STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225499	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Village at West Roxbury	5060 Washington Street West Roxbury, MA 02132

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interviews the facility failed to ensure a resident-centered personalized care plan was developed for two Residents (#59, #) out of a total sample of 19 residents. Specifically,For Resident #46, the facility failed to ensure a resident- centered personalized care plan was developed for a pacemaker.For Resident #59, the facility failed to ensure a resident-centered personalized care plan was developed for a pacemaker. Findings include: Review of facility policy titled Pacemaker, care of a Resident with a, undated, indicated the following: -Documentation: For each resident with a pacemaker, document the following in the medical record upon admission: 1. The name, address and telephone number of the cardiologist. 2. Type of pacemaker c. Date of implant. d. Paced rate. 1. Resident #46 was admitted to the facility in March 2025 with diagnoses that included Parkinson's, adult failure to thrive, bradycardia and presence of a cardiac pacemaker. Review of Resident #46's most recent Minimum Data Set (MDS) Assessment, dated 9/11/25, indicated a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severe cognitive impairment. Review of Resident #46's care plan, initiated 5/7/25 indicated the following: -I have a pacemaker r/t (related to) bradycardia (low heart rate), palpations, HTN (hypertension). -Interventions for the care plan included: follow up with cardiology as needed, pacemaker checks as needed, vital signs as ordered and as needed, report abnormalities to MD if noted. Review of the Resident's care plan failed to indicate a comprehensive person-centered care plan around the care of his/her pacemaker including the name of the cardiologist, the type of pacemaker, implant date and the paced rate. Review of Resident #46's progress notes failed to indicate information regarding his/her pacemaker, (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	including paced rate or appointments for pacemaker checks. Review of Resident #46's physician's orders failed to indicate monitoring orders for the pacemaker or specific pacemaker settings. Review of the unit appointment book since Resident #46's admission and through the end of the year, failed to indicate a scheduled appointment for a pacemaker check. During an interview on 9/25/25 at 7:50 A.M., Nurse #2 said that she does not know what the paced rate for Resident #46's pacemaker is. She said she is not sure if there needs to be a care plan or physician's orders addressing the care of the pacemaker. She also said she is not sure what the schedule is for pacemaker checks for Resident #46. During an interview on 9/25/25 at 8:03 A.M., the Director of Nurses (DON) said that when residents are admitted to the facility, they contact the cardiologist for pacemaker information and information about last and next appointments. The DON said that he would expect the Resident to have a comprehensive care plan and physician's orders regarding the management of the pacemaker to include monitoring the paced rate. He said he was not sure when the Resident's next appointment was, but he was trying to find out. 2. Resident #59 was readmitted to the facility in March 2021 with diagnoses that included hemiplegia and hemiparesis, cerebral infarction, heart failure, and aphasia. Review of Resident #59's Minimum Data Set (MDS) assessment, dated 7/4/25, indicated he/she was assessed by nursing staff to have severe cognitive impairment. Review of Resident #59's physician order, dated 9/15/25, indicated Please check Pacemaker monitor at bedside for functioning every shift. Review of Resident #59's hospital discharge paperwork, dated 1/11/21, indicated Pacemaker Pacer Mode: DDD (01/10 0000). Review of Resident #59's pacemaker care plan failed to indicate paced rate, cardiologist information, frequency of checks or the cardiologist information. Review of Resident #59's Medical Doctor and Nurse Practitioner progress notes since admission in 2021 failed to indicate the Resident had a pacemaker or any details of the pacemaker. During an observation and interview on 9/25/25 at 8:02 A.M., Nurse #2 said there should be a care plan in place that has all of the pacemaker information in it including the paced rate but is not sure what that rate is. During an interview on 9/25/25 at 8:03 A.M., the Director of Nurses (DON) said that when residents are admitted to the facility, they contact the cardiologist for pacemaker information and information about last and next appointments. The DON said that he would expect the Resident to have a comprehensive care plan and physician's orders regarding the management of the pacemaker to include monitoring the paced rate.