STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 48362 Based on observation, interview and record review, the facility failed to ensure four Residents (#11, #30, #33, #35), out of a total sample of 15 residents, had their call bell devices accessible and within reach to utilize them to call for staff assistance while in their rooms. Findings include: Review of the facility's policy titled Answering Call Lights, revised 3/2022, indicated but was not limited to the following: - The purpose of this procedure is to respond to the resident's requests and needs. - Guidelines: 4.) Be sure that the call light is plugged in at all times; 5.) When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. A. Resident #11 was admitted to the facility in December 2024 with diagnoses including history of falling, adult failure to thrive, and anxiety. Review of Resident #11's Minimum Data Set (MDS) assessment indicated he/she was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15. During an observation with interview on 4/6/25 at 8:48 A.M., the surveyor observed Resident #11 in his/her room. The call light was on the ground by the nightstand beside the bed and out of reach. Resident #11 said he/she uses the call light to ask staff for help. Resident #11 was asked to locate his/her call light but said he/she was unable to find it. Resident #11 said if he/she is not able to locate the call light, he/she usually gets in their wheelchair and finds the nurse to ask for help. On 4/7/25 at 8:00 A.M., the surveyor observed Resident #11 sitting at the edge of his/her bed eating breakfast. Resident #11's call light was on the ground by the nightstand beside the bed and out of reach of the Resident. On 4/7/25 at 12:24 P.M., the surveyor observed Resident #11 sitting at the edge of his/her bed eating breakfast. Resident #11's call light was on the ground by the nightstand beside the bed and out of reach of the Resident. (continued on next page)

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
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/7/25 at 2:49 P.M., the surveyor observed Resident #11 sitting at the edge of his/her bed eating breakfast. Resident #11's call light was on the ground by the nightstand beside the bed and out of reach of the Resident. During an interview on 4/7/25 at 4:43 P.M., Certified Nursing Assistant (CNA) #3 said Resident #11 should have his/her call light within reach when he/she is in bed or in the wheelchair. During an interview on 4/7/25 at 4:44 P.M., Nurse #6 and the surveyor entered Resident #11's room. Resident #11 said his/her call light was on the floor on the side of their nightstand. Nurse #6 said the call light was not in reach of Resident #11 and should have been. 48695 B. Resident #33 was admitted to the facility in June 2024 with diagnoses including dementia and history of falling. Review of the MDS assessment, dated 3/19/25, indicated Resident #33 had a severe cognitive impairment as evidenced by a BIMS score of 1 out of 15. On 4/6/25 at 4:20 P.M., the surveyor observed Resident #33 in a low bed with his/her eyes opened. Resident #33's call light was draped over the far side of his/her nightstand out of Resident #33's reach. The surveyor asked Resident #33 if he/she knew where their call light was, Resident #33 did not respond. On 4/7/25 at 8:06 A.M., the surveyor observed Resident #33 in a low bed with his/her eyes closed. Resident #33's call light was draped over the far side of his/her nightstand out of Resident #33's reach. On 4/7/25 at 9:34 A.M. and 10:54 A.M., the surveyor observed Resident #33 in a low bed with his/her eyes opened. Resident #33's call light was draped over the far side of his/her nightstand out of Resident #33's reach. During an interview on 4/8/25 at 2:43 P.M., the Assistant Director of Nursing (ADON) said Resident #33 was a fall risk and should have had access to his/her call light regardless of if he/she could use it. C. Resident #30 was admitted to the facility in May 2024 with diagnoses of dementia and pelvic fracture. Review of the MDS assessment, dated 3/10/25, indicated Resident #30 had a severe cognitive impairment as evidenced by a BIMS score of 1 out of 15. On 4/7/25 at 7:58 A.M., the surveyor observed Resident #30 in a bed with his/her eyes closed. Resident #30's call light was draped over the far side of his/her nightstand with the call light button touching the floor, out of Resident #30's reach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/7/25 at 9:30 A.M., the surveyor observed Resident #30 in bed with his/her eyes opened. Resident #30's call light was draped over the far side of his/her nightstand with the call light button touching the floor, out of Resident #30's reach. The surveyor asked Resident #30 if he/she knew where their call light was, but Resident #30 did not respond. On 4/7/25 at 10:50 A.M. and 2:52 P.M., the surveyor observed Resident #30 in bed with his/her eyes opened. Resident #30's call light was draped over the far side of his/her nightstand with the call light button touching the floor, out of Resident #30's reach. During an interview on 4/7/25 at 4:33 P.M, CNA #3 and the surveyor observed Resident #30's call light draped over the far side of his/her nightstand with the call light button touching the floor. CNA #3 said Resident #30 was unable to reach his/her call light but should have access to it regardless of if he/she could use their call light. D. Resident #35 was admitted to the facility in September 2023 with diagnoses including dementia and chronic pain. Review of the MDS assessment, dated 3/22/25, indicated Resident #35 had a severe cognitive impairment as evidenced by a BIMS score of 2 out of 15. On 4/6/25 at 8:58 A.M., the surveyor observed Resident #35 in bed his/her call light was on the floor on the far side of his/her nightstand, not within his/her reach. Resident #35 said he/she had a call light, but he/she could not find it and did not know where it was. On 4/6/25 at 12:21 P.M. and 4:24 P.M., the surveyor observed Resident #35 in bed with their eyes opened and his/her call light was on the floor on the far side of his/her nightstand, not within his/her reach. On 4/7/25 at 8:07 A.M., 9:35 A.M., 10:55 A.M., and 2:48 P.M., the surveyor observed Resident #35 in bed with their eyes opened and his/her call light was on the floor on the far side of his/her nightstand, not within his/her reach. On 4/7/25 at 4:40 P.M., Nurse #6 and the surveyor observed Resident #35 in bed with their eyes opened and his/her call light was on the floor on the far side of his/her nightstand, not within his/her reach. Nurse #6 said all residents should have access to their call lights regardless of whether they could use their call light or not. Nurse #6 said Resident #35 could not reach his/her call light and did not have access to his/her call light but should. During an interview on 4/8/25 at 3:09 P.M., the Director of Nursing (DON) said all residents must have access to their call lights regardless of their ability to use them. The DON said Resident #11, #33, #30, and #35 should have had access to their call lights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 34145 Based on observation, interviews, and document review, the facility failed to ensure that residents were fully aware of the grievance process. Specifically, for 10 of 10 residents attending the resident group meeting during the facility survey, the facility failed to ensure residents were aware of and had access to grievance forms, and were aware they could formulate grievances anonymously, should they choose not to alert a staff member of their concern(s). Findings include: Review of the facility's policy titled Grievance, last revised 3/2022, indicated but was not limited to: -The resident and/or resident representative will be made aware of the right to voice grievances orally, in writing, and anonymously. -If a resident, and/or health care representative, or another interested family member of a resident has a complaint, a staff member should encourage and assist the resident, or person acting on the resident's behalf, to file a written grievance with the facility using the Grievances/Complaint Report form. -Grievances and complaints may be submitted orally or in writing. The resident, and/or health care representative, or the person filing the grievance or complaint on behalf of the resident, should be encouraged to sign written complaints or grievances. If the person filing the grievance is anonymous or wishes to remain anonymous, confidentiality will be maintained, to the extent possible. On 4/7/25 at 1:00 P.M., the surveyor held a resident group meeting with 10 residents, representing each of the facility's two units, in attendance. Four of 10 residents said that they have not seen any postings about the grievance process and do not know how to file a grievance except for telling a staff member about a problem. The residents said they have to ask for a grievance form, then fill it out and then give it to the Social Worker or Assistant Director of Nursing. One resident said he/she thought they saw grievance forms by the elevator but is not sure and does not know who the grievance officer is. The resident said they could not file a grievance anonymously. Six additional residents nodded their heads up and down in agreement. On 4/7/25 at 2:00 P.M., the surveyor toured the second-floor unit, which was comprised of two perpendicular hallways shaped like a T. There was no posting about the grievance process, grievance forms or instructions on where to find grievance forms. At the end of the long hallway, the walkway became a ramp with two signs posted indicating the ramp was a fall risk, and a stop sign with instructions for residents to wait for a staff member to accompany them down the ramp. At the end of the ramp and to the left, the surveyor observed a wall mounted document file holder with blank grievance forms inside on the wall outside the social worker's office. The social worker's office was not accessible to any residents that did not reside on that hallway without staff assistance, and there were no instructions on how to file the grievance anonymously. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/7/25 at 2:15 P.M., the surveyor toured the third-floor unit and was unable to locate any posting about the grievance process or any grievance forms. During an interview on 4/8/25 at 12:27 P.M., the Social Worker and the surveyor toured the second and third-floor units: -Second-floor unit: the Social Worker said there should be information posted on the unit about the grievance process, how to file a grievance and where to find the grievance forms and there was not. The Social Worker pointed out the wall mounted document holder outside her office at the end of the ramp with grievance forms in it. She said residents can take the forms, fill them out and give them to either her or the Administrator. She said she did not think about how residents could access the forms without staff assistance and file a grievance anonymously. -Third-floor unit: The Social Worker said there should be information posted on the unit about the grievance process, how to file a grievance and where to find grievance forms and there was not. She said she searched the unit and behind the nursing station and said there were no grievance forms available on the unit. She searched the nursing station and found an empty folder labeled grievances. She said she needs to consult with the team about how to ensure forms are available on the unit for residents and families to file and submit grievances and provide for grievances to be filed anonymously.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 34145 Based on record review, policy review, and interview, the facility failed to ensure staff developed baseline or comprehensive care plan within 48 hours of the resident's admission, which included the instructions needed to provide effective and person-centered care to the resident which meet professional standards of quality care for one Resident (#12), in a total sample of 18 residents. Specifically, the facility failed to ensure a baseline care plan was developed for the Resident's: a. diagnosis of Post Traumatic Stress Disorder (PTSD-results from 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); and b. use of the antipsychotic medication Quetiapine (Seroquel). Findings include: Review of the facility's policy titled Baseline Care Plan, last revised 4/2022, indicated but was not limited to: -A baseline care plan to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission. -The Interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: a. Initial goals based on admission orders; b. Physician's orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASARR recommendations, if applicable. Resident #12 was admitted to the facility in February 2025 and had diagnoses including fracture of the left humerus, anxiety, depression, and PTSD. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 2/20/25, indicated Resident #12 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 13 out of 15, expressed having little interest or pleasure in doing things (2-6 days during the review period) and feeling down depressed or hopeless (2-6 days during the review period), had a diagnosis of PTSD, and received antipsychotic medication daily. Review of an initial Nursing Evaluation, dated 2/14/25, indicated but was not limited to: -Admitting diagnosis: PTSD -Is the Resident currently ordered antipsychotic medication: yes -Name of medication: Seroquel a. Review of baseline and comprehensive care plans failed to indicate a care plan had been developed that includes the instructions needed to provide effective and person-centered care for Resident #12's diagnosis of PTSD within 48 hours as required. During an interview on 4/7/25 at 2:45 P.M., the Social Worker said she was aware Resident #12 had a diagnosis of PTSD but does not know what the trauma is or what the Resident's triggers may be. She said she should have developed a care plan for PTSD within 48 hours, but didn't do it. b. Review of Physician's Orders included but was not limited to: -Quetiapine 100 milligrams (mg), give 100 mg at bedtime (2/13/25) Review of February 2025 through April 2025 Medication Administration Records indicated Quetiapine 100 mg was administered according to physician's orders. Review of baseline and comprehensive care plans failed to indicate a care plan had been developed that includes the instructions needed to provide effective and person-centered care for Resident #12's use of the antipsychotic medication Quetiapine within 48 hours as required. During an interview on 4/8/25 at 2:25 P.M., Unit Manager #1 and the surveyor reviewed Resident #12's medical record. She was unable to find a baseline or comprehensive care plan that addressed the Resident's use of antipsychotic medication and said it should have been developed within 48 hours, and it was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 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. 