STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225532	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Village at Mattapan	405 River Street Mattapan, MA 02126

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interviews and records reviewed, the facility failed to implement an effective antibiotic stewardship program that included accurate and complete tracking and monitoring of antibiotic use. Specifically, the facility's antibiotic stewardship documentation was incomplete and did not accurately reflect residents with active antibiotic orders, and the facility was unable to demonstrate consistent monitoring, analysis, or reporting of antibiotic utilization in accordance with regulatory requirements.Findings include:Review of the facility policy titled Antibiotic Stewardship, dated as revised January 2024, indicated but was not limited to the following: -The commitment to oversee the use of antibiotics through a stewardship program is recognized as an integral to this facility's commitment to the highest quality of care and services. -The infection control preventionist will be considered the facility champion and antibiotic stewardship. -The monitoring of antibiotic use will be considered an integral and guiding the process changes tracking tools will include: *Monthly list of Antibiotics and prescribed each month as supplied by the provider pharmacy. *EMR (Electronic Medical Record) reports as available. *Manual chart review for resident symptomology. *Quarterly Antibiogram supplied by the laboratory vendor. *Participation in the antibiotic start reporting program Massachusetts facilities -Results from the data sources will be tracked over time to assess improvement in the need for continued changes and processes aimed at improvement.Review of the facility's Antibiotic Stewardship Program documentation, including monthly antibiotic line listings from February 2025 through January 2026, revealed the facility failed to implement an effective system for tracking and monitoring antibiotic use. The line listing documentation was incomplete and did not include start/stop dates, culture/diagnostic results and did not include an antibiotic time out to reassess the need for the antibiotics prescribed during the months of March 2025, April 2025, June 2025, July 2025, August 2025, September 2025, October 2025, and only one of two units were tracked. Further review indicated the month of May 2025 was missing and contained no documented infection control tracking or data. Review of physician order listing reports indicated multiple residents had active infections and were prescribed antibiotic therapy; however, these residents were not included on the facility's monthly line listings. Review of the electronic medical record indicated but not limited to, Resident #8 who was prescribed antibiotics for pneumonia which was not documented on the line listings and was receiving antibiotics without a documented clinical indication for use. The facility was unable to provide established criteria or guidelines for initiation of antibiotic treatment for pneumonia and failed to include tracking of antibiotic use, review of appropriateness, reassessment of continued need, and implementation of facility-specific prescribing criteria.During an interview on 2/18/26 at 1:25 P.M., the Infection Preventionist (IP) said she assumed the role in October 2025 and said she does not calculate or run monthly antibiotic utilization reports. The IP further said she was not aware of the antibiotic use within the facility and said she does not track antibiotic time-outs but will call the doctor if she feels it is necessary but not for all resident's receiving antibiotics. The IP said infections are discussed at the QAPI meeting with the Director of Nursing, but she does not report antibiotic usage criteria or infection control rates because she does not have that data. During an interview on 2/19/26 at 5:39 A.M., Nurse #5 said there are no line listing reports maintained at the nurse's station however she will document infections in a progress note and said she is not aware 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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	any antibiotic stewardship line listings or reports.During an interview on 2/19/26 at 7:18 A.M., Consultant #2 said the antibiotic stewardship program needs to be tracked and reviewed to monitor the use of prescribed antibiotics and said she expects monitoring and reporting to be in place. Consultant #2 said the facility should be tracking and reporting the use of antibiotics and documenting infection control rates accurately.During an interview on 2/19/24 at 9:08 A.M., the Director of Nursing (DON) said she assumed the role recently and said nursing staff should be aware of the antibiotic stewardship program and said the facility should be tracking and reviewing the use of antibiotics as required monthly. The DON said the facility should have lab results, antibiotic usage reports and tracking data to review trends and to monitor for improvement. During an interview on 2/19/26 at 10:42 A.M., the Medical Director said the use of antibiotics within the