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review and interview, the facility failed to provide a dignified dining experience for one Resident (#46) out of a total sample of 19 Residents. Specifically, facility staff stood over the Resident in bed while assisting with meals. Findings include: Review of facility policy titled Dignity/ Quality of Life, dated as revised 12/6/21, indicated the following:-Purpose: To ensure residents are cared for in a manner that enhances quality of life.-1. Residents shall be always treated with dignity and respect.-2. Treated with dignity means that resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.-11. Demeaning practices and standards of care that compromise dignity is prohibited. Staff shall promote dignity and assist residents as needed. Resident #46 was admitted to the facility in March 2025 with diagnoses that included Parkinson's, adult failure to thrive, bradycardia and presence of a cardiac pacemaker. Review of Resident #46's most recent Minimum Data Set (MDS) Assessment, dated 9/11/25, indicated a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severe cognitive impairment. The MDS further indicated that the Resident required substantial/ maximal assistance with eating. On 9/22/25 at 8:30 A.M., the surveyor observed a staff member standing over the Resident in bed to assist with the breakfast meal. On 9/24/25 at 8:26 A.M., the surveyor observed a staff member standing over the Resident in bed to assist with the breakfast meal. During an interview on 9/25/25 at 8:12 A.M., Certified Nurse Aide (CNA) #1 said that when a resident is being assisted with eating, the staff should be seated next to the Resident. She said it doesn't matter if the Resident is in a chair or in the bed, staff should not stand over them. During an interview on 9/25/25 at 9:56 A.M., the Director of Nurses said that staff should be sitting with residents and making them feel comfortable while they are assisting them with their meals to provide a dignified dining experience.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observations, interview and record review the facility failed to assess the use of a seat belt as a potential restraint for one Resident (#17) out of a total sample of 19 Residents. Findings include: Review of facility policy Physical Restraints, dated as reviewed December 2022, indicated the following:-The facility recognizes the necessity of maintaining a systemic method of evaluating and monitoring restraint use.-The policy includes an interdisciplinary process of assessment and reassessment in order to ensure that when a restraint is necessary to treat a resident's medical condition the least restrictive is utilized for the least amount of time to treat the resident's medical condition with a plan for continued assessment and reduction.-components of restraint use: interdisciplinary assessment, MD (Physician) order, consent, care planning, CNA (Certified Nurse Aide) care card, reduction plan, reassessment.-Physical restraint is defined as any manual method, physical or mechanical device, equipment or material that meets the following criteria: is attached to adjacent to the patient's body, cannot be removed easily by the patient and restricts the patient's freedom of movement or normal access to his/her body.-All potentially restraining devices require assessment to determine if the device constitutes a restraint. If the assessment of the device reveals that it meets the criteria for restraint the policy for restraint use will be utilized.-Device evaluation- any resident who is utilizing a device that could constitute a restraint will be evaluated to determine if the device is a restraint.-b. if the evaluation determines that the device does not meet the guidelines for physical restraint, the device will be addressed on the plan of care. Resident #17 was admitted to the facility in November 2024 with diagnoses including cerebral infarction and major depressive disorder.Review of Resident #17's most recent Minimum Data Set (MDS) Assessment, dated 9/3/25, indicated a Brief Interview for Mental Status score of 15 out of 15 indicating that the Resident was cognitively intact. The MDS failed to indicate that any type of restraint was used.On 9/22/25 at 7:45 A.M. the surveyor observed Resident #17 sitting in his/her motorized wheelchair. The surveyor observed Certified Nurse Aide (CNA) #2 buckle a seatbelt around the Resident's abdomen while the resident sat in the chair.On 9/25/25 at 7:53 A.M., the surveyor observed Resident #17 in his/her wheelchair in the hallway. The Resident had a seat buckle around his/her abdomen as well as across