43935 Based on document review, observation, and interview, the facility failed to develop, implement and individualize comprehensive plans of care for five Residents (#202, #4, #12, #33, and #36) out of a total sample of 15 residents. Specifically, the facility failed: 1. For #202, to individualize and implement the pain and risk for pain care plan; 2. For Resident #4, to develop and implement a care plan for the use of Seroquel (an antipsychotic medication) that included Resident-specific targeted behaviors, interventions and measurable goals of treatment; 3. For Resident #12, to develop and implement a care plan for the use of Seroquel that included Resident-specific targeted behaviors, interventions and measurable goals of treatment; 4. For Resident #33, to develop and implement a care plan intervention after he/she sustained a fall; and 5. For Resident # 36, to develop and implement a care plan for his/her oxygen use. Findings include: Review of the facility's policy titled Comprehensive Assessments and the Care Delivery Process, dated as revised 2/2025, indicated but was not limited to the following: - comprehensive assessments, care planning and the care delivery process involve collecting data and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions - information analysis steps include (how and why?): define issues, including problems, risk factors and other concerns (to which all disciplines can relate) - define and assess conditions and problems that are causing, or could cause, other problems; arrange conditions, problems and outcomes in their proper order based on information gathered - determine the most plausible relationship between conditions and their causes - define current treatments and services; link with problems/diagnoses - identify the current interventions and treatments and link the problem and diagnoses they are supposed to be treating - identify overall care goals and objectives of individual treatments and evaluate if these treatments are accomplishing the anticipated results (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- apply clinical reasoning to assessment information and determine the most appropriate interventions - assessments are used to develop, review and revise the resident's comprehensive care plan 1. Resident #202 was admitted to the facility in April 2025 with diagnoses including spinal stenosis. Review of the nursing admission evaluation indicated the Resident was alert and oriented to person, place, and time; follows commands and has an intact memory. Further review of the medical record indicated an initial pain interview indicated the Resident had almost constant pain over the last five days making it hard to sleep at night and limiting his/her day to day activities, describing the pain as severe. Review of the active Physician's Orders for Resident #202 included but was not limited to: - Tramadol HCL (a narcotic pain medication) tablet 50 milligrams (mg), give two tablets by mouth every six hours as needed (PRN) for moderate to severe pain Review of the current care plans for Resident #202 indicated but were not limited to the following: FOCUS: The Resident has pain (4/2/25) GOAL: The Resident will not have discomfort related to (r/t) the side effects of analgesia through review date; the Resident will verbalize adequate relief of pain or ability to cope with incomplete relieved pain through review date (4/2/25) INTERVENTIONS: Pain is alleviated by (specify); administer analgesic as per orders (specify medication); evaluate the effectiveness of pain interventions (specify frequency) review for compliance alleviating symptoms dosing schedules and resident satisfaction with results; monitor/record pain characteristics (specify frequency) and PRN: quality, severity, anatomical location, onset, duration, and aggravating factors; monitor/record/report to nurse resident complaint of pain or request for pain treatment (4/2/25) The care plan template was incomplete and did not include the Resident specific information. FOCUS: Risk for pain - chronic (4/6/25) GOAL: Resident will not experience a decline in overall function r/t pain through next review date (4/6/25) INTERVENTIONS: Administer and monitor for effectiveness and possible side effects of PRN pain medication (4/6/25) During an interview on 4/6/25 at 11:20 A.M., Resident #202 said they just recently underwent a laminectomy back surgery and are using Tramadol 50 milligrams (mg) two tabs for pain management as needed (PRN) every six hours and receives the medication about three to four times a day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Administration Record (MAR) for Resident #202 on 4/7/25 at 4:42 P.M., indicated but was not limited to the following: - Tramadol 50 mg 1 tablet by mouth every six hours as needed for moderate to severe pain - administered once on 4/3/25 at 8:48 A.M. (ordered 4/2/25-4/3/25) - Tramadol 50 mg 2 tablets by mouth every six hours as needed for moderate to severe pain - no signed off administrations (ordered 4/3/25) Review of the Narcotic count book #28 for the second floor, pages 76 and 78 indicated 13 doses of Tramadol had been provided to the Resident from 4/2/25 through 4/7/25 at 4:45 P.M., and not documented as administered on the MAR. Review of the medical record including nursing progress notes and the MAR failed to indicate the Resident was evaluated for the use of their PRN pain medication before its administration on 13 occasions, or that the effectiveness of that medication was monitored and documented in accordance with the Resident's care plan. During a follow up interview on 4/8/25 at 11:46 A.M., Resident #202 said the Nurses do ask for a pain rating before they provide him/her with their Tramadol, but no one has returned to ask him/her if the medication is effective or what a new pain rating number may be after he/she has taken the medication. He/She said this would be a nice way for the staff to understand whether or not his/her pain medication is effective so they can notify the physician of necessary adjustments without him/her having to request them and provide the physician with a good picture of their overall pain management situation. During an interview on 4/8/25 at 12:21 P.M., Nurse Practitioner (NP) #1 said the Resident was admitted following back surgery and a failed discharge home related to poor pain control and required pain management. He said his expectation and the standard of practice was for the Nurses to evaluate the Resident's pain prior to administering the PRN medication and also after to determine if the current regimen was effective. He said in order to make medical decisions for managing the Resident's pain that information would be necessary and should be documented somewhere in the medical record. During an interview on 4/8/25 at 12:40 P.M., Nurse # 2 said she was unsure of the policy for pain management, but the standard of care includes speaking with a resident to determine where their pain is, have them provide a rating on the 0-10 pain scale and then administer the medication and sign it out of the narcotic book if necessary, then return at a later time to determine if the medication was effective and document that. She said for this Resident she has treated the pain when the Resident requests but she has not signed the medication off on the MAR, documented a pre-medication pain rating or a re-evaluation rating to determine if the medication is effective or not. She said the Resident informed her today that he/she feels the current regimen is ineffective and she has alerted the NP, but on review of the record she could not find any documentation of the Resident's pre-medicated pain rating or post medication rating to help the NP in determining if the current regimen is effective and that is her error, since she has only signed the medication out of the narcotic book and not documented it as required on the MAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/8/25 at 1:29 P.M. the Unit Manager reviewed the medical record and said the comprehensive care plan was not specific to the Resident and had many blanks that required personalization. She said in addition since the Nurses were not documenting a pre-medication rating for the use of the PRN pain medication and a post medication evaluation to determine whether or not the medication was effective, they were not implementing the care plan as they should. During an interview on 4/8/25 at 2:18 P.M., the Director of Nursing (DON) reviewed the care plans and medical record for Resident #202 and said the care plan for Pain is not specific to the Resident as it is supposed to be and had numerous blank areas. She said the Risk for pain care plan is complete and comprehensive, but on review of the medical record, MAR and narcotic book said there is no documentation to demonstrate whether or not the Resident's pain management regimen was effective, and therefore the care plan had not been implemented as it should have been. 2. Review of the facility's policy titled Behavior Management, dated as revised 4/2022, indicated but was not limited to the following: - the interdisciplinary team (IDT) will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a care plan accordingly - interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs and strives to understand, prevent or relieve the resident's distress or loss of abilities; psychiatric recommendations will be reviewed by the IDT and implemented as indicated - when medications are prescribed for behavioral symptoms, documentation will include: a rationale for use, potential underlying causes of the behavior, other approaches and interventions tried prior to the use of psychoactive medications, potential risks and benefits of medications, targeted behaviors and expected outcomes Resident #4 was admitted to the facility in June 2024 and had diagnoses including: dementia with psychotic disturbance and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 3/12/25, indicated Resident #4 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 out of 15. Further review of the MDS indicated the Resident did not exhibit any psychosis or behaviors, expressed having little interest or pleasure in doing things (2-6 days during the review period) and feeling down depressed or hopeless (2-6 days during the review period), diagnoses of dementia and anxiety, and received antipsychotic medication routinely. Review of the active Physician's Orders for Resident #4 included, but was not limited to: -Quetiapine (Seroquel) 25 mg, give 1 tablet by mouth at bedtime for depression (3/3/25) - Behavior monitoring: uncontrolled agitation, physical aggression towards self or others, continued screaming or yelling, danger to self/others. Antipsychotic: alternative interventions; 1 = offer calm area, 2 = diversional activity, 3 = 1:1 during active episodes, N/A (not applicable); number of episodes: 0,1,2,3,4; outcome: I - improved, U unchanged, N/A, every shift (11/5/24) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of February 2025 through April 2025 MARs indicated Quetiapine 25 mg was administered according to physician's orders; and the Resident did not exhibit any behaviors. Review of comprehensive care plans failed to identify specific targeted signs/symptoms for Resident #4's use of the antipsychotic medication or specific interventions, including non-pharmacological approaches, and measurable goals for the use of antipsychotic medication to meet the Resident's needs. During an interview on 4/7/25 at 12:29 P.M., Certified Nurse Aide (CNA) #2 said she knows the Resident well and she had never known the Resident to exhibit yelling, physical aggression or agitation and said the Resident is very nice and compliant and had not ever exhibited any kind of behaviors that she is aware. During an interview on 4/7/25 at 4:47 P.M., CNA #1 said she knows the Resident well and she is unaware of any yelling or physical or verbal aggression or agitation of any kind, in fact, she said she does not know the Resident to have ever exhibited any type of behaviors and said the Resident is very calm and pleasant. During an interview on 4/8/25 at 9:15 A.M., the Resident's Healthcare Proxy (HCP) said she is not sure what Resident #4 takes the antipsychotic medication for and it may possibly be used as a sleep aid. She said the Resident had never had any type of behaviors including yelling or physical aggression or agitation. During an interview on 4/8/25 at 12:38 P.M., Nurse #2 said the Resident is on Seroquel for depression, as far as she knows, and on review of the medical record said there are no targeted behaviors care planned for for the use of the medication and the Resident never exhibits any behaviors. During an interview on 4/8/25 at 2:25 P.M., the DON said it appears the Seroquel is ordered for depression, but the NP notes indicate sleep. She reviewed the care plans and said there is no care plan indicating the reason for the antipsychotic, the targeted behaviors, measurable goal or non-pharmacological interventions. She said the Resident is very nice and doesn't exhibit any behaviors and the behavior monitoring on the MAR is the generic template and not specific to this Resident. 