE outside the Resident's room with a yellow sign taped to the wall above the name plate indicating: -STOP CONTACT PRECAUTIONS-EVERYONE MUST:-Clean their hands, including before entering and when leaving the room-PROVIDERS AND STAFF MUST ALSO -Put on gloves before room entry-Discard gloves before room exit-Put on gown before room entry-Discard gown before room exit-Do not wear the same gown and gloves for the care of more than one person-Use dedicated or disposable equipment. Clean and disinfect the reusable equipment before use on another personReview of the facility's policy titled Infection Control Guidelines for Nursing Procedures, undated, indicated but was not limited to the following:-Contact transmission is infection spread through direct contact with an infectious person (e.g., touching during a handshake) or with an article or surface that has become contaminated. Microorganisms can remain on the surface for 9-11 days if not properly cleaned. These include MRSA. -Infection control measures for contact precautions include:-standard precautions infection control measures, and -patient placement based on infection-PPE, including gloves and gown for all interactions that may involve contact with the residents or their environment. On 11/24/25 at 8:07 A.M., the surveyor observed Certified Nursing Assistant (CNA) #6 enter Resident #71's room with no PPE on or hand hygiene completed. CNA #6 went to assist the Resident in the bathroom and shut off the call bell. CNA #6 was observed touching Resident #71's wheelchair and wheeling the Resident in his/her wheelchair. Resident #71 asked CNA #6 to wipe his/her buttocks and CNA #6 was observed touching the Resident. During an interview on 11/24/25 at 8:20 A.M., CNA #6 said she had to enter the room to make sure the Resident was safe and only assisted him/her and did not provide morning care for the Resident. She said she wasn't sure if the sign outside the room was for him/her and if it was current. She said the Resident did not have a catheter or infection.On 11/24/25 at 9:27 A.M., the surveyor observed CNA #1 enter Resident #71's room without completing hand hygiene and touched the Resident's tray table and picked up his/her breakfast tray and brought it down the end of the hall and placed it in the food truck. During an interview on 11/24/25 at 9:30 A.M., CNA #1 said no PPE is required to pick up or drop off meal trays to residents on contact precautions. During an interview with an observation on 11/24/25 at 10:22 A.M., the surveyor observed Nurse #3 in Resident #71's room administering medications with no PPE worn. Nurse #3 was observed touching Resident #71's bed and hands. She said PPE was not required for medication administration since she was not providing care near the infected areas. She said PPE was required if she was going to change his/her wound dressings. During an observation with interview on 11/24/25 at 10:28 A.M., the surveyor observed the Staff Development Coordinator (SDC) entering the Resident's room with cranberry juice, touching the Resident's environment and person. She said PPE was only needed for direct care of the (continued on next page)

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	225482	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Norwell Nursing & Rehabilitation Center LLC	329 Washington Street Norwell, MA 02061

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident and she did not breach any infection control procedure. During an observation with interview on 11/25/25 at 9:11 A.M., the surveyor observed CNA #5 at the Resident's bedside touching the tray table and Resident's bed. She said that if she is going to answer a call bell or assist the Resident with something simple, she doesn't need to wear PPE. She said if she was going to bring the Resident to the bathroom she would need PPE.During an observation with interview on 11/25/25 at 10:27 A.M., the surveyor observed the Business Office Manager in Resident #71's room leaning against his bed, resting her hand on the footboard. She said that the Resident was on contact precautions, which were to be utilized by staff providing care. She said she was not providing care, so she did not need to adhere. She said touching and making contact with the Resident's bedsheets and bed did not violate any contact precautions and was acceptable. During an observation with interview on 11/25/25 at 10:49 A.M., Nurse #4 entered Resident #71's room, turned off his/her call light and touched his/her tray table in the room. He said contact precautions do not require PPE for medication administration.During an interview on 11/25/25 at 11:00 A.M., Resident #71 said sometimes staff do wear gowns and gloves and he/she said it was related to wounds on his/her legs. He/she said they were not sure when the staff were supposed to wear gowns and gloves and there are staff that come and help him/her and do not have the yellow gowns on. During an interview on 11/25/25 at 12:15 P.M., the Director of Nurses (DON) said anyone entering the room with a resident on contact precautions should wear all the required PPE as described on the signage posted outside the room. She said it is not only required for care but also touching the resident or the resident's environment. She said all staff members should have been wearing gowns and gloves during their interactions. 2. Resident #25 was admitted to the facility in 2019 with diagnoses including unspecified intestinal obstruction. Review of the MDS assessment, dated 10/23/25, indicated the Resident scored 11 out of 15 on the BIMS assessment, indicating moderate cognitive impairment. The MDS also indicated the Resident had an ostomy appliance (a device used to collect waste from surgical openings in the intestines or bladder). On 11/24/25 at 8:23 A.M., the surveyor observed the Resident receive his/her breakfast tray from staff. Staff delivered the tray and assisted with putting sugar on the cereal and then left. Resident #25's hands appeared soiled with a brown, odorous substance on his/her fingers and under his/her nails. Resident #25 began to eat an English muffin with jelly, bacon, and two hard boiled eggs with his/her soiled hands. During an interview on 11/24/25 at 8:33 A.M., Resident #25 said he/she has stomach problems and sometimes the ostomy bag leaks and he/she tries to stop it and will use a sheet or try to clean it up. He/she said the staff usually manage his/her ostomy bag, but his/her hands do end up soiled at times. He/she said staff do not offer or assist him/her with hand hygiene prior to meals. During an interview with observation on 11/25/25 at 9:26 A.M., the surveyor observed the Social Worker take Resident #25's tray from the food truck and deliver it to the Resident. The surveyor observed her place down the tray and assist the Resident with finding a spoon. Resident #25's hands appeared visibly soiled and stained with a brown, odorous substance. The Social Worker said she helps pass meals at times and she has never provided hand hygiene to residents. She said she would hope staff do it during morning care but cannot be certain. She said there is not a process she is aware of. Resident #25 began to eat his/her breakfast with his/her hands.During an interview on 11/25/25 at 9:25 A.M., CNA #5 said the staff pass out the meals to each resident after the nurse has checked the trays. She said there are no wipes on trays and there is no current process for providing or offering hand hygiene to residents eating in their room. She said she knows Resident #25 does have soiled hands at times because of complications with his/her ostomy status. She said there might be some independent residents who complete hand hygiene prior to meals, but it is not something that staff assist as part of passing meals. She said she has not seen any wipes on trays or how they would offer hand hygiene to residents in their rooms. During an interview on 11/25/25 at 12:20 P.M., the DON said hand hygiene should be completed for all residents prior to the meal pass. She said there is risk of infection if a resident is eating with his/her hands soiled from his/her ostomy bag.