his/her thighs. Resident #17 said that he/she utilizes both belts when up in his/her chair. Resident #17 said that he/she has left sided weakness and cannot keep his/her legs in the chair without the buckle. Resident #17 said that he/she has been utilizing the buckles since admission to the facility. Resident #17 said that he/she needs assist to apply and remove the buckles. Review of the medical record failed to indicate a restraint or device assessment addressing the use of the seat belt/buckle had been completed.Review of Resident #17's physician's orders failed to indicate orders for the use of a restraint/device, or specifically a seat belt.Review of the Resident's care plan failed to indicate the use of a seat belt while in his/her wheelchair.Review of progress notes dated 3/23/25- 9/24/25 failed to indicate the use of a seat belt or any type of restraint.Review of the UDA Packet, specifically, the device assessments completed on 3/5/25, 6/8/25 and 9/9/25 indicated the resident was assessed for the use of side rails but no other devices. During an interview on 9/24/25 at 1:45 P.M., CNA #2 said that he takes care of Resident #17 every day. He said that when Resident #17 is up in his/her wheelchair, the seatbelt is in place at all times. He said the Resident is unable to remove it or apply it on his/her own. CNA #2 said that whenever the Resident is up on his/her wheelchair, the seatbelt is utilized. During an interview on 9/24/25 at 1:46 P.M., Nurse #2 said that Resident #17 utilizes a seat belt while up in his/her wheelchair. She said that she would not consider it a restraint. She said that she would not complete a restraint assessment because it does not have the potential to be a restraint. During an interview on 9/24/25 at 1:54 P.M., the Director of Nurses said that staff should have reported to him that the Resident was utilizing a seat belt so that a restraint assessment could have been completed to assess for the use of a potential restraint. The (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nurses said he was not aware that the Resident was utilizing the buckle. He said that there should be a physician's order for use of the seat belt and a care plan initiated for the use.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview the facility failed to ensure that for one Resident's (#46) out of a total sample of 19 residents, their drug regime was free from unnecessary antipsychotic drugs. Specifically, the facility failed to adequately monitor the use of quetiapine (an antipsychotic medication) and evaluate whether a Gradual Dose Reduction (GDR) was indicated. Findings include:Review of facility policy titled Psychotropic Medication Treatment in Long Term Care Centers, dated as January 2021, indicated the following:-It is the [facility's] policy to abide by state and federal regulations when requesting consent and administering psychotropic medications.-GDR: Tapering of a Medication Dose/ Gradual Dose Reduction (GDR). The requirements underlying this guidance emphasize the importance of seeking an appropriate dose and duration for each medication and minimizing the risk for adverse consequences. The purpose of tapering medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident.-There are various opportunities during the care process to evaluate the effects of medications on the resident's function and behavior, and to consider whether the medications should be continued, reduced or discontinue, or otherwise modified. Examples of these opportunities include:-During the monthly medication regimen review, the pharmacist evaluates resident- related information for dose, duration, continued need, and the emergence of adverse consequences for all medications.-When evaluating the resident's progress, the practitioner reviews the total plan of care, orders, the resident's response to medications, and determines whether to continue, modify, or stop a medication; and-During the quarterly MDS review, the facility evaluates mood, function, behavior, and other domains that may be affected by medications. Resident #46 was admitted to the facility in March 2025 with diagnoses that included major depressive disorder and visual hallucinations. Review of Resident #46's most recent Minimum Data Set (MDS) Assessment, dated 9/11/25, indicated a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severe cognitive impairment. The MDS further indicated the use of antipsychotic and antidepressant medications. The MDS further indicated that antipsychotics were received on a routine daily basis and that no Gradual Dose Reduction (GDR) had been attempted. The MDS indicated that there was no documentation from the physician indicating that a GDR was clinically contraindicated. Review of Resident #46's active physician's orders indicated the following:-Quetiapine (an antipsychotic medication) 25 mg, give 0.5 tablet by mouth at bedtime for hallucinations, give with Quetiapine 25 mg tab = 37.5 mg, dated as 3/31/25. (Originally dated 3/7/25 but rewritten for clarification).