34145 3. Resident #12 was admitted to the facility in February 2025 and had diagnoses including fracture of the left humerus, anxiety, depression, and post-traumatic stress disorder (PTSD). Review of the MDS assessment, dated 2/20/25, indicated Resident #12 was cognitively intact as evidenced by a BIMS score of 13 out of 15, expressed having little interest or pleasure in doing things (2-6 days during the review period) and feeling down depressed or hopeless (2-6 days during the review period), had a diagnosis of PTSD, and received antipsychotic medication daily. Review of Physician's Orders included but was not limited to: -Quetiapine 100 mg, give 100 mg at bedtime (2/13/25) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of February 2025 through April 2025 Medication Administration Records indicated Quetiapine 100 mg was administered according to physician's orders. Review of comprehensive care plans failed to indicate Resident #12 was prescribed antipsychotic medication and failed to identify specific targeted signs/symptoms, Resident specific interventions, including non-pharmacological approaches, and measurable goals for the use of antipsychotic medication to meet the Resident's needs. During an interview on 4/8/25 at 2:25 P.M., Unit Manager #1 reviewed Resident #12's medical record and said a care plan should have been developed by nursing staff for the Resident's use of antipsychotic medication but was not. 48695 4. Review of the facility's policy titled Assessing Falls and Causes, dated March 2022, indicated but was not limited to: - Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. - The staff will monitor and document each resident's response to interventions intended to reduce falling or risks of falling. Resident #33 was admitted to the facility in June 2024 with diagnoses including dementia and history of falling. Review of the MDS assessment, dated 3/19/25, indicated Resident #33 had severe cognitive impairment as evidenced by a BIMS score of 1 out of 15. Review of Resident #33's unwitnessed fall incident report, dated 3/3/25, indicated but was not limited to: - At 6:00 A.M., Resident was found by the Certified Nursing Assistant (CNA) lying on his/her back, against the bed with no injury observed. Further review of Resident #33's medical record and care plans failed to indicate a care plan intervention had been implemented to minimize future falls. During an interview on 4/8/25 at 3:09 P.M., the DON reviewed Resident #33's fall incident report and medical record and said after a resident sustained a fall the nurse should put in an intervention to prevent or minimize future falls. The DON said she did not see an intervention in place for the fall Resident #33 sustained on 3/3/25 but there should have been an intervention implemented to prevent or minimize future falls but he/she did not. 5. Resident #36 was admitted to the facility in February 2022 with diagnoses including chronic obstructive pulmonary disease (progressive lung disease characterized by airflow obstruction, making it difficult to breathe). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment, dated 3/12/25, indicated Resident #36 had significant cognitive impairment as evidenced by a BIMS of 3 out of 15. Further review of Resident #36's MDS indicated he/she had shortness of breath or trouble breathing when lying flat. Review of Resident #36's Physician's Orders indicated but was not limited to: - Oxygen at 0.5 liters to 2 liters by nasal cannula continuously to keep oxygen saturations greater than 90%, dated 4/6/25 - Oxygen at 2 liters via nasal canula as needed for shortness of breath, dated 8/18/24 discontinued 4/6/25 Further review of Resident #36's medical record failed to indicate a care plan had been developed for the use of his/her oxygen. During an interview on 4/8/25 at 2:54 P.M., the Assistant Director of Nursing (ADON) reviewed Resident #36's medical record and said Resident #36 did not have a care plan addressing the use of his/her oxygen use but should have had one. During an interview on 4/8/25 at 3:21 P.M., the Regional Nurse said Resident #36 should have a care plan for the use of their oxygen use but he/she did not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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. 48362 Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards for two Residents (#29 and #4), out of a total sample of 15 residents. Specifically, the facility failed to: 1. Ensure a physician's order for the application of compression stockings were applied to Resident #29 daily; and 2. Ensure a healthcare proxy (HCP) invocation was completed for Resident #4 in accordance with the standard of practice. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated but was not limited to: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber 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. Pursuant to 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. They also stipulate that both the Registered Nurse and Practical Nurse incorporate into the plan of care and implement prescribed medical regimens. The Rules and Regulations 9.03 define Standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. 1. Resident #29 was admitted to the facility in October 2021 with diagnoses including chronic kidney disease, stage III, chronic diastolic congestive heart failure, and dementia. Review of Resident #29's Minimum Data Set (MDS) assessment, dated 1/22/25, indicated he/she was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) of 0 out of 15. Furthermore, the MDS assessment indicated Resident #29 required substantial assistance to complete activities of daily living including but not limited to bathing, dressing and transferring. Review of Resident #29's Physician's Orders indicated but were not limited to the following: - 2/28/23: apply compression stockings to bilateral lower extremities (BLEs) in the A.M., remove at HS (at bedtime). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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	On 4/6/25 at 8:34 A.M., the surveyor observed Resident #29 seated in a stationary chair next to his/her bed. Resident #29's BLEs were swollen and discolored. Resident #29 did not have compression stockings applied to his/her lower extremities. On 4/8/25 at 9:27 A.M., the surveyor observed Resident #29 sitting at the edge of his/her bed. Resident #29's BLEs were swollen and he/she did not have compression stockings applied to his/her lower extremities. On 4/8/25 at 10:13 A.M., the surveyor observed Resident #29 lying in bed. A Certified Nursing Assistant (CNA) was in the room with Resident #29 taking his/her vitals. Resident #29's BLEs were swollen and he/she did not have compression stockings applied to his/her lower extremities. On 4/8/25 at 1:00 P.M., the surveyor observed Resident #29 seated in a stationary chair next to his/her bed. Resident #29 had his/her BLEs elevated on a four-wheeled walker. Resident #29's BLEs were swollen and he/she did not have compression stockings applied to his/her lower extremities. Review of Resident #29's April Medication Administration Records (MAR) indicated compression stockings were applied as ordered. Review of Resident #29's medical record failed to indicate application of the compression stockings was on hold or discontinued. Further review of the medical record failed to indicate documentation related to the reasoning for compression stockings to not be applied. During an interview on 4/8/25 at 1:05 P.M., Nurse #8 said she was not sure if she was supposed to check for application of compression stockings to her residents throughout the day. Nurse #8 confirmed Resident #29 had an order for compression stockings. Nurse #8 said Resident #29 did not have any compression stockings on at this time. During an interview on 4/8/25 at 1:15 P.M., the Assistant Director of Nursing (ADON) said Resident #29's compression stockings should be applied unless there is other documentation in the medical record indicating they were on hold or discontinued. The ADON said nursing should document in the MAR or a nursing note if a resident is refusing compression stockings or if the medical team changes the status of the order. 43935 2. Review of Massachusetts healthcare proxy act M.G.L C201D, Section 6 indicated, but was not limited to the following: The authority of a health care agent shall begin after a determination is made, pursuant to the provisions of this section, that the principal lacks the capacity to make or to communicate health care decisions. Such determination shall be made by the attending physician according to accepted standards of medical judgment. The determination shall be in writing and shall contain the attending physician's opinion regarding the cause and nature of the principal's incapacity as well as its extent and probable duration. This written determination shall be entered into the principal's permanent medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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	Resident #4 was admitted to the facility in June 2024 and had diagnoses including: Dementia with psychotic disturbance and anxiety. Review of the MDS assessment for Resident #4, dated 3/12/25, indicated the Resident was severely cognitively impaired with a BIMS score of 4 out of 15. Review of the medical record on 4/8/25 indicated the Resident's HCP had been invoked on 11/22/24 by Nurse Practitioner (NP) #1, the form indicated the following: The Resident lacks the capacity to communicate health decisions. This determination is made in accordance with accepted standards of medical judgement. The cause, nature, extent and probable duration of the resident's incapacity are described below: the cause and nature of the medical judgement on the form remained blank, the extent was completed as moderate/severe and duration as lifelong. During an interview on 4/8/25 at 12:18 P.M., NP #1 said he invoked Resident #4's HCP back in November of 2024 for an increase in cognitive decline. He reviewed the HCP activation form and said the form was not fully completed as it should be and it was his error. He said completing the cause and nature was standard practice. During an interview on 4/8/25 at 2:25 P.M., the Director of Nurses said the HCP invocation form should be complete, in accordance with the regulatory requirements. During an interview on 4/8/25 at 3:24 P.M., the Administrator said she saw the incomplete HCP invocation form for Resident #4 and the incomplete form is not in line with the standard or practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42742 Based on observation and interview, the facility failed to ensure two Residents (#41 and #36), out of a total sample of 18 residents, were free of accident hazards. Specifically, the facility failed: 1. For Resident #41, to ensure a wound treatment cart was locked when unattended by licensed staff to prevent unauthorized access to potentially harmful items; and 2. For Resident #36, to ensure the Resident's freestanding oxygen cylinder was properly stored. Findings include: 1. Review of the facility's policy titled Medication Storage, revised March 2022, indicated but was not limited to the following: -The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. -The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. -Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. Resident #41 was admitted to the facility in July 2024 and had diagnoses including moderate dementia with psychotic disturbance. Review of the Minimum Data Set (MDS) assessment, dated 1/29/25, indicated the Resident had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. On 4/7/25 at 8:13 A.M., the surveyor observed a wound treatment cart located on the 3rd Floor Unit television (TV) sitting area in front of the nurses' station stored against the left wall unlocked and unattended. Resident #41 was seated in close proximity of the cart watching TV. No staff were observed in the immediate vicinity. Contents observed inside the wound treatment cart included but were not limited to the following: Top drawer: -one bottle of ammonium lactate 12% lotion (treats dry or scaly skin) -one tube of clobetasol 0.05% topical cream (topical corticosteroid-treats skin conditions that involve inflammation and itchiness, including psoriasis). Warning includes, do not get this medication in your eyes, mouth, or vagina. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-one tube of nystatin and triamcinolone acetate topical cream (treats fungal skin infections and reduces associated inflammation and itching). Proper use, do not use this medication in or around the eyes. -nystatin powder (treats fungal or yeast infections of the skin). This medication is for external use only. Do not take by mouth. -one tube of 1% silver sulfadiazine cream (topical antibiotic and antimicrobial agent). Only for use on the skin. Do not get topical silver sulfadiazine in your eyes. -hydrocortisone cream (type of topical steroid that treats eczema and other skin conditions that cause swelling, redness, itching, and rashes). Intended for topical use only, not for swallowing. Swallowing could lead to side effects like adrenal gland problems or other complications. -antimicrobial skin and wound gel (formulated to effectively kill a broad spectrum of microorganisms). For external use only and should not be swallowed. Ingesting these products can be harmful and even dangerous. -mupirocin ointment 2% (topical antibiotic). Mupirocin is only for use on your skin. Avoid getting it in your eyes. -diclofenac sodium topical gel 1% (non-steroidal anti-inflammatory drug (NSAID) that can be used to treat arthritis pain, swelling, and inflammation). Do not get topical diclofenac in your eyes, nose, or mouth. 