STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225493	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Rehab & Nursing Care Center	321 Centre Street Dorchester, MA 02122

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one Resident #6 was free from signifigant medication error, out of a total sample of 27 residents. Specifically, for Resident #6 the facility failed to ensure nursing scheduled intravenous (IV) cefazolin (antibiotic) every eight hours as recommended by Infectious Disease (ID) placing Resident #6 at risk for not having a consistent level of antibiotic in his/her blood stream. Findings include:Resident #6 was admitted to the facility in January 2026 with diagnosis including periprosthetic fracture around internal prosthetic left hip joint and an infection and inflammatory reaction due to internal left hip prosthesis. Review of the most recent Minimum Data Set assessment, dated 2/4/26, indicated Resident #6: C: Brief Interview of Mental Status score 11/15, indicating a moderate cognitive impairment. N: antibiotic use, coded as yes. O: IV medications, coded as yes. Review of Resident #120's hospital Discharge summary, dated [DATE], indicated Infectious Disease recommended long term antibiotics:- Cefazolin 2 grams (gm) every 8 hours, end date 3/6/26. Last dose administered on 1/28/26 at 6:14 A.M. Review of Resident #6's physician's orders, 1/28/26, indicated:-Cefazolin Sodium-Dextrose Intravenous Solution 2-4 gm/100 milliliter, use 2 gram intravenously three times a day for infection. Scheduled at 10:00 A.M., 2:00 P.M., and 8:00 P.M., not evenly spaced out every 8 hours as recommended. Review of Resident #6's Nurse Practitioner note, dated 2/9/26, indicated:- Continue IV Cefazolin 2 gr every 8 hours until 3/6/26.- Patient will require lifelong antibiotic suppression after IV antibiotics. Review of Resident #6's Infectious Disease (ID) consultant form, dated 2/11/26, indicated:-Continue cefazolin 2 gram IV every 8 hours through next ID follow up. Review of Resident #6's nursing note, dated 2/11/26, indicated:-Patient returned from appointment Recommendation is to continue on Cefazolin 2g IV Q8h through next ID f/u on 3/4 1:00P.M. During an interview on 2/18/26 at 11:11 A.M., Unit Manager #1 reviewed Resident #6's physician's order for cefazolin, and she said the order was for three times daily, additionally she said if the hospital discharge summary says 'every 8 hours' they would space it every 8 hours. During an interview on 2/18/26 at 1:00 P.M., Nurse #1 said that Resident #6 is on cefazolin for an infection. Nurse #1 said that she thought that Resident #6's cefazolin was originally scheduled at 6:00 A.M., 2:00 P.M., and 10:00 P.M., and she said that 'someone changed the times at some point'. Nurse #1 said that she has been administering Resident #6's cefazolin since his/her admission at 10:00 A.M., and at 2:00 P.M., and Nurse #1 said she was aware that the recommendations were for every 8 hours as she reviewed the ID recommendations on 2/11/26. Nurse #1 said that 'she made a mistake'. Review of Resident #6's Medication Administration Record, indicated between 2/1/26 through 2/16/26, Nurse #1 administered Resident #6 cefazolin at 10:00 A.M., and 2:00 P.M., 13 days out of 16 applicable days reviewed. During an interview on 2/18/26 at 12:19 P.M., the Nurse Practitioner (NP) said that Resident #6 is on IV cefazolin for a recurrent hip infection based on the ID recommendations. The NP said that the cefazolin should be scheduled every 8 hours since the cefazolin is most effective to be spaced apart every 8 hours to ensure there is a steady level of medication in the blood stream, the NP said she was not aware that nursing transcribed the cefazolin doses to be administered so closely together but that was in error. During an interview on 2/18/26 at 3:31 P.M., the Assistant Director of Nursing said that nursing should have transcribed the cefazolin to be administered at 6:00 A.M., 2:00 P.M., and 10:00 P.M., or evenly spaced out, to prevent the medication error.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 interview, the facility failed to ensure that the proper dish machine wash and final rinse temperatures were maintained at the appropriate temperatures to effectively clean and sanitize dishware and cutlery to prevent foodborne illness. Findings include: During the kitchen revisit on 2/18/26 at 11:20A.M., the Foodservice Director (FSD) told the surveyor that there was currently no broken equipment in the kitchen. At 11:34 A.M., the surveyor and the Foodservice Director (FSD) operated the dish machine to observe its functionality. The FSD informed the surveyor that the dish machine is a high temperature conveyor dish machine, and it needs to reach a minimum of 160 degrees Fahrenheit for the wash temperature and a minimum of 180 degrees Fahrenheit for a final rinse temperature. The FSD said the dish machine water was just changed, the FSD proceeded to run the dish machine multiple