-Quetiapine 25 mg give 1 tablet by mouth at bedtime for hallucinations, give with quetiapine 25 mg 1/2 tab = 37.5 mg, dated 3/31/25. (Originally dated 3/7/25 but rewritten for clarification). Review of the medical record indicated that the Resident had been receiving the same dose of Quetiapine since admission to the facility. Review of Resident #46's active care plan, dated as initiated 3/7/25, indicated, I am taking psychotropic medication related to depression and anxiety, with interventions that include the following:-Please give me the lowest dose possible to control my situation/ behavior and prevent adverse side effects as my MD/NP (physician or nurse practitioner) as ordered.-Please review the need for this medication quarterly and as needed. Review of Physician and Nurse Practitioner progress notes failed to indicate that a GDR was attempted or clinically contraindicated.Review of the medical record failed to indicate any behavioral health visits had occurred since Resident #46 was admitted to the facility in March 2025. During an interview on 9/24/25 at 2:01 P.M., the Director of Nurses said that behavioral health services manage GDRs in the facility, and the Resident had not been seen by behavioral health services since admission. He said that a GDR had not been attempted but should have been attempted or documented in the medical record that it was contraindicated for the Resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interview, the facility to ensure that services provided met professional standards for one Resident (#46) out of a total sample of 19 residents. Specifically, for Resident #46 the facility failed to complete a baseline AIMS (Abnormal Involuntary Movement Scale) assessment upon admission and at the initiation of an antipsychotic medication. Findings include:Resident #46 was admitted to the facility in March 2025 with diagnoses that included Parkinson's, adult failure to thrive, bradycardia and presence of a cardiac pacemaker. Review of Resident #46's most recent Minimum Data Set (MDS) Assessment, dated 9/11/25, indicated a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severe cognitive impairment. The MDS further indicated the use of antipsychotic and antidepressant medications and that antipsychotic medications were received on a routine daily basis. Review of Resident #46's physician orders indicated the following:-Quetiapine (an antipsychotic medication) 25 mg give 0.5 tablet by mouth at bedtime for hallucinations give with Quetiapine 25 mg tab = 37.5 mg, dated as 3/31/25. (originally dated 3/7/25 but rewritten for clarification).-Quetiapine 25 mg give 1 tablet by mouth at bedtime for hallucinations, give with quetiapine 25 mg 1/2 tab = 37.5 mg, dated 3/31/25. (originally dated 3/7/25 but rewritten for clarification). Review of the summary for recommendations for DNS (Director of Nurses)/ Medical Director from the Monthly Medication Regime Review, completed by the consultant pharmacist, dated as recommendations made between 4/1/25 and 4/18/25, indicated the following for Resident #46:Nursing Recommendation: This resident is receiving the antipsychotic medication Quetiapine. Please perform AIMS testing now and every 6 months to monitor for tardive dyskinesia. Thank you.Review of the medical record failed to indicate that an AIMS assessment was completed prior to the one completed on 5/27/25, 81 days after admission and initiation of the antipsychotic medication and 40 days after the recommendation to complete it was made (on 4/17/25). The score of the AIMS test when completed was 2, indicating that tardive dyskinesia movements have been identified, but are not severe enough for interventions, and do not interfere with activities of daily living. During an interview on 9/24/25 at 1:53 P.M., Nurse #2 said that an AIMS assessment should be completed on admission if the resident is admitted on antipsychotic medications, or upon the initiation of an antipsychotic medication. She said, however, she was not sure who was responsible to complete the assessment. During an interview on 9/24/25 at 2:01 P.M., the Director of Nurses said that he had asked the psychiatric nurse practitioner to complete an AIMS assessment on Resident #46 in April following a pharmacy recommendation. He said that he noticed that the Resident hadn't been seen by behavioral health services to have the assessment completed, so he completed the assessment in May. He said the assessment should have been completed on admission and then every 6 months thereafter.