facility should be monitored and evaluated for effectiveness and said he would expect the facility to review and report accurate information regarding antibiotics that are prescribed and not needed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a clean, comfortable, and homelike environment for residents on two of two units. Specifically, the facility failed to ensure resident rooms and common areas were maintained in good repair and sanitary condition and failed to consistently identify and correct environmental concerns through routine environmental rounds. Findings include: Review of the facility policy titled, Cleaning and Disinfection of Environmental Surfaces, undated, indicated but was not limited to the following: Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard. 9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur. and when these surfaces are visibly soiled. 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. 11. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. 14. Horizontal surfaces will be wet dusted regularly (e.g., daily, three times per week) using clean cloths moistened with and EPA - registered hospital disinfectant (or detergent). During environmental observations on the 2nd floor nursing unit, conducted on 2/17/26 at approximately 7:58 A.M., the surveyor observed multiple resident rooms with visibly soiled walls containing dark smudges and stains. Resident rooms and common areas were observed to have visible dirt and residue buildup. Floors throughout the unit, including resident rooms and nourishment rooms, were observed to have visible debris, dirt accumulation, and staining. room [ROOM NUMBER]: There were chunks of flooring missing and cracked in the room. Tiles were discolored with dark gray, black and rust colored building up inside the missing pieces. The door frame was scuffed and chipped. The top of the wall along the ceiling had a large dark brown rust colored substance splattered across the wall and ceiling and the wall had dark black scuffs and scratch marks across the middle section. room [ROOM NUMBER]: The bathroom door had dark scuff marks on the bottom right side near the wall, and the bathroom floor had dark brown and black buildup along the tiles. The exterior door to the hallway had gouges in the wood, chipped paint, and chipped laminate flooring with dark discoloration. room [ROOM NUMBER]: The light above the bed near window was flickering off and on. The bathroom vanity mirror was rusty along the inside edges and had broken metal and plastic pieces inside. The underside of the bed was coated in a dark rust colored dried substance and the wheels of the bed had white, dark, gray and rust build up along the sides. The bathroom floor had dark discolored tiles and dark buildup along the edges, and the bathroom door was chipped and dirty along the bottom. The (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bathroom door frame had dark brown and black scuffs with buildup along the edges. room [ROOM NUMBER]: The wall above the door separating two rooms had six large holes with missing and exposed white plaster and exposed yellow electrical cords. There was a piece of wood nailed to the floor under the bed with dark brown and black build up along the edge and top. The closet was missing a door. The bathroom floor had chipped tiles and paneling along the edge, and the door frame was chipped and cracked. Behind the toilet was dark stained floor tiles with cracks and chipped flooring. There was broken and exposed plaster under the hand sanitizing station There was missing and cracked tiles with exposed plaster under the paper towel dispenser. room [ROOM NUMBER]: The bathroom had missing and cracked tiles throughout and the tiles around the toilet had exposed plaster and chipped pieces. The floor was stained and had dark brown and black build up along the edges and throughout the bathroom. room [ROOM NUMBER]: The wall behind the television had multiple open holes and parts of the wall were unpainted with white plaster that was unfinished. room [ROOM NUMBER]: There was missing, chipped, cracked baseboard paneling near the closet, and along the corner of the wall. Chunks of plaster were missing from the wall and the trim around the bedroom door waws chipped and scuffed. The wall behind the bed near the window was unpainted and did not match the rest of the room. The baseboard heat had wires exposed and was missing covers. There was one electrical outlet with a missing cover that had exposed wiring hanging out of the wall. room [ROOM NUMBER]: There was a large piece of wood nailed to the floor located under the bed that had dark brown and black buildup around it. The paper towel dispenser in the bathroom was missing and the baseboard along the wall was chipped and peeling. room [ROOM NUMBER]: The bathroom sink had rust and brown buildup along pipes with loose covers hanging off the wall. The doorway had dark scuff marks along the wall, with chipped and loose paneling peeling off the floor near the closet. room [ROOM NUMBER]: The bathroom floor tiles had dark scuff marks, chipped tiles and dark buildup along the floor and bathroom door. The paper towel holder on the wall had a large rectangle cut out of plaster above the top. During environmental rounds on 2/17/26 at 12:23 P.M., the surveyor observed the following on the 1st floor nursing unit: -The shower room outside room [ROOM NUMBER] had broken and cracked tiles. The floor of the entry way was visibly soiled and the rubber base molding pulling away from tile. The shower curtain was tinged yellow in color. room [ROOM NUMBER]: The baseboard heater was rusted, and the windowsill was visibly dirty with debris. Shared Bathroom between rooms [ROOM NUMBERS]: There were stains on ceiling. A visitor in the room reported that the toilet seat was not secured to the toilet and swiveled around. The visitor said he had alerted staff, but it had been that way for months. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER]: The ceiling was stained and the baseboard heater was visibly dirty and rusted. room [ROOM NUMBER]: There was a hole in the wall by the A side dresser. A resident said that he/she believed the hole was there from someone slamming the dresser into the wall. room [ROOM NUMBER]: There were patches of paint missing from the wall and the window curtains were hanging down from the window. room [ROOM NUMBER]: There were holes around doorframe leading to room [ROOM NUMBER]. room [ROOM NUMBER]: The windowsill was visibly dirty and soiled with dirt and debris. room [ROOM NUMBER]: There was a missing piece of flooring During an interview on 2/18/2026 at 11:09 A.M. the Director of Housekeeping said that he expects that resident rooms are cleaned daily and some rooms are selected for deep cleaning weekly. The Director of Housekeeping said that if residents refuse having their room cleaned, he expects staff to keep returning and trying until they can get in and clean the room. The Director of Housekeeping joined the surveyor and observed the dirty windowsill. The surveyor wiped her hand on the windowsill and showed the Housekeeping Director her palm was now visibly soiled and darkened with dirt. The Housekeeping Director said that the window as not clean, and it was not acceptable. During an observation on 2/19/26 at 6:12 A.M., the surveyor observed the following in the nourishment room on the 1st floor nursing unit: The floor was stained throughout the room and had dark brown and black build up along the edges and along the bottom of the cabinets. The floor in front of the refrigerator had numerous stains and dried spilled substances along the side and directly in front of the refrigerator and was sticky. The door frame had a brown dried liquid stain along the top. The door was cracked, chipped and had dark black and brown build up along the edges and across the bottom of the door. The inside cabinet had pink and brown stains on the bottom shelf. The microwave was placed on top of a broken piece of plaster that had brown-, yellow-, red- and rust-colored stains across the bottom. The microwave had cracked, chipped and peeling edges along the inside and dark brown build up located inside. During an observation on 2/19/26 at 5:58 A.M., the surveyor observed the following in the resident dining room located on the 1st floor: The wall had missing plaster and chunks of wall missing with scuffs and peeling baseboard along the edge. There were old food items, spills and trash located on top of three dining room tables. A dark liquid spill was observed on the floor and along one of the chairs. There were old pieces of food and numerous dried dark, and brown build up on the floor. There were crumbs along the edge of the room along with dead bugs and dust. During an interview on 2/19/26 at 7:49 A.M., the Director of Maintenance said he just started working at the facility a week ago and said there is a work service binder on each unit that is checked daily if staff find issues that need to be fixed withing the facility Review of the facility's environmental rounds documentation provided during the survey failed to indicate these observed environmental concerns were identified, addressed, or corrected. There was no documented evidence the facility had identified or implemented corrective actions to address the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	visibly soiled surfaces, damaged furniture, or flooring concerns observed during the survey. During environmental rounds on 2/19/26 at 9:09 A.M., accompanied by the Director of Maintenance and Consultant #1, the surveyor observed: room [ROOM NUMBER]: The bathroom floor tiles were discolored brown and dirty. The tiles surrounding toilet were cracked in several areas. The exterior sliding glass window had mold growing between panes which covered entire surface. room [ROOM NUMBER]: Approximately 12 floor tiles were cracked and crushed. There was a brown ceiling stain measuring approximately 2' x 2' near foot of Bed C. Approximately 12 areas of unpainted plaster repairs were on the walls. room [ROOM NUMBER]: The bathroom floor tiles were discolored brown, dirty and broken in several areas. There were floor tiles were missing behind the toilet. room [ROOM NUMBER]: The wall plate for television cable was cracked and exposed the electrical box. room [ROOM NUMBER]: In front