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	12/03/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to provide care and services consistent with professional standards of practice for one Resident (#11) who required hemodialysis (a life sustaining treatment that helps the body remove extra fluids and waste products from the blood when the kidneys are not able to), out of a total sample of 17 residents. Specifically, the facility failed:a. To ensure nursing staff did not obtain blood pressures from the Resident's right arm, where his/her AV fistula (arteriovenous fistula, where an artery and vein connect directly, allowing blood to flow) used for hemodialysis access was located; andb. To obtain and implement physician's orders for the care and maintenance of the Resident's hemodialysis catheter (a surgically placed catheter connected to a central vein that exits the skin and attaches to the tubing on the dialysis machine) upon his/her return from the hospital.Findings include:Review of the facility's policy titled Care of a Resident with End-Stage Renal Disease, revised 4/2022, indicated, but was not limited to, the following:-Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care.-Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents.-Education and training of staff include, specifically:g. The care of grafts and fistulas-Agreements between this facility and the contracted dialysis facility include all aspects of how the resident's care will be managed, including:a. How the care plan will be developed and implemented-The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care.Resident #11 was admitted to the facility in July 2025 with diagnoses including end stage renal disease.Review of Resident #11's Minimum Data Set (MDS) assessment, dated 10/9/25, indicated the Resident was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of the MDS assessment indicated the Resident received dialysis treatment.a. Review of Resident #11's Physician's Orders indicated, but was not limited to, the following:-Dialysis: [Dialysis-Center Name Redacted] Days: Mon-Wed-Fri Chair time: 12-4p every day shift every Mon, Wed, Fri for Dialysis (7/8/25)-Monitor and document thrill/bruit of RUE (right upper extremity) dialysis/fistula QS (every shift) (7/8/25)-Monitor Dialysis access site RUE dressing every shift (7/8/25)-No blood pressure/blood draws to be taken on right upper extremity every shift for dialysis/fistula (7/8/25)Review of Resident #11's Care Plans indicated, but was not limited to, the following:-Focus: The resident needs hemodialysis r/t (related to) ESRD (initiated 7/7/25)-Interventions: *Do not draw blood or take B/P (blood pressure) in arm with graft. (initiated 7/7/25)*Protect access site from injury. Site: RUE; Avoid constriction on affected arm, such as carrying purse and constrictive clothing. No BP on limb with fistula. (initiated 7/7/25)Review of Resident #11's Weights and Vitals Summary indicated the Resident's blood pressure was taken in his/her right arm on 21 occasions since the physician's order for no blood pressure in the arm with graft was initiated on 7/7/25. During an interview on 12/3/25 at 9:25 A.M., Nurse #4 said there was a physician's order in place for no blood pressure or lab draws in the Resident's right upper extremity because of the fistula and that only the left side should be used for these tasks.During an interview on 12/3/25 at 9:36 A.M., the Director of Nursing (DON) said if an order is in place for no blood pressure or lab draws on Resident #11's right upper extremity, staff should not be taking blood pressures on the Resident's right arm. b. Review of (continued on next page)

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

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #11's Progress Notes indicated, but was not limited to, the following:-11/25/25 at 7:48 P.M.: Patient sent out to [hospital] from dialysis center r/t clogged fistula. Dialysis not performed. Dialysis scheduled for tomorrow. Dialysis center will call for pick up time. Blood pressure recorded at [hospital] 133/78. Returned to facility at 7:50 P.M.-11/26/25 at 10:14 P.M.: Resident left the facility via Uber to dialysis at 1030. Dialysis unable to access fistula sent patient to [hospital] for further evaluation. This nurse contacted patient at 7 pm via his/her mobile phone. Resident stated that he/she was about to receive dialysis tx (treatment) and that a ride to return to the facility was arranged by the Hospital.