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to develop person centered trauma informed care plans accounting for the residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization for two Residents (#10 and #34) out of a sample of 19 Residents. Specifically, the facility failed to develop person centered (Post Traumatic Stress Disorder) PTSD care plans.Findings include:Review of the facility policy tilted, ?Trauma Informed Care', effective [DATE] indicated the following:-The facility ensures that residents who are trauma survivors receive culturally competent, trauma informed care decisions in accordance with professional standards of practice and account for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident.-Trauma-the result of an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.-Trauma-informed care-an approach to delivering care that involves understanding recognition and response to the effects of all types of trauma. A trauma informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporated knowledge about trauma into policies, procedures and practices to avoid re-traumatization.-Upon admission, the center will assess each resident with a PTSD screen and Traumatic events checklist. Social service personnel will conduct the assessment to identify whether a resident has experienced trauma and PTSD as well as to gather trauma triggers. The information re3ceived from the assessment will be used to identify appropriate services and assist with preventing re-traumatization of the resident. Additional information may be obtained from the medical record, physical and emotional assessments completed with the residents and/or family members who have share this information.Review of the facility policy titled ?Comprehensive Care Plan' with no revision date indicated the following:-An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.1.Resident #10 was admitted to the facility in [DATE] with diagnoses including PTSD.Review of the Minimum Data Set (MDS) Assessment, dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 indicating intact cognition.Review of behavioral health notes dated [DATE] indicated the following:-History of present illness-endorses continues PTSD symptoms including nightmares and flashbacks relating to past exposure to trauma.-Past living arrangements-resident cannot live with spouse due to a question of domestic violence.-Other trauma/loss-sexual assault, miscarriage at 20 weeks.Review of the care plan initiated [DATE] indicated a PTSD care plan that failed to identify the Resident's specific history of trauma, identify the specific triggers, the signs and symptoms of the Resident's trauma to avoid re-traumatization.During an interview on [DATE] at 9:30 A.M., the Social Worker said PTSD care plans should not be generic, they should be person centered, including the resident's specific trauma, identify the specific triggers based on the trauma to avoid re-traumatization. The Social Worker said a trauma informed assessment should be completed at admission to identify the residents' trauma and triggers.During an interview and medical record review on [DATE] at 10:15 A.M., the Director of Nurses (DON) said the Resident's PTSD care plan was in place, but it was not person centered. The DON said the PTSD care plan should identify the resident's specific trauma, identify the specific triggers to prevent the resident from getting retraumatized.During an interview on [DATE] at 12:06 P.M., the Chief Operating Officer said the interdisciplinary team could not locate any trauma informed assessment completed for the Resident.2. Resident #34 was admitted to the facility in [DATE] with diagnoses including PTSD.Review of the Minimum Data Set (MDS) Assessment, dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15 indicating intact cognition.Review of the behavioral health (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notes dated [DATE] indicated the following:-Other trauma loss-childhood abuse, was in foster care, physically abused by ex-husband, daughter was murdered at age [AGE].Further review of the hospital discharge paperwork, psychiatry service dated [DATE] indicated the following:-Resident describes finding his/her mother overdosing at the age of five and performing (cardiopulmonary resuscitation) CPR on her. Resident was sent to foster care where he/she was physically assaulted, locked in a cupboard for three days.Review of the care plan initiated [DATE] indicated a PTSD care plan that failed to identify the Resident's specific history of trauma, identify the specific triggers, the signs and symptoms of the Resident's trauma to avoid re-traumatization.During an interview on [DATE] at 9:30 A.M., the