of bathroom door were broken, dirty floor tiles. The bathroom floor was discolored brown and dirty. The bathroom cabinet interior was cracked and electrical box was exposed. The radiator cover was bent extensively and hanging from the radiator. room [ROOM NUMBER]: The bathroom sink was chipped and the drain was rusty. The floor tiles dirty. The radiator next to Bed B was missing approximately 4' of covers. The windowsill was covered in dirt and food stains. Under Bed B floor tile was crushed and measured approximately 4 x 4. Behind Bed B the electrical outlet was partially hanging from wall. room [ROOM NUMBER]: The ceiling by bathroom entrance had a bubbling, crumbing brown stain measuring approximately 2' x 2'. room [ROOM NUMBER]: The radiator covers by Bed B were covered in dirt and food stains and the cover was bent in several places. The bathroom floor tiles were discolored brown and dirty. During an interview with the Maintenance Director on 2/19/26 at 9:20 A.M., he said he had been working at the facility for only a couple of days and was not familiar with the condition of the bedrooms. The Maintenance Director said he did not know if the facility kept a log of needed repairs or repairs in progress but would look for one and provide it to the surveyor if found. As of the conclusion of the survey the Maintenance Director had not provided a repair log to the surveyor. During an observation on 2/19/26 at 5:40 A.M., the surveyor observed the following in the nourishment room on the 2nd floor nursing unit: The floor was stained with dark brown and black build up along the floor and edges of the door frame. The door frame was cracked and chipped with brown dried liquid stains along the sides. There were two soiled pest traps in the corners of the nourishment room, one in each corner with dead bugs inside. There were pieces of trash inside and surrounding both pest traps. During an interview on 2/19/26 at 8:17 A.M., the Director of Housekeeping said he creates a room (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleaning schedule seven days per week and said housekeeping staff are responsible for cleaning the resident care areas. The Director of Housekeeping said that staff should be cleaning the dining areas, resident rooms and nourishment rooms daily. The Director of Housekeeping said he checks the nursing units and resident rooms daily and if they are not clean, he will clean them himself. The Director of Housekeeping said the housekeeping staff sweep and mop the floors seven days a week. The Director of Housekeeping said the cleaners checked off that the nourishment rooms were cleaned on their check-off list and he did not check any of the nourishment rooms yesterday. The Director of Housekeeping said he would expect the cleaners to go into the nourishment rooms and sweep, mop the floors and wipe down surfaces. During an interview on 2/19/26 at 9:01 A.M., Consultant #1 said it is her expectation that staff report environmental issues daily and that resident rooms and care areas are cleaned thoroughly and appropriately.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation and interviews, the facility failed to ensure concerns reported during the Resident Council related to call light responses were thoroughly documented and acted upon timely.Findings include:Review of the facility policy tilted Grievances/Concerns, revised 12/6/21, indicated the following: -Purpose: To provide residents/resident representatives a means of voicing their grievances/concerns freely without fear of retaliation and for facility administration to follow an established process for investigating grievances and complaints in an efficient, comprehensive, and timely manner. -Policy: Residents or their representatives may file a grievance or complaint concerning treatment, medical care, behaviors of other residents, staff members, theft of property, lost clothing, etc. Employees of the facility will assist residents and or their representatives in the grievance/complaint process when such requests are made. -Grievances/concerns may be submitted orally or in writing. The person/staff receiving an oral grievance/concern will fill out the Grievance/concern form for submission to leadership. -Grievances/Concerns will be recorded on the Grievance Log. The Social Services Department/designee will be responsible for recording and maintaining this log. Grievance/concern forms will be kept for a minimum of three (3) years. -Resident Grievances/Concerns and the Grievance Log will be reviewed for trends by the Quality Assurance and Assessment Committee at least quarterly. During an interview and observation on 2/17/26 at 8:27 A.M., Resident #75 said that staff have attitudes and that it is hard to get staff to take care of him/her. Resident #75 also said that his/her call bell did not work. The surveyor pushed Resident #75's call bell to check if it was functioning and heard the call bell sound outside of the Residents room and observed a light, light up at the top of the Residents door. The sound of the call bell immediately stopped sounding, and staff had not entered the Residents room to turn off the call light or check on the