STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225508	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Springs Post Acute	40 Parkhurst Road Chelmsford, MA 01824

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had a tracheostomy (a surgical procedure that creates and opening in the neck to facilitate breathing when the usual airway is obstructed or compromised) and required continual respiratory care and the administration of humidified oxygen, the facility failed to ensure that care and treatment provided were consistent with professional standards of practice, when physician's orders related to his/her respiratory equipment use/monitoring were not obtained by nursing.Findings include:Review of the Facility's Protocol and Procedure, titled Airvo and myAirvo Unit, undated, indicated the following:-Description: A humidifier, with adjustable flow settings, delivering high flow warm and humidified gases.-Fill the water chamber with sterile or distilled water. Do not allow the water chamber to run dry.-Set the airflow setting on the Airvo and the oxygen liters per minute to achieve the prescribed percentage of oxygen.-Documentation: *Airvo flow settings *Oxygen liter flow *Oxygen percentage *Patient's tolerance to therapyResident #1 was admitted to the facility in November 2025, diagnoses included large intracranial hemorrhage, acute hypoxic respiratory failure, and tracheostomy.Review of Resident #1's medical record which included his/her Medication Administration Record (MAR) and Treatment Administration Record (TAR) indicated there was no documentation to support that nursing obtained Physician's orders for:-the Airvo flow settings-the type of water required to fill the water chamber on the Airvo unit-the frequency to monitor the water chamber on the Airvo unit to ensure it did not run dryDuring a telephone interview on 12/10/25 at 10:35 A.M., Respiratory Therapist (RT) #1 said he programmed the settings on Resident #1's Airvo unit upon his/her admission to the facility and nursing was then responsible for monitoring the settings on the unit.During an interview on 12/09/25 at 4:10 P.M., the Director of Nurses (DON) said that nursing had been working on Resident #1's Physician's orders, including the specific orders related to the Airvo unit, and the orders were not complete upon his/her admission to the facility.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225508	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Springs Post Acute	40 Parkhurst Road Chelmsford, MA 01824

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225508	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Springs Post Acute	40 Parkhurst Road Chelmsford, MA 01824

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), the facility failed to ensure they maintained complete and accurate records related to 1) the care and services associated with his/her tracheostomy (a surgical procedure that creates and opening in the neck to facilitate breathing when the usual airway is obstructed or compromised) and 2) the recording of the events during his/her Cardiopulmonary Resuscitation (CPR) Code.Findings include:Review of the Facility's policy, titled Suctioning the Tracheostomy Tube, with a revision date of 10/2023, indicated the following:-The purpose of this procedure is to remove secretions, maintain a patent airway, and prevent infection of the lower respiratory tract.-The following information should be recorded in the resident's medical record: *The date and time the procedure was performed *The type and size of the catheter used. *The amount of negative pressure millimeters per mercury (mmHg) used to suction. *Amount, color and characteristic of secretions. *Oxygen saturation and pulse during the procedure.Resident #1 was admitted to the facility in [DATE], diagnoses included large intracranial hemorrhage, acute hypoxic respiratory failure, and tracheostomy.1) Review of Resident #1's Nursing Progress Note, dated [DATE], indicated Resident #1 was suctioned once and his/her inner (tracheostomy) cannula (removable tube inserted within the outer cannula tracheostomy tube, used to maintain airway patency) was changed.Review of Resident #1's Treatment Administration Record (TAR) for the month of [DATE] indicated the following physician's orders were not signed off as being completed by nursing on [DATE].-Tracheal suctioning as needed.- Change the disposable inner cannula daily.Review of Resident #1's medical record indicated there was no documentation to support that the type and size of the suction catheter or the amount of negative pressure used to suction him/her were documented per the facility's policy.During an interview on [DATE] at 1:46 P.M., Nurse #2 said he was on duty on the [DATE] evening shift (3:00 P.M. through 11:00 P.M.) and was mentoring another nurse. Nurse #2 said they provided Resident #1's care together, that they provided oral and tracheal suctioning and changed his/her inner cannula. Nurse #2 said the orders should have been signed off on Resident #1's TAR as being completed by nursing and he did not know why they weren't.2) Review of the Facility's Procedure Form, titled Emergency Code Documentation Form, indicated a section to document the narrative of the Code.During an interview on [DATE] at 3:09 P.M., Nursing Supervisor (NS) #1 said she was on duty on [DATE] and was in Resident #1's room when she noticed that Resident #1's chest was not going up and down and she did not feel a pulse. NS #1 said she called for help and initiated a Code Blue.Nursing Supervisor #1 said that when they rolled Resident #1 onto the backboard, his/her tracheostomy tube came out. NS #1 said that they covered the stoma (the surgical opening into the airway) with gauze and proceeded to administer breaths with the ambu bag (used to force air into the lungs) placed over Resident #1's nose and mouth. NS #1 said they also applied the AED and Resident #1 received one or two shocks.Review of Resident #1's Nursing Progress Note and Emergency Code Documentation Form, dated [DATE], indicated at 5:55 P.M. Resident #1 ceased to have a pulse, nursing staff called a Code Blue and initiated Cardiopulmonary Resuscitation (CPR). The Note and Form indicated a backboard was placed underneath Resident #1, CPR was initiated at 5:55 P.M., an Automated External Defibrillator (AED- a portable device used to treat individuals in sudden cardiac arrest by delivering electric shock to restore normal heart rhythm) was applied and CPR continued until the police and paramedics arrived and took over.During an interview on [DATE] at 4:10 P.M., the Director of Nurses (DON) said that several of the staff members who were present during Resident #1's Code documented the events on individual pieces of paper and when the Code was done the summary was rewritten on Resident #1's Emergency Code Documentation Form. The DON said all the events that occurred during the Code, along with the times they occurred, should be on the Form.Further review of the Form indicated that the CPR narrative did not include the details provided by Nursing Supervisor #1 and the DON.The DON said that the number of shocks administered to Resident #1 via the AED and that his/her trach dislodgement during the Code should have been documented in both, the Nursing Progress Note and the Emergency Code Documentation Form, but were not.