Social Worker said PTSD care plans should not be generic, they should be person centered, including the resident's specific trauma, identify the specific triggers based on the trauma to avoid re-traumatization. The Social Worker said a trauma informed assessment should be completed at admission to identify the residents' trauma and triggers. During an interview and medical record review on [DATE] at 10:15 A.M., the Director of Nurses said the Resident's PTSD care plan was in place, but it was not person centered. The DON said the PTSD care plan should identify the resident's specific trauma, identify the specific triggers that may cause the resident from getting re-traumatized.During an interview on [DATE] at 12:06 P.M., the Chief Operating Officer said the interdisciplinary team could not locate any trauma informed assessment completed for the Resident.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on record review and interview, the facility failed to provide behavioral health services for one Resident, (#46) out of a total of 19 sampled Residents. Specifically, the facility failed to ensure behavioral health services were provided for Resident #46 who received antipsychotic medication, antidepressant medication and has diagnoses of anxiety and major depressive disorder. Findings include:Review of facility policy, titled Behavioral Health Services, dated as revised 12/6/21, indicated the following:-The facility will ensure that, a resident who displays or is diagnosed with mental disorder or psychological adjustment difficulty, or who has a history of trauma and / or post-traumatic stress disorder, receives appropriate treatment and services. Resident #46 was admitted to the facility in March 2025 with diagnoses that included anxiety disorder, dementia, major depressive disorder and unspecified psychosis not due to a substance or known physiologic disturbance. Review of Resident #46's most recent Minimum Data Set (MDS) Assessment, dated 9/11/25, indicated a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severe cognitive impairment. The MDS further indicated the use of antipsychotic and antidepressant medications. Review of physician's orders indicated the following:-May be seen by psych as needed, dated 3/7/25.-Quetiapine (an antipsychotic medication) 25 mg (milligrams) give 0.5 tablet by mouth at bedtime for hallucinations give with Quetiapine 25 mg tab = 37.5 mg, dated as 3/31/25. (originally dated 3/7/25 but rewritten for clarification).-Quetiapine 25 mg give 1 tablet by mouth at bedtime for hallucinations, give with quetiapine 25 mg 1/2 tab = 37.5 mg, dated 3/31/25. (originally dated 3/7/25 but rewritten for clarification).-Mirtazapine (an antidepressant medication) 7.5 mg give one tablet at bedtime for depression, dated 3/7/25.-Sertraline (an antidepressant medication) 50 mg give one tablet one time a day for major depressive disorder, dated 3/7/25. Review of Resident #46's active care plan indicated: I am taking psychotropic medication related to depression and anxiety, dated as 3/7/25, with interventions that included:-Please provide [me] with a psych consult as needed. Resident #46's active care plan, dated 3/7/25, further indicated: Sometimes I don't feel happy and get depressed. I feel frustrated over my medical situation and my social situation, I have depression depressive mood, (sic) with interventions that included:-Please provide me with psych services as needed, if my MD/NP (Physician or Nurse Practitioner) thinks this will help. Review of the Nurse Practitioner progress note, dated 3/13/25, indicated the following: Assessments/Plans:-Unspecified psychosis not due to a substance or known physiological condition -Does not appear agitated or delusional in any way -Will have psychiatry follow along with us. Appears comfortable and calm at this time. Review of the Nurse Practitioner progress note, dated 9/11/25, indicated the following:Assessments/Plans:-Unspecified psychosis not due to a substance or known physiological condition - Patient is on Seroquel (another name for Quetiapine) mood is stable. Patient is followed along with psychiatry. Review of the medical record indicated a signed and dated Request for services, indicating that the Resident/ or their health care proxy had consented to receive counseling or behavioral health services. This request for service was signed and dated 5/9/25, two months after admission to the facility. Review of the medical record failed to indicate that the Resident had been evaluated by behavioral health services since admission to the facility. During an interview on 9/24/25 at 2:01 P.M., the Director of Nurses said that Resident #46 had not been seen by psych services, but he/she should have been seen. The Director of Nurses said that residents who take antipsychotic medications and antidepressant medications should be followed by psych for monitoring. He said that the Resident was registered to be seen but never was. During an interview on 9/25/25 at 9:21 A.M., the Social Worker said that all residents who have a signed consent to see behavioral health services and are on psychotropic medications should be provided with psych or behavioral health services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225499	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Village at West Roxbury	5060 Washington Street West Roxbury, MA 02132

