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	03/26/2026

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 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 records reviewed and interviews, for one of three sampled residents (Resident #1), whose physician's orders included wound care and dressing changes to a wound on his/her buttocks, the facility failed to ensure professional standards of practice were maintained when the nursing staff did not document specific wound characteristics, as well as effectiveness of treatment, in accordance with nursing best practice and facility policy.Findings include:Review of the Facility's Policy, titled Wound Care, with a revision date of October 2010, included the following:-The following information should be recorded in the resident's medical record:*The type of wound care given.*The date and time the wound care was given.*The position in which the resident was placed.*All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound.*Any change in the resident's condition.*How the resident tolerated the procedure.Resident #1 was admitted to the facility in January 2026, diagnoses included chronic kidney disease, polyosteoarthritis (affecting multiple joints), and unstageable (full thickness skin loss covered with slough or dead tissue) pressure injury of the sacral region.Review of Resident #1's Nursing admission Assessment, dated 01/28/26, indicated Resident #1 had an unstageable pressure injury on his/her right buttock which measured 5 centimeters (cm) x 1 cm and he/she had a pressure injury (not staged) on his/her left buttock that measured 1.5 cm x 0.3 cm.Review of Resident #1's Physician's Orders, dated 01/28/26, indicated he/she had an order to wash the unstageable wounds with wound wash, apply calcium alginate (used for moderate to heavy wound drainage) and cover with a foam dressing daily and as needed.Review of Resident #1's Wound Nurse Practitioner's Assessment, date 02/04/26, indicated Resident #1 had one unstageable wound on his/her sacrum, which measured 3.9 cm x 3.1 cm and had a moderate amount of serosanguineous (mix of clear and bloody) drainage. The Assessment included a recommendation to change treatment to include Santyl (used to debride wounds) with the daily dressing.Review of Resident #1's Wound Nurse Practitioner's Assessment, dated 02/11/26, indicated Resident #1 sacral wound measured 5.10 cm x 7.80 cm, its status had worsened, and the wound was malodorous with a moderate amount of serosanguineous drainage. The Assessment included a recommendation to change his/her treatment to include crushed Flagyl (antibiotic) to the wound bed with the daily dressing.Review of Resident #1's Treatment Administration Record (TAR) for the months of January and February 2026 indicated that although nurses were changing his/her wound dressings daily, there was no documentation to support that nursing documented the wound appearance, measurements, drainage amount and type, and/or odor, during the daily dressing changes.During a telephone interview on 03/26/26 at 5:08 P.M., Nurse #1 said she had taken care of Resident #1's wound multiple times. Nurse #1 said Resident #1's wounds were on his/her coccyx or buttocks area. Nurse #1 said it was standard practice to include the appearance of the wound, the type of drainage, and if there is an odor, with each dressing change, when documenting the treatment. During an interview on 03/26/26 at 1:00 P.M., Nurse #2 said she was familiar with Resident #1 and had provided his/her wound care. Nurse #2 said there is a template [within the electronic medical record] on the Treatment Administration Record (TAR) that prompts the nurses to enter the wound description, including the wound appearance, drainage, odor, or if the wound has improved or worsened, with each dressing change.During an in-person interview on 03/26/26 at 12:15 P.M., and a (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	telephone interview on 03/27/26 at 1:21 P.M., the Director of Nurses (DON) said that nursing staff should be documenting the appearance and specific characteristics of Resident #1's wounds with each dressing change. The DON said the facility had identified that when nursing staff modified the wound care order within the electronic medical record, the supplementary documentations were mistakenly removed.On 03/26/26, the Facility was found to be in Past Non-Compliance, with an effective date of 03/16/26, and presented the Surveyor with a plan of correction which addresses the areas of concern as evidenced by:A) On 03/15/26 the Director of Nurses educated the nursing staff on Wound Treatment Documentation requirements with mandatory documentation after every wound treatment to include:*Wound Location*Wound Measurements*Wound Appearance*Drainage*Odor*Peri Wound Skin Condition*Signs of InfectionB) On 03/15/26 the Director of Nurses educated the nursing staff on required documentation elements, including supplemental documentation inclusive of wound characteristics.C) On 03/15/26 a facility wide audit was initiated for all residents with wound orders to validate documentation elements in place, and completeness of documentation.D) Weekly wound documentation audits will be conducted weekly x 4 weeks and then monthly x 2 months.E) The Director of Nurses will review audit findings and trends and bring to monthly Quality Assurance Performance Improvement (QAPI) and Wound Committee meetings.F) The Director of Nurses and/or Designee are responsible for overall compliance.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was admitted to the facility with an unstageable pressure injury (full tissue loss covered with slough or dead tissue), the facility failed to ensure they adequately managed his/her pain, when he/she displayed both verbal and non-verbal indicators of pain and analgesics were not offered or administered.Findings include:Review of the facility's Policy, titled Pain Assessment and Management, with a revision date of April 2025, indicated the following:-The purposes of this procedure are to help the staff identify pain in the resident, develop interventions consistent with the resident's goals and needs, and address the underlying causes of pain.-Pain management is a multidisciplinary process that includes the following:*identifying signs and symptoms of existing pain*recognizing situations and conditions with the potential for pain*identifying the underlying causes, intensity, duration, type, and characteristics of pain-Cognitive, cultural, familial, and gender-specific influences on the resident's ability or willingness to verbalize pain are considered when assessing and treating pain.