STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225525	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Harwich	111 Headwaters Drive Harwich, MA 02645

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose Advanced Directives indicated he/she was a full code (attempt resuscitation), the facility failed to ensure nursing provided care and services that met professional standards of nursing practice, when after Nurse #1 found Resident #1 unresponsive, without respirations and without a pulse, the physician was not made aware of Resident #1's change in condition, a Code Blue was not announced, 911 was not activated, therefore other nursing staff in the facility and Emergency Medical Service were not alerted to and could not respond to provide necessary assistance to Nurse #1 with attempts at resuscitation, as a result, the care and treatment provided to Resident #1 by Nurse #1 had not meet acceptable standards of practice. Findings include:Review of the Facility's Policy titled, Code Blue, dated as revised 4/2022, indicated the following:-residents/victims found to be unresponsive or who becomes unresponsive under observation, staff will call a Code Blue and code Blue will be paged overhead two times, the page will include the unit, location, and room number.-the nurse who is the first responder to the situation will determine the code status, lead the code, and remain with the patient throughout the code.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. Review of the Report submitted by the facility, via the Health Care Facility Reporting Systems (HCFRS), dated [DATE], indicated on [DATE] around 5:00 A.M., Resident #1 was found unresponsive by staff, Nurse A (identified as Nurse #1) initiated CPR and CPR was discontinued prior to notifying Resident #1's Physician. The Report indicated that Nurse B (identified as Nurse #2) was contacted by Nurse A (Nurse #1) to complete an RN Pronouncement on Resident #1 and the pronouncement was completed at approximately 5:20 A.M by Nurse B (Nurse #2). The Report further indicated that Nurse A (Nurse #1) did not follow the Facility's policies related to Code Blue, Emergency Code activation, change of condition notification and AED utilization.Resident #1 was admitted to the Facility in [DATE], diagnoses included dementia, Alzheimer's, adult failure to thrive, osteomyelitis of right ankle and foot, hyperlipidemia (high cholesterol), anxiety, severe protein-calorie malnutrition, and pressure ulcers (right heel, left heel and sacral region.Review of Resident #1's Medical Orders for Life Sustaining Treatment (MOLST) Form, dated [DATE], indicated he/she was elected to be a Full Code, for nursing to attempt resuscitation (administer Cardiopulmonary Resuscitation).Review of Resident #1's Physician's Order, dated [DATE], indicated he/she was a Full Code. During an interview on [DATE] at 3:39 P.M., (which included review of her written (continued on next page)

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

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

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(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	statement), Certified Nurse Aide (CNA) #1 said she worked the 11:00 P.M. to 7:00 A.M. (night shift) on [DATE] into [DATE] on Resident #1's unit. CNA #1 said around 4:45 A.M. during rounds she checked on Resident #1, he/she was in bed lying on his/her back, his/her eyes were half open, and he/she did not look good. CNA #1 said she called Resident #1's name, he/she did not respond, and said she asked CNA #2 to come look at Resident #1. CNA #1 said that CNA #2 looked at Resident #1 and she (CNA #2) also said he/she did not look well, and said they needed to tell Nurse #1. CNA #1 said CNA #2 went to get Nurse #1 and that Nurse #1 came right away. CNA #1 said Nurse #1 did not instruct her to call a Code Blue or 911.During an interview on [DATE] at 1:25 P.M., (which included review of her written statement), Certified Nurse Aide (CNA) #2 said on [DATE] around 4:45 A.M. she was doing rounds and CNA #1 asked her to take a look at Resident #1. CNA #2 said she went and looked at Resident #1, he/she did not look well and said she told Nurse #1 that Resident #1 looked like he/she was dead. CNA #2 said Nurse #1 asked her to get the crash cart and bring it to Resident #1's room.Review of Resident #1's Progress Note, dated [DATE], (written by Nurse #1) indicated that around 5:00 A.M., he was notified by a CNA that there was a resident unresponsive (identified as Resident #1). The Note indicated Nurse #1 observed Resident #1 lying in bed, unresponsive to verbal and tactile stimuli, had no response to sternal rub, he/she was not breathing, had no pulse, was cold to the touch and stiff. The Note indicated Nurse #1 verified