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure for two Residents (#46 and #2), out of a total sample of 19 residents, that monthly pharmacy medication regimen review recommendations were implemented in accordance with the physician/nurse practitioner response to the recommendations. Specifically,For Resident #46, the facility failed to implement recommendations timely to complete an AIMS (abnormal involuntary movement scale) Assessment, clarify the frequency of administration for as needed orders, and the pharmacist failed to recommend a Gradual Dose Reduction (GDR) for an antipsychotic medication.For Resident #2 the facility failed to clarify the frequency of administration for an as needed order.Findings include: Review of facility policy titled Psychotropic Medication Treatment in Long Term Care Centers, dated as January 2021, indicated the following:-It is the [facility's] policy to abide by state and federal regulations when requesting consent and administering psychotropic medications.-GDR: Tapering of a Medication Dose/ Gradual Dose Reduction (GDR). The requirements underlying this guidance emphasize the importance of seeking an appropriate dose and duration for each medication and minimizing the risk for adverse consequences. The purpose of tapering medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident.-There are various opportunities during the care process to evaluate the effects of medications on the resident's function and behavior, and to consider whether the medications should be continued, reduced or discontinue, or otherwise modified. Examples of these opportunities include:-During the monthly medication regimen review, the pharmacist evaluates resident- related information for dose, duration, continued need, and the emergence of adverse consequences for all medications. 1a. Resident #46 was admitted to the facility in March 2025 with diagnoses that included Parkinson's, adult failure to thrive, bradycardia and presence of a cardiac pacemaker. Review of Resident #46's most recent Minimum Data Set (MDS) Assessment, dated 9/11/25, indicated a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severe cognitive impairment. The MDS further indicated the use of antipsychotic and antidepressant medications. The MDS further indicated that antipsychotics were received on a routine daily basis and no Gradual Dose Reduction (GDR) had been attempted. The MDS indicated that there was no documentation from the physician indicating that a GDR was clinically contraindicated. Review of the summary for recommendations for DNS (Director of Nurses)/ Medical Director from the Monthly Medication Regime Review, completed by the consultant pharmacist, dated as recommendations made between 4/1/25 and 4/18/25, indicated the following for Resident #46:Nursing Recommendation: This resident is receiving the antipsychotic medication Quetiapine. Please perform AIMS testing now and every 6 months to monitor for tardive dyskinesia. Thank you. Review of the medical record failed to indicate that an AIMS assessment was completed prior to the one completed on 5/27/25, 81 days after admission and initiation of the antipsychotic medication and 40 days after the recommendation to complete it was made (on 4/17/25). The score of the AIMS test when completed was 2, indicating that tardive dyskinesia movements have been identified, but are not severe enough for interventions, and do not interfere with activities of daily living. 1b. Review of the pharmacist progress note, dated 9/16/25, indicated the following:-NURSE REC (recommendation)-Please clarify frequency of MOM (milk of magnesia), Bisacodyl suppository, and Fleet enema PRN (as needed) orders. Review of Resident #46's active physician orders as of 9/24/25 indicated the following:- Milk of Magnesia Oral Suspension 400 mg/5 ml give 30 ml by mouth as needed for constipation, dated 3/7/25.