STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225531	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sudbury Pines Extended Care	642 Boston Post Road Sudbury, MA 01776

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. Based on observation, and interview, the facility failed to adhere to professional standards of practice for food safety and sanitation to prevent contamination and the spread of foodborne illness to residents.Specifically, the facility failed to discard spoiled food and food that was past the use by date, failed to label and date prepared food and opened food packaging, and also failed to ensure dietary staff were wearing hair restraints in the main kitchen while preparing food.the facility failed to discard food that was past the use by date and failed to maintain the Station 2 nourishment kitchenette in a clean and sanitary manner. Findings include:Review of the facility policy titled Food Safety, revised 5/2025, indicated: -It is the policy of this facility to provide safe and sanitary storage, handling and consumption of all food including food and fluids brought to residents by family and other visitors. This includes storage, preparations, distribution, and serving food in accordance with professional standards for food service and safety. -The facility will follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling processes. -Education of safe food handling will be provided to all staff, family, residents, resident council, visitors and community groups who may provide foods or fluid restrictions to residents of the facility. This education will include at a minimum: proper food handling to prevent foodborne illness. Proper labeling and dating of each item. Leftover foods will be used within 3 days or discarded. Review of the facility policy titled Food Storage, revised 6/2018, indicated: -It is the policy of this facility that food storage areas be maintained in a clean, safe, and sanitary manner -Food storage areas shall be clean at all times -all food stored in dry good freezer or refrigerator will be dated month and year, unless opened this will be wrapped or put in a container with the Month/Day/Year label on it. 1. During the initial tour of the facility main kitchen on 4/16/26 at 7:23 A.M., the surveyor observed the following: >In the walk-in refrigerator: (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sealed bagged salad that expired 4/11/26, which was wilted and had brown lettuce and vegetables in the bag. -13 containers of strawberries in manufacturer's plastic containers. Eight containers had multiple strawberries with mold. -a bag of opened parmesan cheese in the manufacturer's bag, not sealed, no opened date, or expiration date on the bag. -a plastic bag of unopened broccoli with no expiration date. The broccoli stems were black and some of the broccoli florets had brown and yellow discolorations. -two glass containers with vegetables, no label or date. >In the reach in refrigerator: -Four dessert cups, no label or date. >In the food preparation area: -at the end of the steam tables, two trays of dessert cakes in metal sheet pans with plastic wrap on the trays, no label or date. On 4/21/26 at 11:47 A.M., during the follow-up visit to the facility main kitchen the surveyor observed: >In the walk-in refrigerator: -Three containers of strawberries in manufacturer's plastic containers, all three containers had moldy strawberries. -Five containers of blackberries in manufacturer's plastic containers. Two out of the five containers had moldy blackberries inside of the containers. >In the reach in refrigerator: -Three covered dessert cups, no label or date -Two Thick and Easy juices were opened, not dated -Two Thick and Easy dairy beverages that were opened, not dated >Two Dietary Aides with beards were preparing food for the lunch meal. Dietary Aide #1 had facial hair on the upper lip and chin which extended past the bottom of his chin and was not wearing a beard restraint. Dietary Aide #2 was wearing a surgical mask that was partially covering his facial hair, with exposed hair on the cheeks and neck. During an interview on 4/21/26 at 12:20 P.M., the Administrator said there should not be expired or (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	moldy food in the kitchen. The Administrator said Dietary Aides #1 and #2 should be wearing facial hair restraints and that the hair restraints were available to the staff. During an interview on 4/21/26 at 12:50 P.M., the Food Service Director (FSD) said the moldy and expired food in the refrigerators should have been thrown out and should not have been in the refrigerators. The FSD said all the food that was open should have been labeled and dated when opened. The FSD said Dietary Aides #1 and #2 should have had beard restraints on while they were in the kitchen. The FSD further said beard covers are available for the staff to wear. 2. On 4/16/26 at 11:35 A.M., during a tour of Station 2 nourishment kitchenette the surveyor observed: -one sandwich labeled PBJ (peanut butter and jelly) and dated 4/10, and two sandwiches labeled PBJ and dated 4/11. -the dry snack drawer had a significant amount of food debris. During an interview on 4/16/26 at 11:45 A.M., Unit Manager (UM) #1 said the PBJ sandwiches should have been thrown away after three days but had not been thrown away. UM #1 also said that the snack drawer should not have food debris. UM #1 said it was the responsibility of the kitchen staff to maintain the refrigerator and the snack drawer in the nourishment kitchenette, and they had not done so.