-Possible behavioral signs of pain include:*behaviors such as resisting care, depressed mood-Review the resident's clinical record to identify conditions or situations that may predispose the resident to pain, including:*pressure ulcers-Review the resident's treatment record to identify any situations or interventions where an increase in the resident's pain may be anticipated, for example:*treatments such as wound care or dressing changes*ambulation or physical therapy*turning/repositioningResident #1 was admitted to the facility in January 2026, diagnoses included chronic kidney disease, polyosteoarthritis (affecting multiple joints), and unstageable pressure injury of the sacral region.Review of Resident #1's Minimum Data Set (MDS) assessment, dated 02/02/26, indicated he/she scored a 12 on the Brief Interview for Mental Status (BIMS) - (a score of 13-15 suggests intact cognition, a score of 8-12 suggests moderate cognitive impairment, a score of 0-7 suggests severe cognitive impairment).Review of Resident #1's Physical Therapy (PT) Treatment Note, dated 02/06/26, indicated he/she adamantly declined to mobilize out of bed and was too sore to participate in therapy. Review of Resident #1's PT Treatment Note, dated 02/09/26, indicated he/she rated his/her pain at rest and with movement to be 5 out of 10 (on a scale of 0-10, 0 being no pain - 10 being worst pain ever) constant, affecting his/her lower back.Review of Resident #1's PT Treatment Note, dated 02/10/26, indicated his/her pain level was determined based upon behaviors exhibited and per the note, he/she was agitated and tense.Review of Resident #1's PT Treatment Note, dated 02/11/26, indicated he/she was premedicated (prior to therapy) and he/she rated his/her pain to be 7 out of 10, all over aching and sharp. The Note indicated that nursing was aware, and Resident #1 agreed to participate in light bed mobility activities.Review of Resident #1's PT Treatment Note, dated 02/12/26, indicated he/she rated his/her pain 5 out of 10, affecting his/her bilateral hips, and he/she declined to get out of bed. The Note indicated that a re-visit later in the day was attempted and Resident #1 continued to be in a lot of pain despite being pre-medicated and refused to participate in the PT session.During an interview on 03/26/26 at 1:39 P.M., Physical Therapy Assistant (PTA) #1 said she had PT visits with Resident #1 on 01/29/26, 02/03/26, 02/05/26, 02/09/26, 02/10/26, and 02/12/26. PTA #1 said that the first few visits she had with Resident #1, he/she participated and as time went on, he/she became more agitated, and did not want to participate in therapy and did not want to get out of bed because of pain.PTA #1 said that she reported Resident #1's pain to nursing and she thought he/she was given Tylenol. PTA #1 said after a few visits with Resident #1, he/she avoided touch and complained of low back and whole body pain. PTA #1 said she documented that Resident #1 was premedicated on 02/12/26 because she thought he/she had been.During a telephone interview on 03/27/26 at 10:36 A.M., Nursing Supervisor #2 said he was on duty 02/11/26 and cared for Resident #1. Nursing Supervisor #2 said that if a therapist (PT/OT/PTA) told him Resident #1 was in pain, he would assess him/her and administer pain medications. Nursing Supervisor #2 said he could not remember if he gave Resident #1 any pain (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications on 02/11/26 or not, and if he had, it would be documented on his/her Medication Administration Record (MAR). Review of Resident #1's MAR, dated 02/11/26, indicated there was no documentation to support Nursing Supervisor #2 administered pain medication to Resident #1 that day. During an interview on 03/26/26 at 1:56 P.M., the Director of Rehabilitation (DOR) said she was aware Resident #1 refused to participate in therapy at times and it was due to his/her fatigue and low motivation. The DOR said if he/she refused therapy due to pain, they would schedule therapy around pain medication administration and determine if pain was an on-going issue. The DOR said she was only aware of Resident #1's refusals to get out of bed.Review of Resident #1's Physician's Orders for February 2026 indicated he/she had orders for the following:-Methocarbamol (muscle relaxant) 500 milligrams (mg) one tablet by mouth three times per day for muscle spasm- discontinued on 02/05/26.-Acetaminophen (non-prescription analgesic) 325 mg give two tablets every four hours as needed for mild pain.-Acetaminophen 500 mg give one tablet by mouth every six hours as needed for pain.Review of Resident #1's Medication Administration Record (MAR) for the month of February 2026 indicated that although Resident #1 reported and displayed signs and symptoms of pain during several Physical Therapy Treatments and the PT Notes indicated he/she was either premedicated and/or received prescribed medications, there was no documentation to support that nursing administered Resident #1 an analgesic from 02/06/26 through 02/12/26.Review of Resident #1's Nurse Practitioner #1's Progress Note, dated 02/11/26, indicated Resident #1 had increased tenderness to his/her sacral pressure ulcer. The Note indicated that Resident #1 had declined to get out of bed due to bilateral hip pain but did participate in bed exercises with PT and he/she had Tylenol ordered for pain management as needed.During a telephone interview on 03/27/26 at 9:04 A.M., Nurse Practitioner (NP) #1 said that she had visited Resident #1 multiple times during his/her stay at the facility. NP #1 said she was unaware that Resident #1 was reporting pain during several Physical Therapy visits and if she had known she would have initiated a new pain management plan, especially if his/her pain was a barrier for him/her to complete therapy sessions. NP #1 said she had discontinued Resident #1's scheduled Methocarbamol due to him/her having increased lethargy. NP #1 said she was unaware that nursing had not administered Tylenol to Resident #1.Nurse Practitioner (NP) #1 said other indicators of pain included facial grimacing, not getting out of bed or moving as well. NP #1 said if Resident #1 had been displaying those behaviors the nursing staff could have offered him/her Tylenol.During a telephone interview on 03/27/26 at 1:21 P.M., the Director of Nurses (DON) said that the departments should be talking to each other and if Resident #1 had signs and symptoms of pain during PT visits, nursing staff should have been notified and should have followed through. The DON said if there is communication between departments, it should be documented in a progress note.