times and the temperature gauge for the wash temperature did not go above 140 degrees Fahrenheit. The FSD said she was not aware that there was an issue with the dish machine and she was going to contact the contracted dish machine vendor. As the surveyor was leaving the dish machine room, the surveyor observed the Dish Machine Temperature Log for February 2026 hanging on the wall which documents the dish machine wash and rinse temperatures three times daily every day. Review of the log indicated that there were 17 occurrences where the wash temperature was below 160 degrees Fahrenheit and 25 occurrences where the final rinse temperature was below 180 degrees Fahrenheit. On the bottom of the temperature log sheet the following was written High Temperature Machines wash 160 > degrees Fahrenheit, Rinse temperature > 180 degrees Fahrenheit. ***Notify supervisor when temps not adequate. The FSD said she was not aware of the low temperatures and staff have never told her about it and she said her expectations are that staff should have notified her of the inadequate temperatures. During a follow up interview on 02/18/2026 1:40 PM, the FSD said she interviewed all of the kitchen staff, and she said none of them contacted herself of the cook despite knowing about the low dish machine temperatures. During an interview on 02/19/26 at 7:05 A.M., the FSD said the dish machine is still not reaching the proper wash temperature, so food is being served using disposable plates and cutlery and they are still waiting for the contracted dish machine vendor to come into the facility.

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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 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, record review, and interviews, the facility failed to ensure that services met professional standards of practice for one Resident (#120), out of 27 sampled Residents. Specifically, for Resident #120 the facility failed to ensure nursing dated and labelled tube feeding formula as required, nursing failed to stop a tube feeding as ordered, and nursing failed to ensure free water flushes were scheduled in accordance with the physician's order. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following:- 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.Review of the facility policy titled Enteral Feeding Guidelines, dated as effective 2/21/22, indicated the ensure the safe administration of enteral nutrition. *Preventing errors in administration6. On the formula label document initials, date and time the formula was hung, and initial that the label was checked against the order. *Flushes 1.Provide flushes as ordered to maintain gastric tube patency. Flush the tube according to physician orders prior to administering medications. 3.The physician may order free water infusion via g-tube to maintain resident's hydration status in the even the resident cannot tolerate oral intake of fluids. Resident #120 was admitted to the facility in October 2025 with diagnosis including diabetes, moderate protein malnutrition, dysphagia, and a mild cognitive impairment. Review of Resident #120's Minimum Data Set assessment, dated 2/4/26, indicated he/she had a memory problem and required supervision with eating. This MDS indicated Resident #120 experienced no weight loss, he/she required a feeding tube, and he/she received greater than 51% of meals via feeding tube. Review of Resident #120's risk for malnutrition care plan related to g-tube, dated as revised 12/4/25, indicated: - Administer tube feed and flushes as ordered. Review of Resident #120's physician's orders, dated 2/2/26, indicated:- two times a day Enteral Feed Order, via G-Tube Nepro 1.8 at 70 ml/hr (start at 2000 and end at 0600) Free water Flush 30 ml pre/post regimen for patency. Elevate Head of Bed. Further review of the order indicated for nursing to start at 8:00 P.M., and end at 6:00 A.M.,- four times a day bolus via g-tube, free water flush 200 milliliters (ml) Q6 (every six hours). Further review of the order indicated for nursing to administer at 9:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M., not every six hours according to the order. Review of Resident #120's nutrition note, dated 1/7/26, indicated: - Free water flush 30 milliliter (ml) pre/post regimen for patency.- Free water flush 220 ml Q6.