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that two Residents (#5 and #49) out of a total sample of 18 residents, were treated in a dignified manner by Certified Nurse Aides (CNA #2 and #1) who were providing assistance with meals.Specifically, the facility failed to:for Resident #5, provide a dignified dining experience when CNA #2 remained standing over the Resident at his/her bedside while assisting the Resident with his/her breakfast meal.for Resident #49, provide a dignified dining experience to the Resident, when CNA #1 remained standing while providing assistance with the breakfast meal at the Resident's bedside. Findings include:Review of the facility policy titled Assistance with Meals: Dignified and safe dining experience, revised April 2025, indicated: -Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. Not standing over residents while assisting them with meals Review of the facility policy titled [Facility Name] Feeding Protocol, undated, indicated: -For residents requiring assistance: -Nursing staff or Feeding Assistants will place tray on over bed table, position themselves at eye level and feed resident at a pace to ensure safety and dignity 1) Resident #5 was admitted to the facility in November 2023 with diagnoses including Dementia and nausea and vomiting, unspecified. Review of Resident #5's clinical record indicated: a diagnosis of Pneumonitis due to inhalation of food and vomit was added in February 2026. the Resident's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated was rarely or never understood. the Resident's Care Plan indicated his/her eating ability was dependent on staff. the Resident's Care Plan summary (Kardex) indicated he/she was dependent on staff for eating for all meals. the Resident's CNA flow sheets for March 2026 and April 2026 indicated that the Resident received total support from staff with eating for all meals. On 4/21/26 at 8:31 A.M., the surveyor observed CNA #2 standing above the Resident's eye level at the bedside of Resident #5 while assisting the Resident with the breakfast meal. The surveyor observed that 2 chairs were available adjacent to the Resident's bed for seating use. During an interview on 4/21/26 at 8:33 A.M., CNA #2 said that she always stood while assisting the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents with their meals. CNA #2 further said that she preferred to stand while assisting with resident meals. During an interview on 4/21/26 at 8:38 A.M., with Unit Manager (UM) #1 and CNA #2, CNA #2 said that she was instructed to sit while assisting residents with their meals, but she was standing today while assisting Resident #5 with his/her breakfast meal. 2) Resident #49 was admitted to the facility in April 2019 with diagnoses including Schizophrenia and carcinoma of unspecified bronchus and lung. Review of Resident #49's clinical record indicated: diagnoses of Dementia and Dysphagia were added to the Resident's clinical record in August 2023. the Resident's MDS assessment dated [DATE], indicated he/she was severely cognitively impaired in both short and long-term memory as evidenced by staff being unable to complete the Brief Interview for Mental Status (BIMS) Assessment. the Resident's Care Plan indicated his/her eating ability was dependent on staff. the Resident's Care Plan summary (Kardex) indicated he/she was dependent on staff for eating all meals. the Resident's CNA flow sheets for March 2026 and April 2026 indicated that the Resident received total support from staff with eating for all meals. On 4/21/26 at 8:25 A.M., the surveyor observed CNA #1 standing at the bedside of Resident #49 while assisting the Resident with the breakfast meal. During an interview on 4/21/26 at 8:35 A.M., CNA #1 said that she had been taught to stand while providing eating assistance to residents. During an interview on 4/21/26 at 8:40 A.M., with UM #1 and CNA #1, CNA #1 said she should have been seated beside Resident #49 while assisting him/her with the breakfast meal, but she was not seated. During an interview on 4/21/26 at 8:45 A.M., UM #1 said that the CNA's should always be seated beside the residents when physically assisting with a meal. UM #1 said that all staff have been instructed to sit during meal assistance provided to the residents. During an interview on 4/21/26 at 1:20 P.M., the Director of Nursing (DON) said that all CNA's were expected to sit when providing physical assistance during dining. The DON said CNA #1 and CNA #2 should have been sitting next to Resident #5 and Resident #49 as they assisted them with breakfast.