Resident #1's code status, (which was a full code) and proceeded to give CPR. The Note indicated that Nurse #1 sent a text message to the Physician, the Director of Nursing (DON, and Unit Manager.During an interview on [DATE] at 12:49 P.M., Nurse #1 said around 5:00 A.M. CNA #2 called for him to go to Resident #1's room. Nurse #1 said when he entered the room, Resident #1 was lying in bed on his/her back, he/she was unresponsive, not breathing, had no pulse and his/her body was cold to the touch and stiff. Nurse #1 said he checked Resident #1's code status, noted he/she was a full code, and he asked CNA #2 to bring the crash cart (mobile cart stocked with life-saving equipment and medication, designed for rapid deployment during medical emergencies) to Resident #1's room. Nurse #1 said he went back to Resident #1's room and started CPR on him/her. Nurse #1 said while he was doing CPR on Resident #1 another resident came into the room, tried to touch Resident #1's body so he stopped performing CPR to redirect the resident out of the room. Nurse #1 said he had not called a Code Blue, had not called 911 and had not directed one of the CNAs to do so prior to starting CPR on Resident #1. Nurse #1 said he knew what the Facility's policies were for calling a Code Blue and administering CPR. Nurse #1 said you are not supposed to stop CPR once you start and have to wait for Emergency Medical Services (EMS) or other staff to arrive.Nurse #1 said he sent a text message to the Director of Nursing (DON) informing her that Resident #1 had passed away. Nurse #1 said he called the DON because he realized that he had messed up by not calling a Code Blue and 911 before starting CPR on Resident #1.Further Review of Resident #1's Medical Record indicated that, although Nurse #1 asked Nurse #2 to do an RN Pronouncement there was no documentation to support that Nurse #1 spoke with the Physician to obtain an order for the RN Pronouncement.During an in-person interview on [DATE] at 4:13 P.M. and a telephone interview on [DATE] at 10:22 A.M., the Director of Nursing (DON) said when Nurse #1 found Resident #1 unresponsive and not breathing, Nurse #1 should have made sure a called Code Blue was called so that there would have been other staff member respond to assist him. The DON said Nurse #1 could not process what to do and had not followed the Facility's policies for calling a Code Blue and performing CPR. The DON said it is her expectation that all nurses follow the Facility's Policies and process.On [DATE], the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction with an effective date of [DATE], which addressed the area(s) of concern as evidenced by:A. On [DATE] Nurse #1 was suspended pending investigation.B. On [DATE], the Administrator conducted a Root Cause Analysis to determine why the staff member (Nurse #1) had not followed protocol to perform CPR or call a Code Blue, or 911 per the Facility's policies.C. On [DATE], the Nursing Administration conducted a Facility wide audit on all residents' Advanced Directives to verify that resident's code status (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation was present, current and readily accessible in the medical record.D. On [DATE], the Human Resource Director conducted an audit on all Licensed Nursing staff to determine their Basic Life Support (BLS)/CPR certifications were current.E. On [DATE], Nursing Administration conducted an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting to discuss the Facility's Improvement Plan.F. On [DATE], Nursing Administration provided education to all Licensed Nursing staff and Certified Nurse Aides on the Facility's Policies and Procedures for Emergency Code Activation, Code Blue Response, Change of Notification and AED (Automated Electronic Defibrillator) use.G. Nursing Administration staff conducted Mock Code Blue drills on all shifts for 72 hours ([DATE] through [DATE]) after the incident on [DATE], to reinforce appropriate emergency procedures.H. Nursing Administration staff will continue to conduct Mock Code Blue drills weekly for four weeks and then monthly for four months. I. The results of the Mock Code Blue drills will be presented and reviewed at the monthly QAPI meeting for a minimum of four months or until substantial compliance is achieved.J. The Director of Nursing and/or designee are responsible for overall compliance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was found unresponsive by nursing staff and whose Physician's orders indicated he/she was a full code (in the event of cardiac or respiratory arrest, attempts at resuscitation will be initiated), the Facility failed to ensure nursing staff provided appropriate and necessary basic life saving measures to him/her that were consistent with his/her Advanced Directives and Physician orders. Findings include:Review of the Facility's Policy titled, Code Blue, dated as revised 4/2022, indicated the following:-residents/victims found to be unresponsive or who becomes unresponsive under observation, staff will call a Code Blue and code Blue will be paged overhead two times, the page will include the unit, location, and room number.