- Total Regimen Provides 1800 kcal, 81g protein, 1667ml total fluid (60ml FWF pre/post + free water flush 880, free water TF 727ml) On 2/17/26 at 7:40 A.M., the surveyor observed Resident #120 in bed, he/she was connected to a tube feeding pump. The pump was set at 70 ml an hour for the tube feeding rate and water flushes were set to 200 ml every 3 hours. The pump indicated 849 ml of feeding had been administered (greater than the estimates per the Dietitian). The tube feeding bag did not have a label or date of the contents inside the bag and therefore contents and the expiratory date could not be verified. Additionally, the feeding was still infusing one hour and 41 minutes after the feeding should have been completed. During an interview on 2/19/26 at 6:55 A.M., Nurse #4 said that he worked the overnight shift on Monday into Tuesday, and he said that the tube feeding should have been stopped at 6:00 A.M. Nurse #4 said that during the night shift that Resident #120's tube feeding pump is auto set to have water flushes of 200 ml every 3 hours. Nurse #4 said that tube feeding bags should be dated and labelled with the contents of the type of tube feed should be written on the bag and Nurse #4 said that sometimes the facility has bottles of tube feeding and sometimes the facility has bags that need to be filled from cartons of tube feeding. During an interview on 2/18/26 at 2:15 P.M., the Registered Dietitian (RD) said that Resident #120 receives nocturnal feedings and Resident #120 receives free water flushes every 6 hours. The RD (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed the physician's orders, and she said that the free water flushes were not scheduled every 6 hours but should be. During an interview on 2/18/26 at 2:25 P.M., Nurse #3 said that Resident #120 has tube feeding free water flushes based on the physician's order. Nurse #3 said that he only had to flush Resident #120's g-tube once this morning and he did it around 9:00 A.M. Review of the Medication Administration Record, dated 2/18/26, indicated that Nurse #3 administered the free water flush at 9:00 A.M. and again at 1:00 P.M., conflicting with his interview on 2/18/25 at 2:25 P.M., which was 1 hour and 25 minutes after he documented he administered a free water flush at 1:00 P.M. During an interview on 2/18/26 at 3:34 P.M., the Assistant Director of Nursing said that nursing should label and date the tube feeding bags. The ADON said that nursing should have stopped the tube feeding at 6:00 A.M. on 2/17/26, as ordered. The ADON reviewed the flush orders, and she said that orders indicate every 6 hours, and she said that the flushes are not scheduled according to the physician's orders, and she said nursing should have updated the order to reflect every 6 hours as ordered.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record review, and interview for two Residents (#78 and #85) out of four residents observed the facility failed to ensure it was free from a medication error rate of greater than 5%. When two out of four nurses observed made two errors out of 27 opportunities resulting in a medication error rate of 7.41%. Specifically, 1. For Resident #78 the facility failed to ensure Nurse #1 administered the correct vitamin B complex with C and folic acid. 2. For Resident #85 the facility failed to ensure Nurse #2 administer the correct dose of MiraLAX. Findings include: Review of the facility policy titled, General Dose Preparation and Medication Administration, dated as revised 11/15/24, indicated:2.2 Only prepare medications for one resident at a time, using a 3-way-check (i.e, comparing the medication to the Medication Administration Record). 1. On 2/18/26 at 8:11 A.M., the surveyor observed Nurse #1 prepare and administer Resident #78 one tablet of B-complex plus vitamin C. Review of Resident #78's physician's order, dated 12/31/25, indicated:- B-Complex-C (with Folic Acid) Oral Tablet, give 1 mg by mouth one time a day for MULTIVITAMINS. During an interview on 2/18/26 11:10 A.M., Nurse #1 said she did not give the correct vitamin B complex with folic acid, but she should have. Nurse #1 said she administered the vitamin B complex with C which she always has on hand. Review of Resident #78's Medication Administration Record (MAR), dated 2/1/26 through 2/18/26, indicated Nurse #1 administered the vitamin B complex with C on 14 occasions. During an interview on 2/18/26 at 3:41 P.M., the Assistant Director of Nursing (ADON) said that Nurse #1 should have administered the correct vitamin B complex with folic acid. 2. On 2/18/26 at 8:52 A.M., the surveyor observed Nurse #2 prepare and administer Resident #85 Polyethylene Glycol Powder (MiraLAX) 17 grams mixed in 8 ounces of water. Review of Resident #85's physician's order, dated 1/21/25, indicated:-Polyethylene Glycol Powder (MiraLAX), give 8.5 gram by mouth one time a day for constipation mix with 8 ounces of liquid of resident choice. During an interview on 2/18/26 at 11:14 A.M., Nurse #2 said she administered Resident 17 grams of MiraLAX, and she filled the cap full of the medication to ensure she gave the full dose. Nurse #2 and the surveyor reviewed the order that indicated to administer 8.5 grams of MiraLAX, and she said she didn't realize the order was for 8.5 grams. Nurse #2 said that she always administers Resident #78 a full cap of MiraLAX. Review of Resident #85's MAR, dated 2/1/26 through 2/18/26, indicated Nurse #2 administered Resident #85's MiraLAX on 8 occasions. During an interview on 2/18/26 at 3:43 P.M., the ADON said Nurse #2 should have administered the correct dose of MiraLAX.