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure that one Resident (#3) of five applicable residents sampled for unnecessary medications, out of a total sample of 18 residents, was free from unnecessary psychotropic (any drug that affects behavior, mood, thoughts or perception) medications.Specifically, for Resident #3, the facility failed to ensure that laboratory monitoring was completed as ordered by the Physician for Clozaril (Clozapine: an antipsychotic medication used to treat severe Schizophrenia) medication use and levels, placing the Resident at risk of Clozaril toxicity and medical complications. Findings include:Review of the facility policy titled Antipsychotic Medication Use, revised September 2025, indicated:-Diagnoses of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident.-All antipsychotic medications will be monitored with necessary lab values and EKG (an electrocardiogram) monitoring as indicated by the Attending Physician (i.e. see Clozaril guidelines for ANC [absolute neutrophil count] monitoring). Review of the Clozapine Monitoring National Protocol Guidance, dated March 2025, provided by the facility indicated:*Purpose: to provide general guidance on absolute neutrophil count (ANC) monitoring during Clozapine initiation and maintenance treatment.-Appropriate monitoring of Clozapine is still recommended. *Indications: reducing suicidal behavior in patients with Schizophrenia or schizoaffective disorder.*Precautions: Hepatoxicity (liver failure), Eosinophilia (elevated number of eosinophils in the blood). Resident #3 was admitted to the facility in June 2022 with diagnoses including Alzheimer's Disease, delusional disorders, neurocognitive disorder, Dementia and Psychotic Disturbance.Review of the Minimum Data Set (MDS) Assessment, dated 1/24/26, indicated Resident #3:-has severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of a possible 15 points.-received an antipsychotic medication and the antipsychotic was administered on a scheduled basis. Review of Resident #3's April 2026 Physician's orders indicated:-Clozaril levels every 6 months, start date 11/26/24.Review of Resident #3's Clinical Record titled Results indicated:-Clozaril level was drawn and resulted on 6/7/25. -Clozaril level was drawn on December 2025 but there was no result.Further review of Resident #3 clinical record failed to indicate any further evidence that the Clozaril level was drawn or resulted in December 2025.During an interview on 4/21/26 at 2:30 P.M., Nurse #1 said there was no evidence that a Clozaril level was drawn for Resident #3 after June 2025.During an interview on 4/21/26 at 3:00 P.M., the Director of Nursing (DON) said she would review the clinical record and get back to the surveyor.During an interview on 4/22/26 at 7:49 A.M., the DON said there was no evidence that the Clozaril that was drawn in December 2025 ever resulted. The DON said the Clozaril level was important as Resident #3 was hospitalized in October 2024 for Altered Mental Status changes and the hospital identified the Resident's Clozaril level was extremely elevated. The DON said while the Resident was hospitalized , the Clozapine medication was decreased, and the hospital recommended that the Clozaril levels be monitored every six months to avoid toxic levels in the Resident's blood. The DON said there was no evidence that the Clozaril level was drawn or resulted since June 2025 and there had not been any follow up until the surveyor requested to review the December 2025 Clozaril lab results on 4/21/26.During a follow-up interview on 4/22/26 at 10:15 A.M., the DON said the facility could not identify why there was no Clozaril level lab results available for December 2025. The DON further said the facility staff should have followed up with the Clozaril level, but they did not.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post daily required nurse staffing information as required.Specifically, the facility failed to:-post the actual hours worked by licensed and unlicensed nursing staff (Registered Nurses [RN], Licensed Practical Nurses [LPN] or Licensed Vocational Nurses [LVN], and Certified Nurses' Aides [CNA]) directly responsible for providing resident care per shift.-maintain a copy of the facility staffing records for 18 months.-post the staffing information in an area easily assessable to residents, staff, visitors. Findings include:The surveyor observed for the duration of the facility survey, that the nurse staffing information was handwritten with an erasable marker on a wipe-off board posted in the corner of the entrance to the Unit One dining room. The surveyor also observed that the wipe-off board with the handwritten nurse staffing information was located above eye level. The surveyor further observed that the handwritten information on the wipe-off board did not include the following requirements:-posting of the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift.-the staffing information was posted in an area that was easily assessable to residents, staff, visitors. During an interview on 4/22/26 at 7:19 A.M., the Director of Nursing (DON) said she was unsure where the nursing staffing information posting was located.During an interview on 4/22/26 at 8:15 A.M., the Scheduler said he reviews the daily census and writes the: -number of RNs per shift.