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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 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. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the facility failed to ensure they maintained an accurate and complete medical record related to 1) the anatomical location of a pressure injury and 2) the frequency of repositioning.Findings include:Review of the Facility's Policy, titled Charting and Documentation, with a revision date of July 2017, included the following:-All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.Review of the Facility's Policy, titled Prevention of Pressure Injuries, with a revision date of April 2020, included the following:-Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by their interdisciplinary care team.Resident #1 was admitted to the facility in January 2026, diagnoses included chronic kidney disease, polyosteoarthritis (affecting multiple joints), and unstageable (full tissue loss covered with slough or dead tissue) pressure injury of sacral region.1) Review of Resident #1's Nursing admission Assessment, dated 01/28/26, indicated Resident #1 had an unstageable pressure injury on his/her right buttock which measured 5 centimeters (cm) x 1 cm and he/she had a pressure injury (not staged) on his/her left buttock that measured 1.5 cm x 0.3 cm.Review of Resident #1's Wound Nurse Practitioner's (NP) Assessment, date 02/04/26, indicated Resident #1 had one unstageable wound on his/her sacrum. Review of Resident #1's Treatment Administration Record (TAR) for the month of February 2026, indicated that although the Wound NP identified the anatomical location of Resident #1's unstageable pressure injury to be on his/her sacrum, nursing continued to sign off that they completed wound care for unstageable pressure injuries on Resident #1's right and left buttock.During a telephone interview on 03/26/26 at 5:08 P.M., Nurse #1 said she had taken care of Resident #1's wound multiple times. Nurse #1 said Resident #1's wounds were on his/her coccyx or buttocks area.During an in-person interview on 03/26/26 at 12:15 P.M., and a telephone interview on 03/27/26 at 1:21 P.M., the Director of Nurses (DON) said they identified that nursing documented Resident #1's wounds were on his/her right and left buttocks, when the Wound NP had identified the anatomical site to be his/her sacrum.2) Review of Resident #1's Wound Nurse Practitioner's (NP) Progress Note, dated 02/05/26, included recommendations to offload pressure and reposition him/her every two hours.Review of Resident #1's Wound NP's Progress Note, dated 02/11/26, indicated that strict adherence to pressure injury prevention protocols remains essential, including frequent repositioning.Review of Resident #1's Certified Nurse Aide (CNA) flow sheets for the months of January 2026 and February 2026 indicated there was no documentation to support that Resident #1 was repositioned every two hours as recommended by the Wound NP.During an interview on 03/26/26 at 3:33 P.M., Certified Nurse Aide (CNA) #1 said she had taken care of Resident #1 and he/she required assistance with repositioning. CNA #1 said they were supposed to document the repositioning on his/her flow sheet.During an in-person interview on 03/26/26 at 12:15 P.M., and a telephone interview on 03/27/26 at 1:21 P.M., the Director of Nurses (DON) said they had previously identified that the option to document every two-hour repositioning was not automatically appearing on the CNA flow sheets and had been missed for Resident #1.On 03/26/26, the Facility was found to be in Past Non-Compliance, with an effective date of 03/24/26, and presented the Surveyor with a plan of correction which addresses the areas of concern as evidenced by:A) On 03/02/26 through 03/16/26, the Director of Nurses educated the nursing staff on anatomical wound locations.B) On 03/21/26 the Director of Nurses educated the nursing staff on Repositioning and Offloading, which included the need to ensure completion of daily flow sheet documentation. C) On 3/15/26 an audit was initiated, and is on-going, for all residents with wounds for accurate anatomical location documentation.D) Audits were also initiated, and remain on-going, for all residents for every two-hour repositioning need, documentation accuracy and completion.E) The Director of Nurses will review (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	audit findings and trends and bring to monthly Quality Assurance Performance Improvement (QAPI) and Wound Committee meetings.F) The Director of Nurses and/or Designee are responsible for overall compliance.