-11/28/25 at 11:08 P.M.: Patient returned from dialysis. No new recommendations noted. Vital signs stable. Patient stable. Safety maintained. Review of Resident #11's hospital After Visit Summary, dated 11/26/25, indicated, but was not limited to, the following:-Reason for visit: Vascular Access Problem-Diagnoses: Thrombosis of arteriovenous fistula, hemodialysis patientIncluded with Resident #11's 11/26/25 After Visit Summary was a Bedside Handoff Post-Procedure document, noting the Resident had a 23-centimeter-long tunneled catheter. Also included was the Patient Implant Card, indicating a Bard Access System Hemostar Long-Term Hemodialysis Catheter had been placed.Review of Resident #11's medical record failed to indicate physician's orders were obtained for care and maintenance of the Resident's hemodialysis catheter until 12/2/25. During an interview with observation on 12/1/25 at 10:05 A.M., Resident #11 said he/she has a right upper arm AV fistula for dialysis. The Resident showed the surveyor a gauze dressing secured with a transparent dressing over top on his/her right upper arm and indicated that was where his/her AV fistula was located. The Resident said he/she also had a catheter in his/her right chest that was placed at the hospital the week before because his/her AV fistula was clotted. Resident #11 said the dialysis center is now using the chest catheter for his/her dialysis access. The Resident showed the surveyor a dual-lumen catheter on his/her right chest with a dressing in place. The Resident said staff at the facility had not done anything with the dressing on his/her right arm or right chest since he/she returned from the hospital 11/26/25.During an interview on 12/2/25 at 12:39 P.M., the DON said no new physician's orders were in place for care and maintenance of Resident #11's hemodialysis catheter because he/she returned from the hospital 11/26/25 with limited paperwork and the facility's Admissions Director was not present until 12/2/25 to pull additional documentation from the hospital's electronic system. During an interview on 12/3/25 at 9:25 A.M., Nurse #4 said Resident #11 had been having trouble with the dialysis access in his/her right arm and had been recently sent to the hospital because the dialysis center was unable to use the access for treatment. Nurse #4 said the Resident returned from the hospital the week prior with a chest catheter in place.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were provided care in accordance with professional standards of practice for two Residents (#95, #5), out of a total sample of 17 residents. Specifically, the facility failed:1. For Resident #95, to ensure administration of antipsychotic and psychotropic medications were properly documented in the Resident's medical record; and2. For Resident #5, to ensure physician's orders were in place for the provision of Hospice services. Review of [NAME], Manual of Nursing Practice 11ed, dated 2019, indicated the following: -The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers 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. -In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. Review of 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. 1. Resident #95 was admitted to the facility in March 2021 with diagnoses including dementia, delusional disorders, and depression. Review of Resident #95's Minimum Data Set (MDS) assessment, dated 9/11/25, indicated he/she was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15. Furthermore, the MDS assessment indicated he/she was administered antipsychotic and antidepressant medications on a routine basis. Review of Resident #95's Physician's Orders indicated but were not limited to the following: - 2/15/23: Duloxetine (antidepressant) HCl Oral Capsule Delayed Release Sprinkle 20 milligrams (MG); give one capsule by mouth two times a day; and - 4/29/25: Risperidone (antipsychotic) Oral Tablet 0.25 MG; give one tablet by mouth two times a day (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #95's psychotropic drug care plan, initiated 8/1/22, indicated but was not limited to the following interventions: - Administer medications per physician order. Review of Resident #95's Medication Administration Record (MAR) for September 2025 indicated but was not limited to the following: - Risperidone 0.25MG Oral Tablet: six missing administrations - Duloxetine 20MG Oral Tablet: six missing administrations Review of Resident #95's MAR for October 2025 indicated but was not limited to the following: - Risperidone 0.25MG Oral Tablet: nine missing administrations - Duloxetine 20MG Oral Tablet: nine missing administrations Review of Resident #95's MAR for November 2025 indicated but was not limited to the following: - Risperidone 0.25MG Oral Tablet: 12 missing administrations - Duloxetine 20MG Oral Tablet: 12 missing administrations Review of Resident #95's medical record failed to indicate documentation related to the blank/missing administrations on the