2nd drawer: -clobetasol propionate cream 0.05% 3rd drawer: -one box of 1% hydrocortisone cream -bottom drawer 2 bottles of hydrogen peroxide 3% ,16 ounce -one bottle of povidone iodine 10% solution (topical antiseptic) 3/4 full. Not intended for oral consumption. Ingesting can cause nausea, vomiting, abdominal pain, thyroid problems, kidney damage, and cardiovascular complications. On 4/7/25 the surveyor made the following additional observations: 12:55 P.M. - Resident #41 opening drawers of treatment cart then sit down in chair next to unlocked treatment cart, housekeeping staff member observed to watch Resident #41 but did not alert any nursing staff or stop the Resident from rummaging through the drawers (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12:57 P.M. - Resident #41 rummaging through the treatment cart, opened three to four drawers in the cart, stopped by a Certified Nursing Assistant (CNA) and the Resident gestured with his/her hands as though he/she was looking for something to eat, nurse got up from nurses' station desk and redirects the Resident but did not lock the treatment cart 1:01 P.M. - Resident #41 rummaging through unlocked treatment cart, housekeeping staff member walks over to the Resident and ask what he/she needs, Resident gestures and asks for a new pair of socks or shoes, staff member gets resident a new pair of socks 1:21 P.M. - Resident #41 pulled a chair from the table next to the treatment cart, Resident remains seated, treatment cart remains unlocked During an interview on 4/7/25 at 3:08 P.M., Nurse #6 and Nurse #7 said they didn't know the treatment cart wasn't locked but both said they didn't have a key for it to lock it. They said there are Alzheimer's disease and dementia residents residing on the unit and said the potential was there for the residents to gain access to items that could be harmful to them. During an interview on 4/8/25 at 10:54 A.M, the Director of Nursing (DON) said treatment carts are supposed to be locked at all times if left unattended. She said, if not, anybody can go in them, and they did not want that that to happen. She said nurses have keys so she wasn't sure why they wouldn't have been locked. The DON said there was a potential hazard for residents as they could ingest the medications. She said no residents should have access to medications. 48695 2. Review of the National Fire Protection Association (NFPA) 99, Health Care Facilities Code, 2012 Edition Chapter 11: Gas Equipment, section 11.6.2.3 (11) states that freestanding oxygen cylinders shall be properly chained or supported in a proper cylinder stand or cart. Resident #36 was admitted to the facility in February 2022 with diagnoses including chronic obstructive pulmonary disease (progressive lung disease characterized by airflow obstruction, making it difficult to breathe). Review of the MDS assessment, dated 3/12/25, indicated Resident #36 had a significant cognitive impairment as evidenced by a BIMS of 3 out of 15. Review of Resident #36's Physician's Orders indicated but was not limited to: - Oxygen at 0.5 liters to 2 liters by nasal cannula continuously to keep oxygen saturations greater than 90%, dated 4/6/25 - Oxygen at 2 liters via nasal cannula as needed for shortness of breath, dated 8/18/24 discontinued 4/6/25 On the following days and times, the surveyor observed an E-Tank (cylinder or tank of compressed oxygen approximately 3 feet tall) standing next to Resident #36's nightstand against the wall, not secured to the wall or in a cylinder stand, and near his/her roommate's head of the bed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 4/6/25 at 9:35 A.M., - 4/6/25 at 12:12 P.M., - 4/6/25 at 4:21 P.M., - 4/7/25 at 7:59 A.M., - 4/7/25 at 10:51 A.M., and - 4/7/25 at 2:53 P.M. During an interview on 4/8/25 at 7:18 A.M., Nurse #3 and the surveyor observed an E-Tank standing next to Resident #36's nightstand against the wall, not secured to the wall or in a cylinder stand, and near his/her roommate's head of the bed. Nurse #3 said the E-Tank should not be stored in a resident's room when not in use but should be stored in the oxygen storage room. Nurse #3 said if an E-Tank was in a resident's room then it should be secured in a cylinder stand. During an interview on 4/8/25 at 2:54 P.M., the Assistant Director of Nursing (ADON) said E-Tanks should not be left in a resident's room unattended and not secured but instead should be stored in the oxygen storage room when not in use. The ADON said if an E-Tank was in a resident's room then it should be stored in a secure cylinder stand or secured to the resident's wheelchair. During an interview on 4/8/25 at 3:09 P.M., the DON said E-Tanks should be stored in a cylinder stand or secured to the resident's wheelchair when in use. The DON said an E-Tank should not have been stored in a resident's room but instead should have been stored in the oxygen storage room. During an interview on 4/8/25 at 3:21 P.M., the Regional Nurse said E-Tanks should not be improperly stored in residents' rooms when not in use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 42742 Based on observation, interview, and record review, the facility failed to provide care and maintenance of a Peripherally Inserted Central Catheter (PICC-a flexible tube inserted through a vein in one's arm and passed through to larger veins near the heart, used to deliver medications intravenously (IV)), consistent with professional standards of practice for one Resident (#200), out of a total sample of 18 residents. Specifically, the facility failed to: -ensure documentation of PICC line dressing changes -measure and document the external catheter length to ensure the PICC line had not migrated (moved from the heart to another area, which could have significant impact on treatment, or cause serious harm) -measure and document arm circumference -measure and document the total catheter length when the PICC line was pulled out by the Resident to ensure the catheter was intact. Findings include: Review of the facility's policy titled Central Venous Catheter Care and Dressing Changes, revised April 2022, indicated but was not limited to the following: Purpose: -The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. General Guidelines: -Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g. damp, loosened or visibly soiled). -Maintain sterile dressing (transparent semi-permeable membrane (TMS) dressing or sterile gauze) for all central vascular access devices. The type of dressing is based on the condition of the resident and his or her preference. -Change the dressing if it becomes damp, loosened, or visibly soiled and: a. at least every 7 days for TSM (transparent semi-permeable) dressing; b. at least every 2 days for sterile gauze dressing (including gauze under a TSM unless the site is not obscured); or (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. immediately if the dressing or site appear compromised. 7. Measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare the length documented at insertion. 8. Assess the integrity of securement devices with each dressing change. 9. For PICCs, measure arm circumference and compare to baseline when clinically indicated to assess for edema and possibly deep-vein thrombosis. Resident #200 was readmitted to the facility in March 2025 from the hospital with a triple lumen PICC line device inserted in the right arm and was being treated intravenously for a diagnosis of sepsis due to methicillin susceptible staphylococcus aureus. Review of the Minimum Data Set (MDS) assessment, dated 2/17/25, indicated Resident #200 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. During a telephonic interview on 4/6/25 at 2:41 P.M., the Resident's Representative said the Resident was on IV antibiotic therapy for an infection throughout his/her body. Review of current Physician's Orders indicated the following: -May have PICC line, 4/1/25 -Observe insertion site at least every shift and PRN with intermittent infusion, as needed every shift, observe for redness, swelling, or pain at site. If redness, swelling, or pain at site observed then contact MD, 3/28/25 -cefazolin sodium (antibiotic) solution reconstituted 1 gram (GM), use 2 GM IV every 8 hours for infection until 5/4/25 6:00 A.M., 4/3/25 Review of the PICC Insertion Record indicated Resident #200 had a new non-valved single lumen Power Injectable PICC placed in the left brachial vein on 4/1/25 at 3:20 P.M. with a total catheter length of 38 centimeters (cm) and post-procedure arm circumference of 34 cm. The external catheter length was documented as 0 cm. An adhesive securement device was used. There were no corresponding paper infusion therapy orders located in the medical record. Review of manufacturer's guidelines, revised November 2010, indicated but was not limited to the following: Indications: -The PowerPICC SV catheter is indicated for short- or long-term peripheral access to the central venous system for intravenous therapy, blood sampling, power injection of contrast media, and allows for central venous pressure monitoring. Warnings: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Do not use the catheter if there is any evidence of mechanical damage or leaking. Damage to the catheter may lead to rupture, fragmentation, possible embolism, and surgical removal. -The StatLock catheter stabilization device should be monitored daily and replaced at least every 7 days. -Caution: To minimize the risk of catheter breakage and embolization, the catheter must be secured in place. Suggested Catheter Maintenance: -Dressing changes: Assess the dressing in the first 24 hours for accumulation of blood, fluid, or moisture beneath the dressing. During all dressing changes, assess the external length of the catheter to determine if migration of the catheter has occurred. Periodically confirm catheter placement, tip location, patency, and security of dressing. Review of physician's orders did not indicate an order for PICC line dressing changes, measuring the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected and compare to the length documented at insertion, to assess the integrity of securement devices with each dressing change, and to measure arm circumference and compare to the baseline when clinically indicated to assess for edema and possibly deep-vein thrombosis. On 4/7/25 at 2:41 P.M., the surveyor observed Resident #200 lying in bed. A left single lumen PICC was observed in the brachial vein. The catheter stabilization device was intact, however, there was no transparent dressing observed over the device and insertion site potentially exposing it to environmental contaminants. A white gauze wrap was observed loosely around the Resident's left wrist. Resident #200 was observed touching and playing with the PICC line device. On 4/7/25 at 2:42 P.M., Nurse #2 entered the room with the surveyor and said she did a dressing change yesterday and the transparent dressing was intact at that time. She said the Resident must have taken it off. Review of the medical record failed to indicate a dressing change had been performed on Resident #200 the day before (4/6/25) by Nurse #2 including external catheter length and arm circumference measurements to compare to the baseline measurements for any potential adverse event. Further review of the medical record failed to indicate a dressing change had been performed on Resident #200 by staff after surveyor intervention on 4/7/25 including external catheter length and arm circumference measurements to compare to the baseline measurements for any potential adverse event including dislodgement of the catheter device by the Resident. During an interview on 4/8/25 at 10:36 A.M., Nurse #2 said the Resident was sent out to the hospital early this morning because he/she pulled out his/her PICC line again. Nurse #2 said they would replace the PICC line there. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Nurse Progress Note, dated 4/8/25 at 4:02 A.M., indicated the Resident was transferred to the hospital after he/she pulled out his/her PICC line from the left upper arm. The note stated all pieces were there and intact. The note and medical record, however, failed to indicate the total catheter length measurement compared to the baseline to ensure the PICC was intact. During an interview on 4/8/25 at 11:34 A.M., Nurse Practitioner (NP) #1 said he was aware the Resident pulled out his/her PICC again this morning. He said while he isn't sure how the order sets go in by nurses, he said the PICC line dressing should be changed and the external catheter length measured during the dressing change. He said if it's pulled out by the Resident, then then nursing staff should be measuring the total catheter length to ensure it's intact and compare it to the insertion record. During an interview on 4/8/25 at 11:36 A.M., Nurse #2 said the Resident had a diagnosis of sepsis at the hospital associated with a urinary tract infection and that's why he/she was on IV antibiotics. The surveyor reviewed the medical record with Nurse #2 who said there should be an order to do dressing changes and check the external length for potential migration but there wasn't. She said she wasn't sure what the protocol was at the facility for dressing changes. Nurse #2 said she didn't measure the external catheter length when she did the dressing change yesterday when the surveyor informed her there wasn't one but should have. She said when the Resident pulled out the PICC earlier this morning it was documented by another nurse that it was intact, but said she wouldn't know how if there was no measurement taken. Nurse #2 and the Unit Manager reviewed the PICC insertion record with the surveyor and said the baseline total catheter length was 38 cm, arm circumference was 34 cm, and the external catheter length was documented as 0. The UM said the external measurement and total catheter length is usually something that's included in the batch orders but wasn't and there was nowhere on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) to document it. Nurse #2 said there was a potential risk of infection if dressing changes are not being done. During an interview on 4/8/25 at 2:15 P.M., the surveyor overheard the Director of Nursing (DON) ask the Assistant Director of Nursing (ADON) to enter a note from the IV incident the day before (4/7/25) for Resident #200 and to make sure he put everything in there. During an interview on 4/8/25 at 3:48 P.M., the ADON said he didn't write a progress note until today, but everything was fine, and said he measured the total catheter length, and it was 38 cm (PICC had not been removed at this time for the ADON to have measured it). During an interview with the DON and Regional Nurse #1 on 4/8/25 at 1:43 P.M., the DON said the Resident returned from the hospital with a PICC line for antibiotics related to sepsis. Regional Nurse #1 said there was no current order for dressing changes or measuring the external catheter and said it may have been dropped. She said staff follow the policy for dressing changes and measuring. The surveyor reviewed the policy with the DON and Regional Nurse #1 who said the dressing should be changed at least every seven days and as needed and the monitoring of external catheter length and arm circumference should be done with it. Regional Nurse #1 said the ADON changed the dressing on 4/1/25 and with all the commotion, documentation may have slipped from being done and she would have to ask him about it. She said the skilled nursing notes did not include measurement of external catheter length but said staff are monitoring it. The DON said Nurse #2 said she was going to measure it and didn't know why she didn't.