-Dulcolax suppository 10 mg (bisacodyl) Insert 1 suppository rectally as needed for Constipation If Milk of Magnesia is ineffective give Dulcolax 10mg Suppository via rectum, dated 4/21/25-Fleet Enema Enema 7-19 GM/118ML (Sodium Phosphates) Insert 1 applicatorful rectally as needed for Constipation If no bowel movement after Dulcolax suppository (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	give Fleet Enema via rectum, dated 4/21/25Review of the above physician orders failed to indicate a frequency for administration as recommended by the consultant pharmacist. 1c. Review of Resident #46's physician's orders indicated the following:-Quetiapine (an antipsychotic medication) 25 mg give 0.5 tablet by mouth at bedtime for hallucinations give with Quetiapine 25 mg tab = 37.5 mg, dated as 3/31/25. (originally dated 3/7/25 but rewritten for clarification).-Quetiapine 25 mg give 1 tablet by mouth at bedtime for hallucinations, give with quetiapine 25 mg 1/2 tab = 37.5 mg, dated 3/31/25. (originally dated 3/7/25 but rewritten for clarification). Review of the progress notes since Resident #46's admission to the facility pertaining to Monthly Medication Regime Reviews completed by the consultant pharmacist failed to indicate any recommendations for a Gradual Dose Reduction (GDR) of an antipsychotic medication. Review of Provider progress notes failed to indicate any review for a GDR was completed For Resident #46, or that a GDR was clinically contraindicated for the Resident. During an interview on 9/24/25 at 1:52 P.M., Nurse #2 said that she is not sure who addresses pharmacy recommendations, there is a specific nurse, but she is not sure who it is. She said that they are not brought to the floor for the staff nurses to address. During an interview on 9/24/25 at 2:01 P.M., the Director of Nurses said that all of the pharmacist's recommendations come to him and he addresses a majority of them. He said that they should be addressed right away. The Director of Nurses said that the AIMS assessment was completed on 5/27/25 by him, and it was not completed at the time of the recommendation. He said that he noticed it was never done so he completed it. He said that initially when the recommendation came in in April, he realized that behavioral health services had not seen the Resident and asked for him/her to be seen, and the AIMS completed. The Director of Nurses said that behavioral health services not being in place also contributed to the lack of a GDR attempt or documentation that it was not indicated, but it should have been picked up on. He further said that the frequency of the as needed orders should have been clarified when the recommendations were received. 2. Resident #2 was admitted to the facility in September 2019 with diagnoses that include dementia, persistent mood disorder and lower back pain. Review of the most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated a Brief Interview for Mental Status score of 9 out of a possible 15, indicating moderate cognitive impairment. Review of the pharmacist progress note pertaining to the Monthly Medication Regime, dated 9/16/25, indicated the following:-MD (physician) REC (recommendation)- please consider ordering a lipid panel/ Atorvastatin-Nurse REC- Please clarify strength and frequency of PRN (as needed) Fleet enema order. Review of Resident #2's active Physician's orders as of 09/24/25 indicated the following:-Fleet enema Insert 1 application rectally as needed for Constipation, dated 9/1/2020. (The order failed to indicate a strength/ dose or frequency for administration). During an interview on 9/24/25 at 1:52 P.M., Nurse #2 said that she is not sure who addresses pharmacy recommendations, there is a specific nurse, but she is not sure who it is. She said that they are not brought to the floor for the staff nurses to address. During an interview on 9/24/25 at 2:01 P.M., the Director of Nurses said that pharmacy recommendations come to him first and he usually addresses them. He said they should be addressed right away. He said the physician's orders should indicate a dose and frequency of administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the medications on one of two units.Findings include:Review of the facility policy titled storage of Medications, not dated, indicated that medication rooms, carts and medication supplies are locked when not attended by persons with authorized access. On 9/22/25, at 6:56 A.M. the surveyor observed a medication cart open, and the surveyor opened the drawer without interference. The surveyor also observed several residents and staff members in the hall. On 9/22/25, at 8:28 A.M., the surveyor observed 2 capsules in a medication cup on a resident's bedside table. The surveyor observed that the resident was in bed asleep. The surveyor also observed that the resident's roommate was awake. During an interview on 9/25/25 at 7:57 A.M., Nurse #1 said that medications should not be left at bedside and medication carts should not be left open.