MAR. Furthermore, the medical record failed to indicate documentation related to the refusal of medications. During an interview on 12/3/25 at 8:28 A.M., Nurse #3 said all medications are checked off on the MAR as they are being administered to the residents. Nurse #3 said if a resident refuses a medication or a nurse is unable to administer a medication it can be documented on the MAR as such. Nurse #3 said there should not be any blanks on the MAR and if medication is not administered it should always be documented in the record. During an interview on 12/3/25 at 8:40 A.M., the Director of Nursing (DON) said all medications should be signed off on the MAR in real time during a nurse's medication pass. The DON said if a medication is not administered it should be documented in the MAR and/or medical record as to the reasoning. The DON and the surveyor reviewed Resident #95's MAR. The DON said there should not be any blank spots on Resident #95's MAR. 2. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling #9324, titled Accepting, Verifying, Transcribing and Implementing Orders, dated as last revised 4/11/2018, indicated but was not limited to the following: - It is the responsibility of the licensed nurse to ensure there is a proper patient care order from a duly authorized prescriber prior to the administration of any prescription or non-prescription medication or activity that requires which order in accordance with accepted standard of practice and in compliance with the Boards regulations. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. - The nurse is accountable for ensuring that any orders he or she implements are reasonable based on the nurse's knowledge of that particular patient's care. -It is the responsibility and obligation of the nurse to question a patient care order that is deemed inappropriate by a nurse according to his/her educational preparation and clinical experience. Resident #5 was admitted to the facility in August 2025 and had diagnoses including Alzheimer's disease and dementia with behavioral disturbance. Review of the MDS assessment, dated 8/25/25, indicated Resident #5 had severe cognitive impairment as evidenced by a BIMS score of 1 out of 15, and required partial/moderate assistance from staff for activities of daily living. Review of the medical record indicated Certification of Terminal Illness, admission documents, a Plan of Care Summary and visit documentation from the facility's contracted Hospice provider with services commencing on 10/16/25. Review of comprehensive care plans included, but was not limited to: -Focus: Resident is receiving Hospice related end stage dementia (10/16/25) -Approach: Allow and encourage resident to eat at own leisure (10/16/25); Discontinue all unnecessary medications per physician's order (10/16/25); End of Life and is on comfort measures (10/16/25); Hospice/Palliative and facility team to review the plan of care to ensure integration (10/16/25); Monitor for signs and symptoms of discomfort (10/16/25) -Goal: Resident will remain comfortable through end of life with necessary support needed through next review (10/16/25; Target Date: 5/18/26) Further review of the medical record failed to indicate a physician's order was obtained for the provision of Hospice services. During an interview on 12/2/25 at 9:36 A.M., Unit Manager #1 reviewed Resident #5's medical record and said there was not a physician's order to screen and admit the Resident for Hospice services but there should be an order. During an interview on 12/3/25 at 1:45 P.M., the DON said residents receiving Hospice services must have a physician's order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure that medications were labeled and stored in accordance with accepted professional principles. Specifically, the facility failed:1. For Resident #121, to ensure the Resident's Insulin Lispro (a fast-acting insulin used to manage blood sugar levels) 100 units/milliliter (u/ml) Kwikpen was labeled with the date opened; and2. To ensure an open Lantus Solostar (a long-acting insulin used to manage blood sugar levels) insulin pen was labeled with a resident's name; and3. To ensure two bottles of Acidophilus (a probiotic over-the-counter medication) were stored in the refrigerator after opening as indicated by the manufacturer's label in two of three medication carts inspected.Findings include: 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.-The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals.-Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location.1. Resident #121 was admitted to the facility in November 2025 with diagnoses including diabetes. Review of Resident #121's Physician's Orders indicated, but was not limited to, the following:-Insulin Lispro 100 u/ml - Inject subcutaneously before meals as per sliding scaleReview of Resident #121's Medication Administration Record (MAR) indicated Resident #121 had received Lispro sliding scale insulin daily since admission.On 12/1/25 at 3:12 P.M., the surveyor observed an open Insulin Lispro 100 u/ml Kwikpen for Resident #121 in the Arborview Unit B-Side medication cart. The Insulin Lispro Kwikpen was not labeled with the date opened. Per manufacturer's instructions, the Insulin Lispro Kwikpen should not be used for more than 28 days after opening.During an interview on 12/1/25 at 3:24 P.M., Nurse #5 said insulin pens should be labeled with the date opened and/or use by date.During an interview on 12/2/25 at 11:07 A.M., the Director of Nursing (DON) said all insulin pens should be labeled with the date opened and the use-by date.2. On 12/1/25 at 3:12 P.M., the surveyor observed an open Lantus Solostar insulin pen in the Arborview Unit B-Side medication cart with no patient name label. Per manufacturer's instructions, Lantus Solostar is a disposable single-patient-use prefilled insulin pen and should not be shared.During an interview on 12/1/25 at 3:24 P.M., Nurse #5 said insulin pens should be labeled with a resident's name.During an interview on 12/2/25 at 11:07 A.M., the DON said all insulin pens should be labeled with a resident's name.3. On 12/1/25 at 3:12 P.M., the surveyor observed an open bottle of Acidophilus in the Arborview Unit B-Side medication cart.On 12/1/25 at 3:43 P.M., the surveyor observed an open bottle of Acidophilus in the Bayview Unit A-Side medication cart. Per manufacturer's instructions, Acidophilus should be stored in the refrigerator once opened. During an interview on 12/1/25 at 3:24 P.M., Nurse #5 said she did not know the bottle of Acidophilus in the Arborview Unit B-Side medication cart required refrigeration. Nurse #5 said in the past, the facility had used a type of Acidophilus that did not require refrigeration after opening.During an interview on 12/2/25 at 11:07 A.M., the DON said the facility had switched to ordering a non-refrigerated brand of Acidophilus and she was unaware that the staff member maintaining the facility's central supply had been ordering a brand requiring refrigeration. ˆ

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interviews, the facility failed to review and revise the care plan for one Resident (#5), out of a total sample of 17 residents. Specifically, the facility failed to ensure the care plan for disposition was revised to reflect the Resident Representative's decision for the Resident to remain in the facility for long term care. Findings include:Review of the facility's policy titled Comprehensive Care Plans, last revised 4/2022, indicated but was not limited to:-The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.-The comprehensive, person-centered care plan will include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire.-Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.Resident #5 was admitted to the facility in August 2025 and had diagnoses including Alzheimer's disease and dementia with behavioral disturbance.Review of the comprehensive Minimum Data Set (MDS) assessment, dated 8/25/25, indicated Resident #5 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 1 out of 15, wished to be discharged to the community and had an activated Health Care Proxy (health care agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions).Review of comprehensive care plans included, but was not limited to:-Focus: Disposition: Plans to discharge to community (8/8/25)-Approach: Allow Resident and health care representative to express goals and any barriers that are concerning my safety for a safe discharge (8/8/25); Make the appropriate referrals to the community for me (8/8/25); Appropriately assist me with discharge planning (8/8/25)Goal: Resident and health care representative will participate in discharge planning prior to discharge through next review (8/8/25; Target date: 5/18/26)Review of a Social Services Note, dated 9/9/25, indicated the facility Social Worker met with Resident #5's Health Care Proxy who indicated he was unable to care for the Resident at home and wanted Resident #5 to remain at the facility for long term care.Review of interdisciplinary care plan meeting documentation indicated a care plan meeting was held on 11/18/25 without a revision to the care plan to reflect the change in disposition status to long term care.During an interview with Social Worker #1 and Unit Manager #1 on 12/2/25 at 9:40 A.M., they said the disposition care plan should have been revised to reflect the change to long term care at the care plan meeting held on 11/18/25 if not sooner and was not.