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 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. 34145 Based on record review and interview, the facility failed to assess a history of trauma and failed to assess and to develop a plan of care accounting for Resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization for one Resident (#12), with a history of trauma, out of a total sample of 18 residents. Findings include: Review of the facility's policy titled Trauma Informed Care, last revised 4/2022, indicated but was not limited to: -Purpose: To guide staff in appropriate and compassionate care specific to individuals who have experienced trauma. -Nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization. - As part of the comprehensive assessment, identify a history of trauma or interpersonal violence when possible. -Identifying past trauma or adverse experiences may involve record review or the use of screening tools. -Utilize trained and qualified staff members who have established a rapport with the resident to assess him or her for previous trauma. Resident #12 was admitted to the facility in February 2025 and had diagnoses including anxiety, depression, and post-traumatic stress disorder (PTSD). Review of the Minimum Data Set (MDS) assessment, dated 2/20/25, indicated Resident #12 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 13 out of 15, expressed having little interest or pleasure in doing things (2-6 days during the review period) and feeling down depressed or hopeless (2-6 days during the review period), and had a diagnosis of PTSD. Review of the facility's Consultant Psychiatric Nurse Practitioner's note, dated 3/19/25, indicated the clinician identified Resident #12 reported a history of PTSD. However, the documentation failed to indicate the nature of the trauma, its effects on the Resident or any interventions accounting for Resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization. Further review of the entire medical record failed to indicate any staff collaboration with the Resident, or any other health care professional who may have provided care to Resident #12 to gather information related to his/her self-reported and documented PTSD diagnosis in order to develop a person-centered plan of care which identified potential triggers or trauma with interventions to prevent re-traumatization. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 4/7/25 at 2:00 P.M. and 4/8/25 at 9:25 A.M., Resident #12 shared that he/she experienced significant trauma when he/she was eight or nine years old and also as an adult. During an interview on 4/7/25 at 2:45 P.M., the Director of Social Services said it is her responsibility for conducting the trauma assessments and developing care plans for PTSD and must have missed doing it for Resident #12. She said she was aware Resident #12 has a diagnosis of PTSD but does not know what the trauma was or what any triggers may be. The Social Worker said that she should have conducted a trauma assessment and developed a care plan to address the Resident's needs upon his/her admission to the facility. During an interview on 4/8/25 at 2:25 P.M., Unit Manager #1 and the Regional Nurse reviewed Resident #12's medical record with the surveyor. Neither Unit Manager #1 nor the Regional Nurse were able to identify the nature of Resident #12's PTSD or any triggers the Resident may have.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 34145 Based on observations, record review, and interviews, the facility failed to assess one Resident (#12), out of a sample of 18 residents, for the use of a bed rail. Specifically, the facility failed to assess the risk of entrapment from the use of a bed rail (side rails, bed side rails, safety rails, grab bars and assist bars: adjustable position, rigid bars that attach to the sides of a bed, ranging in sizes from full to one-half, one-quarter, or one-eighth lengths), review the risks and benefits of side rails and obtain informed consent from the resident prior to installation of a bed rail. Findings Include: Review of the facility's policy titled Proper Use of Side Rails Policy, last revised 4/2022, indicated but was not limited to: -An assessment will be conducted to identify the reason for using side rails and the risk of entrapment. When used for mobility or transfer, an assessment will include a review of the resident's: -Bed mobility -Ability to change positions, transfer to and from bed or chair, and to stand and toilet -Risk of entrapment from the use of side rails -That the bed's dimensions are appropriate for the resident's size and weight -The use of side rails as an assistive device will be addressed in the resident's care plan. -If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the physician or nurse practitioner, and input from the resident and/or legal representative about the benefits and potential hazards associated with side rails. -Consent for the use of side rail use will be obtained from the resident or legal representative. -When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of space may vary, depending on the type of bed and mattress being used). Resident #12 was admitted to the facility in February 2025 following an acute hospitalization for a left proximal humerus fracture after sustaining a fall at home. Review of the Minimum Data Set assessment, dated 2/20/25, indicated Resident #12 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 13 out of 15, and had functional limitation in range of motion on one side of both upper and lower extremity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/7/25 at 8:10 A.M., the surveyor observed Resident #12 sitting upright in bed eating breakfast. A bed rail was attached to the left side of the Resident's bed with foam material covering it. The Resident said the facility attached the rail to the right side of the bed because he/she cannot use the other arm because it was fractured and is still painful. The Resident said he/she used to have a cast, but it was removed a few weeks ago. Resident #12 said he/she is not able to use the rail to reposition him/herself. On 4/8/25 at 9:25 A.M., the surveyor observed Resident #12 sitting upright in bed eating breakfast. A bed rail was attached to the left side of the Resident's bed with foam material covering it. Review of Resident #12's Admission Nursing Evaluation, dated 2/14/25, indicated but was not limited to the following: Side Rail Assessment: -The Resident not currently using a grab bar for positioning or support -Type of rail needed: None During an interview on 4/8/25 at 2:25 P.M., Unit Manager #1 and Regional Nurse reviewed Resident #12's medical record. They said there was no physician's order, no care plan, and no informed/signed consent for use of the rail.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 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. 34145 Based on interviews and record review, the facility failed to ensure monthly Medication Regimen Review (MRR) recommendations made by the pharmacy consultant were addressed timely and maintained as part of the permanent medical record for two Residents (#12 and #4), out of a total sample of 18 residents. Specifically, the facility failed: 1. For Resident #12, to ensure the February 2024 consultant pharmacist recommendation was acted upon timely by the physician to add instructions for Trelegy Ellipta inhaler (used to treat chronic obstructive pulmonary disease (COPD) and works by opening airways, reducing inflammation, and keeping the airways open and improving lung function) orders; and 2. For Resident #4, to ensure recommendations left by the consultant pharmacist were addressed in a timely manner, for a clarification for the continued appropriate use of Seroquel (an antipsychotic medication), including a rationale for the medication. Findings include: Review of the facility's policy titled Medication Regimen Review, dated November 2021, indicated but was not limited to the following: - The facility assures that the consultant pharmacist has access to the residents and their medical records - the consultant pharmacist reviews the medication regimen of each resident at least monthly - while monthly medication review (MRR) is generally conducted in the facility, off-site MRR are acceptable when a review is requested and the pharmacist is not in the facility and cannot possibly make it to the facility in a reasonable time frame - in performing MRRs the consultant pharmacist incorporates federally mandated standards of care, in addition to other applicable professional standards, such as the American society of consultant pharmacists practice standards, and clinical standards such as the Agency for healthcare research and quality clinical practice guidelines and American medical directors association clinical practice guidelines - the consultant identifies irregularities through a variety of sources including the resident's clinical record, pharmacy records, and other applicable documents; in addition to reviewing pharmacy and clinical records the pharmacist may need to interview facility staff, the attending physician and the resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the resident's active medical record and reported to the Director of Nurses (DON), Medical director and/or prescriber as appropriate - notification mode is dependent on severity of irregularity and is determined through consultation between the consultant pharmacist and DON; if no irregularities are found the consultant pharmacist documents this as well - if a continuing irregularity is deemed to be clinically significant, or evidence of a valid clinical reason for rejecting the recommendation is provided, the consultant pharmacist will reconsider whether to report the irregularity again or make a new recommendation on an annual basis - recommendations are acted upon and documented by the facility staff and/or prescriber - prescriber accepts and acts upon suggestions or rejects and provides an explanation for disagreeing - the DON or designated licensed nurse address and document recommendations that do not require a physician's intervention (example: monitoring blood pressure) - at least monthly, the consultant pharmacist reports any irregularities to the attending physician, medical director and DON, at a minimum 1. Resident #12 was admitted to the facility in February 2025 and had diagnoses including COPD. Review of Physician's Orders indicated but was not limited to: -Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 10-62.5-25 micrograms/actuation, one puff inhale orally one time a day for COPD (2/14/25) Review of the medical record indicated a Pharmacy progress note/recommendation to the Physician/Prescriber, dated 2/16/25, to add instructions to the orders for use of Trelegy Ellipta inhaler to rinse mouth after using to avoid thrush (a fungal infection in the mouth caused by the overgrowth of Candida albicans yeast). Review of Resident #12's medical record failed to indicate that the Consultant Pharmacist recommendation was addressed by the physician. During an interview on 4/8/25 at 10:25 A.M., the Director of Operations said the pharmacy recommendation, dated 2/16/25, has not been addressed by the physician. During an interview on 4/8/25 at 1:30 P.M., the Director of Nursing (DON) said that she had just spoken to Resident #12's physician today to inform him of the Pharmacist's recommendation dated 2/16/25. She said the recommendation should have been addressed prior to 4/8/25. 43935 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's policy titled: Psychotropic Medication, dated as revised 2/2025, indicated but was not limited to the following: -The consultant pharmacist reviews the appropriateness of psychoactive medication orders as part of each drug regimen review and monitors for: appropriateness of psychoactive medication based on diagnoses, clinical indications and prescribing guidelines and reassessment for trial dose reduction in accordance with state and federal regulations. Resident #4 was admitted to the facility in June 2024 and had diagnoses including: dementia with psychotic disturbance and anxiety. Review of the Physician's Orders indicated Resident #4 has been receiving Seroquel (Quetiapine) since admission in June 2024, initially for sleep and currently for depression. Review of the consultant pharmacist recommendations indicated but were not limited to the following: - 7/23/24: The resident receives Seroquel, please consider a psych consult for review of appropriateness of medication and/or possible decrease in dosage if you feel warranted at this time. Please indicate rationale if you feel it is not needed below. Response: Disagree, no GDR (gradual dose reduction) at this time (7/26/24) The recommendation failed to indicate a rationale for the ongoing use of the medication. - 8/23/24: This resident has a diagnosis (DX) for Seroquel in PCC (point click care - the facility electronic medical record system) for sleep; this diagnosis is not sufficient. Please update the diagnosis, thank you. - 9/25/24: Recommendation: This resident has a diagnosis for Seroquel in PCC for sleep; this diagnosis is not sufficient. Please update the diagnosis; there had been no response in the status section of the report. 11/24/24: The resident receives Seroquel & Prozac please consider a psych consult for review of appropriateness of medication and/or possible decrease in dosage if you feel warranted at this time. Please indicate rationale if you feel it is not needed below. Response: Psych follow up (f/u); requires both per healthcare proxy (HCP) 1/27/25: Please update the current medical record with the following DX in the order within the medication direction field for medication Seroquel the diagnosis of sleep appears incorrect or not sufficient. There is no response to the recommendation available in the medical record, but the diagnosis on the medication changed in March 2025 from sleep to depression. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/25 at 1:33 P.M., the Unit Manager said the MRR process is that they are sent by email each month and once she receives them, she provides them to the Nurse Practitioner for completion and once they are completed it is documented on the form and the form is scanned into PCC. She said she tries to have them completed within a few days, but they definitely need to be completed before the next pharmacy visit so the pharmacist can see that they have been addressed in some way. She reviewed Resident #4's medical record and said there were no documents in the record to indicate the pharmacy recommendations from August 2024 or January 2025 for the Seroquel medication had been addressed in any way, which would indicate to her that they were incomplete. During a telephone interview on 4/8/25 at 2:42 P.M., the Pharmacy consultant said the facility typically uploads the recommendation sheets into PCC, but the physical recommendation is not always available in the computer system for him to review and he reviews orders and MD/NP progress notes as well to determine whether or not recommendations have been addressed timely or appropriately. He said he has left recommendations for this Resident four times regarding an appropriate diagnosis for or possible reduction of their Seroquel medication. He said at this point he has requested the clarification for the Seroquel or a GDR if no such DX exists but he has not yet been able to identify an appropriate diagnosis anywhere in the record or any evidence that these recommendations have been addressed appropriately. He said his expectation is that they are addressed either on the form directly, which is standard or at a minimum documented some way in the medical record, by his next visit and at this point that has not occurred routinely as it should and the process is not being followed. During an interview on 4/8/25 at 4:21 P.M., the DON said there are no additional documents or completed MRRs that she could provide or locate to demonstrate this repeat recommendation was addressed appropriately or timely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 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. 42742 Based on observation, interview, and document review, the facility failed to ensure all drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. Specifically, the facility failed to: 1. Ensure medication carts were locked when not in direct supervision of the licensed nurse on one of two units; 2. Ensure two of two medication rooms were locked when not in direct supervision of the licensed nurse; and 3. Ensure the over the counter (OTC) medication room was locked when not in direct supervision of the licensed nurse on one of one units. Findings include: Review of the facility's policy titled Medication Storage, revised March 2022, indicated but was not limited to the following: -The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. -The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. -Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. -Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys. According to the facility's Resident Matrix (used to identify pertinent care categories for newly admitted residents in the last 30 days who are still residing in the facility and all other residents) five residents on the 2nd Floor Unit and 19 residents on the 3rd Floor Unit had a diagnosis of Alzheimer's disease or dementia of any type. 1. On 4/6/25 at 11:23 A.M., the surveyor observed the low side medication cart on the 2nd Floor Unit belonging to Nurse #2 unlocked and unattended in the hallway outside resident rooms. A housekeeper and Certified Nursing Assistant were observed walking by the cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation with interview on 4/6/25 at 11:25 A.M., the surveyor observed Nurse #2 return to her cart. Nurse #2 said her medication cart should have been locked but she got distracted by a family member who called her away and forgot to lock it when she walked away. Nurse #2 said the medication cart needed to be locked for safety when not in the direct line of sight of the nurse. 2a. 2nd Floor Medication Room During an observation with interview on 4/7/25 at 11:56 A.M., during the 2nd Floor Unit medication room storage review with Nurse #2, the surveyor observed the door to the medication room unlocked upon entry. The Unit Manager (UM) joined the surveyor and Nurse #2 and said the medication room door should have been locked when unattended. b. 3rd Floor Medication Room On 4/7/25, the surveyor made the following observations of the 3rd Floor Unit medication storage room: 8:09 A.M., 8:28 A.M., and 8:48 A.M. - room unlocked and unattended, no licensed staff in the immediate vicinity, two residents sitting directly outside the medication room in the television sitting area, one of two Residents (#41) diagnosed with dementia 12:29 P.M. - room unlocked and unattended, no licensed staff in the immediate vicinity, one Resident (#41) sitting directly outside the medication room in the television sitting area 3:02 P.M. - room unlocked and unattended, no licensed staff in the immediate vicinity During an interview on 4/7/25 at 3:08 P.M., Nurse #6 said she was just in the medication room and used her key to open the door and said it was locked. The surveyor asked Nurse #6 to attempt to open the medication room door without her key. Nurse #6 was able to freely open the door without her key and said it should have been locked. She said it was unlocked from the inside, that's why. Nurse #6 and Nurse #7 said there were Alzheimer's disease and dementia residents residing on the unit and said the potential was there for residents to gain access to items stored which could be harmful to them. 3. On 4/7/25 at 8:34 A.M., the surveyor observed the 3rd Floor Unit OTC medication room door unlocked. Four shelves of OTC medications were stored inside and accessible to any passersby. Nurse #7 joined the surveyor and said the door should have been locked when unattended. She said long term care residents, a few with diagnoses of Alzheimer's disease and dementia, resided on the unit and the potential was there for residents to enter the OTC medication room and either take or ingest the medications. During an interview on 4/8/25 at 10:54 A.M., the Director of Nursing (DON) said the medication carts and medication rooms are supposed to be locked at all times if left unattended. She said, if not, anybody can go in them, and they did not want that that to happen and to also avoid drug diversion. She said nurses have keys so she wasn't sure why they wouldn't have been locked. The DON said there was a potential hazard for residents as they could ingest the medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48695 Based on observations, interviews, and meal test tray results, the facility failed to serve meals that were palatable and at appetizing temperatures on two of two units. Findings include: Review of the facility's policy titled Daily Food Temperature Checks, last revised 8/15/24, indicated but was not limited to: - It is the policy of the facility that temperatures be recorded at each meal to assure that all meals be served to the residents within the proper temperature range. - Cold food or beverage is to be at or below 41 degrees or hot food or beverage will be maintained at or above 135 degrees. During the Resident Council Meeting, on 4/7/25 at 1:00 P.M., 5 out of 10 residents, who actively participated, said the food at breakfast and lunch would come up cold and the facility needed to ensure there were enough staff passing trays. On 4/8/25 at 7:37 A.M., the surveyor requested a breakfast tray to the Second Floor Unit. The food truck left the kitchen at 7:44 A.M., and arrived at the unit at 7:46 A.M. The test tray was conducted with Dietary Aide #2 at 7:55 A.M., with the following results in degrees Fahrenheit (F): - Scrambled Eggs: 125.1, F lukewarm to taste and little flavor. - Waffle: 111.6 F, cold to taste, dry, and little flavor. - Sausage: 122.8 F, lukewarm to taste, Dietary Aide #2 confirmed the sausage was lukewarm. - Oatmeal: 164.5 F, palatable and hot. - Milk Carton: 51.3 F, lukewarm to taste. - Orange Juice: 46.5 F, lukewarm to taste and touch. On 4/8/25 at 7:44 A.M., the surveyor requested a breakfast tray to the Third Floor Unit. The food truck left the kitchen at 7:50 A.M., and arrived at the unit at 7:52 A.M. The test tray was conducted with the Food Service Director (FSD) at 8:00 A.M., with the following results: - Scrambled Eggs: 115.5 F, lukewarm to taste and little flavor. FSD confirmed lukewarm to taste. - Waffle: 102 F, cold to taste and soggy. FSD confirmed lukewarm to taste and parts of the waffle were soggy from touching the eggs. - Sausage: 126.6 F, lukewarm to taste. FSD confirmed lukewarm to taste. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Oatmeal: 153 F, palatable and hot. - Milk Carton 45 F, cool and palatable. - Orange Juice 45.9 F, cool and palatable. - Cup of coffee served on the unit was 165 F palatable and hot. During an interview on 4/8/25 at 10:23 A.M., the FSD said the temperatures were not within the appropriate ranges, and the hot items should have been hotter for the residents and colder foods colder. The FSD said her expectation was for hot foods to be served at 148 F to 150 F and food items should be hot and flavorful when served to the residents. The FSD said that one column of the plate warmer had not been working for a while; the dietary staff had to rotate hot plates from one side to the other and cover it with a stainless-steel pot. The FSD said the kitchen needed a new plate warmer and everyone was aware.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Ensure food was properly stored in the walk-in freezer in the main kitchen; 2. Ensure to properly date, label, and store food and drink items in one of two kitchenettes; 3. Ensure, a. the wall in the main kitchen behind the dishwashing station was kept in a clean and sanitary manner; b. the counter next to the sink in one of two kitchenettes was kept in a clean and sanitary manner; 4. Ensure staff wore hair restraints in the main kitchen during meal preparation and service; and Findings include: Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated but was not limited to: -,d+[DATE] Hair Restraints ,d+[DATE].11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. -,d+[DATE] Duties ,d+[DATE].11 Person in Charge. The PERSON IN CHARGE shall ensure that: (B) PERSONS unnecessary to the FOOD ESTABLISHMENT operation are not allowed in the FOOD preparation, FOOD storage, or WAREWASHING areas, except that brief visits and tours may be authorized by the PERSON IN CHARGE if steps are taken to ensure that exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES are protected from contamination. ,d+[DATE].18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in ,d+[DATE].17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3- 501.17(A), except time that the product is frozen; P (2) Is in a container or PACKAGE that does not bear a date or day; P or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in ,d+[DATE].17(A). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. ,d+[DATE].19 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment that are exposed to splashes, spillage, or other food soiling or that require frequent cleaning shall be constructed of a corrosion-resistant, nonabsorbent, and smooth material. 1. On [DATE] at 7:31 A.M., the surveyor observed in the main kitchen walk-in refrigerator: - One opened container of thickened cranberry juice refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - One pouch of whipped cream, open date [DATE] use by [DATE]; - Five canisters of Dessert Topping, all dated best by [DATE]; - One open plastic container of chopped peppers, dated [DATE]; - One plastic pop-top water bottle containing a staff member's drink; - Two cartons containing milk on the walk-in floor; On [DATE] at 7:36 A.M., the surveyor observed in the main kitchen refrigerator: - One bowl of icing covered with plastic wrap, open date [DATE] and use by [DATE]. On [DATE] at 12:50 P.M., the Food Service Director (FSD) and surveyor observed in the main kitchen walk-in refrigerator: - One opened container of thickened cranberry juice refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - One pouch of whipped cream, open date [DATE] use by [DATE]; - Five canisters of Dessert Topping, all dated best by [DATE]; - One open plastic container of chopped peppers, dated [DATE]; - Two cartons containing milk on the walk-in floor; and, On [DATE] at 12:50 P.M., the FSD surveyor observed in the main kitchen refrigerator: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One bowl of icing covered with plastic wrap, open date [DATE] and use by [DATE]. During an interview on [DATE] at 12:50 P.M., the FSD said all refrigerators were checked daily for expiration dates. The FSD said all foods should be labeled with date opened and use by date, and food should be used and/or discarded by the use by the date. The FSD said the thickened cranberry juice should have been labeled with the date opened and used per manufacturer's guidelines. The FSD said the milk should not have been stored on the floor of the walk-in refrigerator. The FSD said there was a small area in the walk-in refrigerator where staff could keep their food. On [DATE] at 11:30 A.M., the surveyor observed in the main kitchen walk-in refrigerator: - Two plastic pop-top water bottles containing staff members' drinks; and - Plastic container containing a staff member's meal. During an interview on [DATE] at 4:08 P.M., the Director of Operations (DOO) said staff should store their food and beverages in the employee break room and not in the main kitchen. 