-the nurse who is the first responder to the situation will determine the code status, lead the code, and remain with the patient throughout the code.-for a Full Code patient/victim: upon arrival to the scene the nursing staff will assess victims who are unconscious, not breathing normally and showing no sign of circulation, such as normal breathing, coughing, and movement and if the victim is noted to have neither pulse nor respiration, the staff will initiate CPR.Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, titled Nursing Practice and Cardio-Pulmonary Resuscitation (CPR), revised [DATE], indicated that to guide the decision making of the nurse, in context of practice in all settings where healthcare is delivered require initiating cardio-pulmonary resuscitation when a patient has been found unresponsive and has not yet been declared dead by a provider authorized pursuant to M.G.L c. 469 except when a patient has a current valid Do Not Resuscitate (DNR) order/status.Review of the Report submitted by the facility, via the Health Care Facility Reporting Systems (HCFRS), dated [DATE], indicated on [DATE] around 5:00 A.M., Resident #1 was found unresponsive by staff, Nurse A (identified as Nurse #1) initiated CPR and CPR was discontinued prior to notifying Resident #1's Physician. The Report indicated that Nurse B (identified as Nurse #2) was contacted by Nurse A (Nurse #1) to complete an RN Pronouncement on Resident #1 and the pronouncement was completed at approximately 5:20 A.M by Nurse B (Nurse #2). The Report further indicated that Nurse A (Nurse #1) did not follow the Facility's policies related to Code Blue, Emergency Code activation, change of condition notification and AED utilization.Resident #1 was admitted to the Facility in [DATE], diagnoses included dementia, Alzheimer's, adult failure to thrive, osteomyelitis of right ankle and foot, hyperlipidemia (high cholesterol), anxiety, severe protein-calorie malnutrition, and pressure ulcers (right heel, left heel and sacral region.Review of Resident #1's Medical Orders for Life Sustaining Treatment (MOLST) Form, dated [DATE], indicated he/she was elected to be a Full Code, for nursing to attempt resuscitation (administer CPR).Review of Resident #1's Physician's Order, dated [DATE], indicated he/she was a Full Code. Review of Resident #1's Progress Note, dated [DATE], (written by Nurse #1) indicated that around 5:00 A.M., he was notified by a CNA that there was a resident unresponsive (identified as Resident #1). The Note indicated Nurse #1 observed Resident #1 lying in bed, unresponsive to verbal and tactile stimuli, had no response to sternal rub, he/she was not breathing, had no pulse and was cold to the touch and stiff. The Note indicated Nurse #1 verified Resident #1's code status, (which was a full code) and proceeded to give CPR. The Note indicated that during the incident another resident was in and out of Resident #1's room, became aggressive and Nurse #1 terminated CPR on Resident #1. The Note further indicated a Registered Nurse (later identified as Nurse #2) was notified of Resident #1's death.During an interview on [DATE] at 12:49 P.M., Nurse #1 said around 5:00 A.M. CNA #2 called for him to go to Resident #1's room. Nurse #1 said when he entered the room, Resident #1 was lying in bed on his/her back, he/she was unresponsive, not breathing, had no pulse and his/her body was cold to the touch and stiff. Nurse #1 said he checked Resident #1's code status, verified he/she was a full code, and he asked CNA #2 to bring the (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	crash cart (mobile cart stocked with life-saving equipment and medication, designed for rapid deployment during medical emergencies) to Resident #1's room. Nurse #1 said he went back to Resident #1's room and started CPR on him/her. Nurse #1 said while he was doing CPR on Resident #1 another resident came into the room. Nurse #1 said he stopped performing CPR on Resident #1 because he needed to redirect the resident out of the room. Nurse #1 said after he had redirected the other resident, he went to another unit and asked Nurse #2 to do an RN Pronouncement on Resident #1.Nurse #1 said he had not called a Code Blue, had not called 911, and had not told one of the CNAs to do so prior to starting CPR on Resident #1 by himself. Nurse #1 said he did not have another staff member helping him while he was performing CPR. Nurse #1 said he started and stopped performing CPR on Resident #1, that night. Nurse #1 was unable say how long he had attempted to perform CPR on Resident #1 before deciding to stop. Nurse #1 said he knew that he was not supposed to stop CPR once it's started and needed to wait for Emergency Medical Services (EMS) or other staff to arrive.During an interview on [DATE] at 3:39 P.M., (which included review of her written statement), Certified Nurse Aide (CNA) #1 said she worked the 11:00 P.M. to 7:00 A.M. (night shift) on [DATE] into [DATE] on Resident #1's unit. CNA #1 said around 4:45 A.M. during rounds she checked on Resident #1, he/she was in bed lying on his/her back, his/her eyes were half open, and he/she did not look good. CNA #1 said CNA #2 went to get Nurse #1 and that Nurse #1 came right away. CNA #1 said that Nurse #1 did not instruct her to call a Code Blue or 911.During an interview on [DATE] at 1:25 P.M., (which included review of her written statement), Certified Nurse Aide (CNA) #2 said on [DATE] around 4:45 A.M. CNA #1 asked her to take a look at Resident #1. CNA #2 said she went and looked at Resident #1, he/she did not look well and said she told Nurse #1 that Resident #1 looked like he/she was dead. CNA #2 said Nurse #1 only asked her to get the crash cart and bring it to Resident #1's room.During an interview on [DATE] at 3:04 P.M., (which included review of her written statement), Nurse #2 said on [DATE] sometime after 5:00 A.M. Nurse #1 informed her that Resident #1 was deceased and asked her (Nurse #2) to do an RN Pronouncement on him/her. Nurse #2 said she assessed Resident #1 and pronounced him/her deceased at 5:15 A.M. Nurse #2 said she thought Resident #1's code status was a Do Not Resuscitate (DNR) because she had not heard anyone call a Code Blue that morning. Nurse #2 said that Nurse #1 never told her that he had started and stopped CPR on Resident #1.During an in-person interview on [DATE] at 4:13 P.M. and a telephone interview on [DATE] at 10:22 A.M., the Director of Nursing (DON) said on [DATE] Nurse #1 notified her that Resident #1 had passed away and that Nurse #2 had done the RN Pronouncement. The DON said she asked Nurse #1 what Resident #1's code status was, and Nurse #1 told her he/she was a full code. The DON said she asked Nurse #1 if he had called a Code Blue, called 911 and if he started CPR. The DON said Nurse #1 told her that he had not called a Code Blue. The DON said Nurse #1 said he had started CPR on Resident #1 then stopped because another resident had become problematic for the CNAs and he had to help them.The DON said when Nurse #1 found Resident #1 unresponsive and not breathing, he should have called Code Blue to have other staff arrive to assist him and should have had a staff member call 911, so EMS could respond. The DON said Nurse #1 could not process what to do and had not followed the Facility's policies for performing CPR. On [DATE], the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction with an effective date of [DATE], which addressed the area(s) of concern as evidenced by:A. On [DATE] Nurse #1 was suspended pending investigation.B. On [DATE], the Administrator conducted a Root Cause Analysis to determine why the staff member (Nurse #1) had not followed protocol to perform CPR or call a Code Blue, or 911 per the Facility's policies.C. On [DATE], the Nursing Administration conducted a Facility wide audit on all residents' Advanced Directives to verify that resident's code status documentation was present, current and readily accessible in the medical record.D. On [DATE], the Human Resource Director conducted an audit on all Licensed Nursing staff to determine their Basic Life Support (BLS)/CPR certifications were current.E. On [DATE], Nursing Administration conducted an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting to discuss the (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's Improvement Plan.F. On [DATE], Nursing Administration provided education to all Licensed Nursing staff and Certified Nurse Aides on the Facility's Policies and Procedures for Emergency Code Activation, Code Blue Response, Change of Notification and AED (Automated Electronic Defibrillator) use.G. Nursing Administration staff conducted Mock Code Blue drills on all shifts for 72 hours ([DATE] through [DATE]) after the incident on [DATE], to reinforce appropriate emergency procedures.H. Nursing Administration staff will continue to conduct Mock Code Blue drills weekly for four weeks and then monthly for four months. I. The results of the Mock Code Blue drills will be presented and reviewed at the monthly QAPI meeting for a minimum of four months or until substantial compliance is achieved.J. The Director of Nursing and/or designee are responsible for overall compliance.