-number LPNs per shift.-CNAs per shift.The Scheduler further said he did not have a record of previous nursing staffing postings as he only writes the nursing staffing information on a wipe-off board daily with an erasable marker. The Scheduler further said he did not include total hours worked per each discipline and that he was not aware the nursing staffing posting was supposed to be easily accessible to residents, visitors, and staff. During an interview on 4/22/26 at 11:15 A.M., the Administrator said she was unaware that the actual number of staff and total number of hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift needed to be on the nursing staffing posting. The Administrator also said the facility has not maintained the posted daily staffing information for 18 months as required. The Administrator further said she was not aware the nursing staffing information posting was supposed to be easily accessible to staff, residents and visitors.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review the facility failed to adhere to professional standards of practice for medication administration and ensure that significant medication errors did not occur for one Resident (#54) of four applicable residents for medication administration, out of a total sample of 18 residents.Specifically, for Resident #54, the facility failed to ensure that a Myrbetriq Extended Release Medication (used to treat overactive bladder) was not crushed per the manufacturing and pharmacy instructions on the medication label prior to the Nurse administering the medication to the Resident, when crushing the Myrbetriq Extended Release Medication would increase the likelihood of destroying the extended-release mechanism, causing the entire dose to be released at once (dose dumping), placing the Resident at risk of serious medical side effects. Findings include:Review of Highlights of Prescribing Information, revised on 3/2021, retrieved fromhttps://www.accessdata.fda.gov/drugsatfda_docs/label/2021/213801s000lbl.pdf, indicated:-Adult patients: Swallow MYRBETRIQ whole with water. Do not chew, divide, or crush. -Swallow the tablet whole with water.-Do not chew, divide, or crush the tablet under any circumstances.-Consult the doctor or pharmacist for alternatives, such as Myrbetriq granules for oral suspension, which can be prepared by a pharmacist and taken as liquid. Why this matters: -Crushing the tablet can alter the pharmacokinetics, leading to unpredictable absorption and potentially compromising safety and efficacy. This is particularly important for patients with conditions like high blood pressure, as Myrbetriq can increase blood pressure, and sudden release of the full dose could exacerbate the effect of the Myrbetriq medication. Review of the facility policy titled Administering Medication, revised October 2025, indicated:-The individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medication. Resident #54 was admitted to the facility in January 2020 with diagnoses including overactive bladder, Hypertension, Anxiety and Depression. On 4/21/26 at 7:48 A.M., during a medication administration procedure, the surveyor observed Nurse #1 prepare and administer medications to Resident #54. The surveyor observed Nurse #1 pour Resident #54's Myrbetriq extended-release medication into a plastic pouch, then crushed the Myrbetriq medication and put the crushed medication in a container of apple sauce. Nurse #1 was observed administering the crushed Myrbetriq extended-release medication in apple sauce to Resident #54. Review of Resident #54's April 2026 Physician Orders indicated:-Myrbetriq Oral Tablet Extended Release 24 Hour 25 mg (Mirabegron), give one tablet by mouth one time a day related to Overactive Bladder, ordered 3/25/26. Review of the Myrbetriq Oral Tablet Extended Release 24 Hour 25 mg (Mirabegron) pharmacy label located on the plastic bag containing the Myrbetriq medication indicated Do Not Crush this medication. During an interview on 4/21/26 at 8:34 A.M., Nurse #1 said Resident #54 would only take his/her medications crushed in apple sauce. Nurse #1 said she has worked in the facility for 10 years and knew how the Resident took his/her medications. Nurse #1 said that she was unaware the Myrbetric medication was extended-release. Nurse #1 also said that she had not read the instructions on the Myrbetriq Extended-Release medication label that indicated Do Not Crush this medication. During a follow-up interview on 4/21/26 at 8:54 A.M., Nurse #1 said she should not have crushed the Myrbetriq extended-release medication, but she had crushed the medication. During an interview on 4/21/26 at 11:15 A.M., the Director of Nursing (DON) said her expectation was for Nurses to read all medication instructions located on the medication packaging before they administered medications. The DON said Nurse #1 should have followed the instructions on the medication label and should not have crushed the Myrbetriq extended-release medication. The DON further said it was a significant medication error because of the health risks related to crushing an extended-release Myrbetriq medication.