2. Review of the facility's policy titled Family/Visitor Provided Food, effective date [DATE], indicated but was not limited to: - Disposal of Foods: - NOTE: to maintain sanitary conditions and resident safety, it is the facility's policy to discard resident food if observed or evidenced to be spoiled. - Nursing, Dietary, and housekeeping staff are responsible to discard: - Foods outside of the expiration dates. - Show signs of spoilage. - Foods received more than 3 days prior. On [DATE] at 9:12 A.M., in the Third Floor Kitchenette refrigerator the surveyor made the following observation: - One open vanilla very high calorie nutritional drink, undated, manufacturer label stated: once open refrigerate and use within 24 hours; - One frozen container of a resident's food brought in from home, dated [DATE]; - One custard pastry of a resident's brought in from home, undated; - Five unopened containers of probiotic milk beverage labeled with a resident's name, date best if used by [DATE]; - One container of a resident's store-bought soup, dated use by [DATE]; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One container of applesauce open, undated; - Two open containers of dairy free milk, undated with open date and dated best by [DATE], manufacturer label stated: once open use within 7 days; - One open container of chocolate balanced nutritional drink, undated, manufacturer label stated: once open refrigerate and use within 24 hours; - One frozen closed container chocolate balanced nutritional drink, manufacturer label stated: DO NOT FREEZE; - Two frozen containers of a resident's food brought in from home, undated; - One container of a resident's food brought in from home, dated [DATE], with a black fuzzy looking substance under the cover; and - One broken plastic container with missing pieces of plastic containing a resident's food brought in from home, undated. On [DATE] at 12:14 P.M., during a follow tour of the Third Floor Kitchenette refrigerator, the surveyor made the following observations: - One open container of chocolate balanced nutritional drink, undated, manufacturer label stated: once open refrigerate and use within 24 hours; - One frozen closed container chocolate balanced nutritional drink, manufacturer label stated: DO NOT FREEZE; - One broken plastic container with missing pieces of plastic containing a resident's food brought in from home, dated [DATE] use by [DATE]. On [DATE] at 12:46 P.M., during a follow tour of the Third Floor Kitchenette refrigerator, the FSD and surveyor made the following observations: - One open container of chocolate balanced nutritional drink, undated, manufacturer label stated: once open refrigerate and use within 24 hours; - One frozen closed container chocolate balanced nutritional drink, manufacturer label stated: DO NOT FREEZE; - One broken plastic container with missing pieces of plastic containing a resident's food brought in from home, dated [DATE] use by [DATE]. On [DATE] at 12:39 P.M., during a follow tour of the Third Floor Kitchenette refrigerator, the surveyor made the following observations: - One open container of chocolate balanced nutritional drink, undated, manufacturer label stated: once open refrigerate and use within 24 hours; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One frozen closed container chocolate balanced nutritional drink, manufacturer label stated: DO NOT FREEZE; - One broken plastic container with missing pieces of plastic containing a resident's food brought in from home, dated [DATE] use by [DATE]. During an interview on [DATE] at 12:46 P.M., the FSD said foods from home should be labeled and dated with a resident's name and the date brought in from home. The FSD said if a store bought food was brought in for a resident and is sealed it should be used by the expiration date or best by date. During an interview on [DATE] at 10:23 A.M., the FSD said the kitchenette refrigerators are cleaned daily, and the dietary staff go through the refrigerator daily to ensure foods brought in from home are labeled and stored appropriately. The FSD said the expectation was for foods to be labeled and stored appropriately and per manufacturer guidelines and expired foods to be discarded. 3a. On the following days and times, the surveyor observed the wall behind the soiled side of the dishwashing area with scattered black mold-like residue: - [DATE] at 7:31 A.M., - [DATE] at 12:38 P.M., - [DATE] at 11:40 A.M., and - [DATE] at 2:24 P.M. During an interview [DATE] at 2:30 P.M., the FSD and surveyor observed the soiled side of the dishwashing area with the scattered black mold-like residue. The FSD said after the wall behind the soiled side of the dishwashing area was wiped down each time the dietary staff would finish doing dishes. The FSD said the scattered black mold-like residue on the wall behind the dishwasher was caused by the water splashing onto the wall and not completely drying. During an interview on [DATE] at 2:56 P.M., the Administrator, the DOO, and the surveyor observed the soiled side of the dishwashing area with the scattered black mold-like residue. The Administrator said she would do environmental rounds weekly, but the kitchen was last checked a month ago. The DOO said the black mold-like residue needed to be scrubbed off and washed with bleach. b. On the following days and times, the surveyor observed on the countertop next to the sink in the third floor kitchenette to have a black mold-like residue: - [DATE] at 9:12 A.M., - [DATE] at 12:14 P.M., - [DATE] at 12:39 P.M., and - [DATE] at 1:08 P.M. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview [DATE] at 1:08 P.M., the FSD and surveyor observed on the countertop next to the sink to have a black mold-like residue. The FSD said housekeeping was responsible for cleaning the counters in the kitchenette, but the dietary department was responsible for ensuring they were clean. The FSD said the black mold-like residue was caused by moisture. 4. On [DATE] at 7:35 A.M., the surveyor observed the following: - [NAME] #1 plating breakfast. [NAME] #1 had her hair pulled back with a clip with loose hair sticking out. [NAME] #1 was not wearing a hair net. - Dietary Aide #1 was not wearing a hair net or beard cover. - The hair net holder inside the kitchen the door was empty. The surveyor asked for a hair net upon entering the kitchen. [NAME] #1 entered the storeroom and when she came out. [NAME] #1 said she could not find any hair nets. During an interview on [DATE] at 10:23 A.M., the FSD said staff should not be serving breakfast or be near the steam table without a hair net or beard cover on. The FSD said the expectation was for staff to wear an appropriate hair restraint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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. 43935 Based on document review and interview, the facility failed for two Residents (#4 and #202), out of a total sample of 15 residents, to maintain a complete and accurate medical record. Specifically, the facility failed to: 1. Ensure the healthcare proxy (HCP) activation form was completed for Resident #4, including the cause and nature of the document, which were left blank; and 2. Ensure the administration of Tramadol (a pain medication) was documented on the medication administration record (MAR) for Resident #202 each time it was administered. Findings include: 1. Review of Massachusetts healthcare proxy act M.G.L. C 201 D, Section 6 indicated, but was not limited to the following: The authority of a health care agent shall begin after a determination is made, pursuant to the provisions of this section, that the principal lacks the capacity to make or to communicate health care decisions. Such determination shall be made by the attending physician according to accepted standards of medical judgment. The determination shall be in writing and shall contain the attending physician's opinion regarding the cause and nature of the principal's incapacity as well as its extent and probable duration. This written determination shall be entered into the principal's permanent medical record. Resident #4 was admitted to the facility in June 2024 and had diagnoses including: dementia with psychotic disturbance and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 3/12/25, indicated Resident #4 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 out of 15. Review of the medical record on 4/8/25 indicated the Resident's HCP had been invoked on 11/22/24 by Nurse Practitioner (NP) #1. The form indicated the following: The Resident lacks the capacity to communicate health decisions. This determination is made in accordance with accepted standards of medical judgement. The cause, nature, extent and probable duration of the resident's incapacity are described below: the cause and nature of the medical judgement on the form remained blank, the extent was completed as moderate/severe and duration as lifelong. During an interview on 4/8/25 at 12:18 P.M., NP #1 said he invoked Resident #4's HCP back in November of 2024 for an increase in cognitive decline. He reviewed the HCP activation form and said the form was not fully completed as it should be and it was his error. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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	During an interview on 4/8/25 at 2:25 P.M., the Director of Nurses (DON) said the HCP invocation form should be complete and it not being complete makes the medical record incomplete and potentially inaccurate for Resident #4. During an interview on 4/8/25 at 3:24 P.M., the Administrator said she was not sure a policy existed for the accuracy and completion of medical records, however her expectation is that the records are complete and accurate to demonstrate the current conditions of the residents. She reviewed the HCP invocation form for Resident #4 and said the form was incomplete. 2. Review of the facility's policy titled Charting and Documentation, dated as revised 4/2022, indicated but was not limited to the following: - services provided to the resident, progress toward the care plan goals or any changes, shall be documented in the resident's medical record as indicated - the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care - the following information is to be documented in the resident's medical record: medication administration Resident #202 was admitted to the facility in April 2025 with diagnoses including spinal stenosis. Review of the nursing admission evaluation indicated the Resident was alert and oriented to person, place, and time; follows commands and has an intact memory. During an interview on 4/6/25 at 11:20 A.M., Resident #202 said they just recently underwent a laminectomy back surgery and are using Tramadol 50 milligrams (mg) two tabs for pain management as needed (PRN) every six hours and receives the medication about three to four times a day. Review of the Medication Administration Record (MAR) for Resident #202 on 4/7/25 at 4:42 P.M., indicated but was not limited to the following: - Tramadol 50 mg 1 tablet by mouth every six hours as needed for moderate to severe pain - administered once on 4/3/25 at 8:48 A.M. (ordered 4/2/25-4/3/25) - Tramadol 50 mg 2 tablets by mouth every six hours as needed for moderate to severe pain - not signed off administrations (ordered 4/3/25) Review of the Narcotic count book #28 for the second floor, pages 76 and 78 indicated 13 doses of Tramadol had been provided to the Resident from 4/2/25 through 4/7/25 at 4:45 P.M., and not documented as administered on the MAR. During an interview on 4/8/25 at 12:40 P.M., Nurse #2 said the process for administering a PRN pain medication is to evaluate the resident, verify the order, if necessary, sign the medication out of the narcotic book and then dispense the medication into a cup and document it on the MAR. She said on review of the MAR that she had administered Resident #202 Tramadol pain medication a few times and did not sign it off on the MAR. She said the MAR was incomplete and did not accurately reflect the medications the Resident was receiving as it should. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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	During an interview on 4/8/25 at 2:18 P.M., the DON said staff are required to document the administration of medication on the MAR to ensure the record is complete and accurate. The DON reviewed the MAR and narcotic book pages for Resident #202 and said the staff did not document the administration of the medication as they should have and the MAR was incomplete and inaccurate. During an interview on 4/8/25 at 3:24 P.M., the Administrator said her expectation is that the records are complete and accurate to demonstrate the current conditions of the residents. The Administrator reviewed the missing documentation on the MAR for Resident #202 and said the record was incomplete and inaccurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48362 Based on observation, interview, and record review, the facility failed to maintain an infection 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. Specifically, the facility failed to: 1. Implement a complete and accurate infection surveillance plan to identify, track and monitor for infection; 2. Ensure treatment carts were secured and locked to prevent Resident #41 from gaining unauthorized access resulting in infection control concerns; and 3. For Resident #36, ensure oxygen concentrator filters were clean and free of debris. Findings include: 1. Review of the facility's policy titled Infection Surveillance, revised 2/2024, indicated but was not limited to the following: - The Infection Preventionist (IP) will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have a substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions. - Infections that will be included in routine surveillance include those with a. evidence of transmissibility in a healthcare environment; b. available processes and procedures that prevent or reduce the spread of infection; c. clinically significant morbidity or mortality associated infections (e.g., pneumonia, UTIs (urinary tract infections), C. difficile (highly contagious bacterial infection of the colon); d. pathogens associated with serious outbreaks. - The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. The Infection Control Committee and/or QAPI Committee may be involved in the interpretation of the data. - For all residents with infections that meet the criteria for the definition of infection for surveillance, collect the following data as appropriate: a. identifying information (i.e., resident's name, age, room number, unit, and attending physician); b. diagnoses; c. admitted , date of onset of infection may list onset of symptoms, if known, or date of positive diagnostic test); d. infection site (be as specific as possible e.g., cutaneous infections should be listed as pressure ulcer, left foot, pneumonia as right upper lobe, ETC.); e. pathogens; f. invasive procedures or risk factors (i.e., surgery, indwelling tubes, Foley, ETC., fractured hip, malnutrition, altered mental status, ETC.); g. pertinent remarks (additional relevant information, i.e., temperatures, other symptoms of specific infection, white blood cell count, ETC.). Also, record if the resident is admitted to the hospital, or expires; and h. treatment measures and precautions (interventions and steps taken that may reduce risk). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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	Review of the facility provided infection surveillance line listing for December 2024 indicated but was not limited to the following: - 2 of 2 HAI skin infections failed to include a complete and accurate listing of symptoms. - 1 of 2 HAI skin infections failed to include information related to site and results of cultures (both were left blank) and failed to indicate if the infection had cleared (blank). Review of the facility provided infection surveillance line listing for January 2025 indicated but was not limited to the following: - 2 of 2 HAI skin infections failed to include a complete and accurate listing of symptoms and culture site information was left blank. - 1 of 2 HAI skin infections failed to indicate if the infection had cleared. - 2 of 2 urinary tract infections (UTI) failed to include a complete and accurate list of symptoms. - 1 of 2 UTIs failed to include information regarding culture site (BLANK) and results (BLANK). - 1 of 1 Pneumonia infections failed to indicate a complete and accurate listing of symptoms. Review of the facility provided infection surveillance line listing for February 2025 indicated but was not limited to the following: - 1 of 1 UTIs failed to include a complete and accurate listing of symptoms and failed to indicate if the infection had cleared. - 2 of 2 skin infections failed to include a complete and accurate listing of symptoms, failed to indicate the culture results (BLANK), and failed to indicate if the infection cleared (BLANK). During an interview on 4/8/25 at 1:16 P.M., the Assistant Director of Nursing (ADON)/IP said he maintained a list of infections being treated throughout the facility and reviewed them on a daily basis. The ADON/IP said the facility utilized McGeer's Criteria for infections and has an assessment in the electronic medical record that he completes when a resident presents with potential signs/symptoms of an infection. The ADON/IP and the surveyor reviewed the monthly line listings. The ADON/IP said the information on the line listings should be complete and not left blank. The ADON/IP said the information about symptoms should include all information identified during his review and be complete. 2. Review of the facility's policy titled Medication Storage, revised 3/2022, indicated but was not limited to the following: - The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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	- Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. On 4/7/25 at 12:55 P.M., the surveyor observed Resident #41 opening drawers of two treatment carts on the 3rd floor unit. Resident #41 was observed to reach his/her hand inside multiple drawers of each cart and touch items in the cart. The surveyor observed a housekeeping staff member watch Resident #41 rummage through the treatment cart drawers but did not stop the Resident or alert any nursing staff. Resident #41 was not observed to perform hand hygiene prior to rummaging through the drawers of the two treatment carts. On 4/7/25 at 12:57 P.M., the surveyor observed Resident #41 opening drawers of two treatment carts on the 3rd floor unit. Resident #41 was observed to reach his/her hand inside multiple drawers of each cart and touch items in the cart. The surveyor observed a Certified Nursing Assistant (CNA) staff member watch Resident #41 rummage through the treatment cart drawers but did not stop the Resident. The surveyor observed a nurse getting up from the nurses' station and redirect Resident #41 away from the treatment cart. Resident #41 was not observed to perform hand hygiene prior to rummaging through the drawers of the two treatment carts. On 4/7/25 at 1:01 P.M., the surveyor observed Resident #41 opening drawers of two treatment carts on the 3rd floor unit. Resident #41 was observed to reach his/her hand inside multiple drawers of each cart and touch items in the cart. The surveyor observed a housekeeping staff member redirect Resident #41 away from the two treatment carts and into his/her room. Resident #41 was not observed to perform hand hygiene prior to rummaging through the drawers of the two treatment carts. On 4/7/25 at 1:05 P.M., the surveyor observed Resident #41 opening drawers of two treatment carts on the 3rd floor unit. Resident #41 was observed to reach his/her hand inside multiple drawers of each cart and touch items in the cart. Resident #41 was not observed to perform hand hygiene prior to rummaging through the drawers of the two treatment carts. On 4/7/25 at 1:21 P.M., the surveyor observed Resident #41 opening drawers of two treatment carts on the 3rd floor unit. Resident #41 was observed to reach his/her hand inside multiple drawers of each cart and touch items in the cart. Resident #41 was not observed to perform hand hygiene prior to rummaging through the drawers of the two treatment carts. During an interview on 4/8/25 at 1:47 P.M., the ADON/IP said treatment carts should be locked at all times. The ADON/IP said he would expect anyone entering a treatment cart to perform hand hygiene as to not compromise any of the treatment items in the cart. The ADON/IP said it was a breach in infection control protocols to have a resident rummaging through treatment cart drawers. The ADON/IP said a resident on the unit should never have access to the treatment cart and the items inside the treatment cart were now compromised due to the infection control breach. 48695 3. Review of the facility's policy titled Oxygen Use, dated April 2022, indicated but was not limited to: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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	- Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Review of the manufacturer's guidelines, last updated March 2024, indicated but was not limited to: - Filters: Air enters the oxygen concentrator unit through an air intake gross particle filter located on the back of the oxygen concentrator. This filter removes dust particles and other impurities from the air - Filters: Do not operate the unit without the air intake gross particle filter in place. On a weekly basis, wash the air intake gross particle filter, located on the back of the unit. Your Equipment Provider may advise you to clean it more often depending on your operating conditions. - Follow these steps to properly clean the air intake gross particle filter: 1. Remove the filter and wash in a warm solution of soap and water. 2. Rinse the filter thoroughly and remove excess water with a soft absorbent towel. 3. Replace the filter. Review of the World Health Organization: Care, Cleaning and Disinfection of Oxygen Concentrators Checklist (2022) indicated: -Inspect and clean air intake filter (1-2 times per week) 1. Pull the filter gently out and replace with spare one. 2. Put the filter in cool, soapy water and swirl gently to remove debris. 3. Remove from soapy water and place it in [NAME] area until completely dry. 4. Store the spare filter until next cleaning is needed. Review of the National Library of Medicine (NLM), dated 1/19/22, indicated but was not limited to: -One of the main issues affecting the oxygen concentrators, is that related to the filters, which are designed to filter out dust, particles, and bacteria. https://pmc.ncbi.nlm.nih.gov/articles/PMC8768026/ Resident #36 was admitted to the facility in February 2022 with diagnoses including chronic obstructive pulmonary disease (progressive lung disease characterized by airflow obstruction, making it difficult to breathe). Review of Resident #36's Physician's Orders indicated but was not limited to: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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	- Oxygen at 0.5 liters (L) to 2 L by nasal cannula continuously to keep oxygen saturations greater than 90%, dated 4/6/25 - Oxygen at 2 L via nasal canula as needed for shortness of breath, dated 8/18/24 discontinued 4/6/25 - Wipe down the concentrator, change oxygen tubing, date it and clean filter weekly. Every night shift on Wednesdays, dated 4/6/25 The Surveyor made the following observations: - On 4/6/25 at 9:35 A.M., 12:12 P.M., and 4:21 P.M., Resident #36 in bed with his/her oxygen on at 1.5L via nasal canula (undated), the filter of the oxygen concentrator had a filter that was caked with dust and gray/white debris. - On 4/7/25 at 7:59 A.M., 10:51 A.M., and 2:53 P.M., Resident #36 in bed with his/her oxygen on at 1.5L via nasal canula (dated 4/6/25), the filter of the oxygen concentrator had a filter that was caked with dust and gray/white debris. During an interview on 4/8/25 at 7:18 A.M., Nurse #3 said weekly on the 11:00 P.M. to 7:00 A.M. shift the nurses would change the oxygen tubing, and clean the filter and wash the oxygen concentrator. Nurse #3 examined Resident #36's oxygen concentrator and said Resident #36's was dirty and covered with dust. Nurse #3 said Resident #36's filter needed to be cleaned. During an interview on 4/8/25 at 2:54 P.M., the ADON reviewed Resident #36's medical record and said Resident #36 did not have an order to clean his/her oxygen concentrator and filter prior to 4/6/25 and did not know the last time their oxygen filter had been cleaned. During an interview on 4/8/25 at 3:09 P.M., the Director of Nursing (DON) said her expectation was for oxygen equipment to be clean and follow infection control protocols.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0908 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep all essential equipment working safely. 48695 Based on observation and interview, the facility failed to maintain equipment in safe working order. Specifically, the facility failed to maintain: 1. One of two microwaves located in the resident kitchenettes on the third floor; 2. The food processor in the main kitchen used for resident food; and 3. The plate warmer in the main kitchen used to heat residents' plates. Findings include: Review of the facility's policy titled Marinating [sic] Functional Equipment, last revised 1/18/23, indicated but was not limited to: - It is the policy of this Facility that Kitchen Equipment will be maintained functionally as designed. - Kitchen equipment is maintain [sic] functional. - Anytime kitchen equipment is damaged or fails to operate properly, the FSD (Food Service Director) and Maintenance are to be notified. 1. On 4/6/25 at 9:12 A.M., the surveyor observed the microwave on the third-floor unit kitchenette and observed the microwave door open button not in operational order. The surveyor pushed the door open button the microwave five times and the door did not open. On 4/6/25 at 12:14 P.M., the surveyor observed the microwave on the third-floor unit kitchenette and observed the microwave door open button not in operational order. The surveyor pushed the door open button the microwave five times and the door did not open. During an interview on 4/4/25 at 12:26 P.M., the Food Service Director (FSD) and the surveyor observed the microwave on the third-floor unit kitchenette and observed the microwave door open button not in operational order. The FSD said the microwave had been broken for about a week. The FSD said she had notified the Director of Maintenance, but he was no longer at the Facility. The FSD said the microwave was used for residents to heat up their own food or have their food heated up for them. The FSD said the expectation was for all microwaves to be kept in working and operational order. 2. During an interview on 4/6/25 at 12:53 P.M., [NAME] #1 said the food processor in the main kitchen used to puree residents' food was broken and the canister would not register as being placed on the machine. [NAME] #1 demonstrated to the surveyor the following: - [NAME] #1 placed the food processor cover onto the processing cup locking it into place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225522	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Quincy	211 Franklin Street Quincy, MA 02169

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 0908 Level of Harm - Potential for minimal harm Residents Affected - Some	- [NAME] #1 placed the processing cup on to the base of the food processor and pressed start, the food processor did not start. - [NAME] #1 then attempted to move the food processor cup on the base and pressed start, the food processor did not start. - [NAME] #1 then took a magnet and place it on the food processor base and pressed start. The food processor started. - [NAME] #1 said the food processor had been broken for almost a year and it was reported the FSD and Maintenance. During an interview on 4/6/25 at 12:57 P.M., the FSD said the food processor had not been functioning correctly for more than six months but less than a year. The FSD said she had verbally reported it to the Maintenance Director and the Regional Food Service Director, but it had not been fixed. 3. On 4/7/25 at 11:40 A.M., the surveyor observed, during lunchtime service, a two-column plate warmer (a device used to heat plates before serving food), one column had a stack of plates in the column covered with a stainless-steel pot covering the plates in the plate warmer. During an interview on 4/7/25 at 11:58 A.M., the Regional FSD said the plate warmer was in operational order. The Regional FSD said staff rotate the plates prior to starting service then cover the plates with a stainless-steel pot to keep them warm. During an interview on 4/7/25 at 2:30 P.M., the FSD said one column of the plate warmer had not been working for a while. The FSD said the dietary staff had to rotate hot plates from one side to the other and cover it with stainless-steel pot. The FSD said the kitchen needed a new plate warmer and everyone was aware. The FSD said she was unaware of how long it had not been in working order.