Resident. The surveyor had a second observation of the call bell sounding outside of the Residents room once the bell was pressed again and immediately sounding off, with no staff entering the Residents room to check on the Resident and turn off the call light. Review of the Resident Council meeting notes dated November 2025, December 2025 and January 2026 did not indicate concerns related to call lights. Review of the Grievance binder failed to indicate recent concerns/issues regarding call lights or long waiting times. On 2/18/26 at 1:30 P.M., the surveyor held a group meeting with ten residents in attendance. The residents shared the following information:-Nine of ten residents said they do not believe their concerns are thoroughly addressed when issues are brought forward and they are not provided a rationale for the response.-Nine of ten residents said they do not feel comfortable to complain about care without worrying that someone will get back at them. - Nine of ten residents said they do not get the help and care they need without waiting a long time and they are waiting 45 minutes to hours for staff to respond to their call lights. -Nine of ten residents said they are afraid to call for help because when staff finally respond to their call bells, they are rude and start yelling at them questioning why the call bell was pushed.-Nine of ten residents said they have complained about long call light wait times at resident council and feel like nothing is being done to address the issue. -Four out of ten residents said they stopped using their call light in fear of the response from the staff. During an interview and observation on 2/19/26 at 8:07 A.M., Nurse #3 said that staff can mute the sound of the call bell from the nurse's desk but that the actual call light must be cancelled from the resident's room. Nurse #3 went into a Residents room and pushed the call bell to demonstrate the call light system. The light lit up on top of the resident's door and the call bell sounded as the light was lit up. Nurse #3 came back to the nurse's desk and clicked a button on the call light system screen and the sound to the call bell had immediately muted but the light outside the Residents room remained lit up. The Maintenance Director was present during this observation. During an interview on 2/19/26 at 9:26 A.M., the Activities Director said that call bells have been a complaint a long time ago and that residents continue to complain of long call light waiting times at resident council. The Activities Director said that there (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was an in-service that was conducted by the Administrator with the staff regarding the call lights and that the issue was resolved. She furthermore said that the continued complaints about the long call light waiting times did not arise to a grievance being documented from her perspective because the in-service is an ongoing process and the issue was resolved by the Administrator. She also said that the concerns would be brought to morning meeting. During an interview on 2/19/26 at 9:45 A.M., the Administrator said that he would expect to be told about ongoing complaints coming from resident group and that he was not made aware of concerns with long call light waiting times. The Administrator said call lights have not been something that was brought up in the morning meeting and that the complaints should be in the resident council minutes.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to alert the physician and the behavioral health provider of an increase in sexually inappropriate behaviors for one Resident (#8) out of a total of 18 sampled Residents. Findings include: Review of the facility's Change in Resident's Condition or Status and Notification policy, dated 1/1/20 indicated: The RN (Registered Nurse) Supervisor/Charge Nurse will notify the resident's Attending Physician, Physician extender or on-call physician when there has been a significant change in the residents medical/mental conditions and/or status but not limited to: d.) a change/deterioration in the residents physical/emotional/mental condition.Resident #8 was admitted to the facility in July 2024 with diagnoses including schizophrenia, toxic encephalopathy and epilepsy. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #8 is severely cognitively impaired evidenced by a score of 6 out of a possible 15 on the Brief Interview for Mental Status Exam. On 2/17/26 at approximately 10:00 A.M., the surveyor observed Resident #8 agitated and swearing in the hallways of the unit. Review of the nurse progress notes indicated: 1/20/26: Cursing/screaming/yelling at people sometimes with 1:1 redirection and fair effect. 1/21/26: Cursing/screaming/yelling at people at times with little effect when redirected. 1/23/26: Sometimes cursing/screaming/yelling and touching people inappropriately with effect when redirected. 1/26/26: Cursing/screaming/yelling/coming out of his/her room with no pants on or topless/touching people inappropriately with little effect when redirected. 1/29/26: Cursing/screaming/yelling at people at times with little effect when redirected. 2/2/26: Cursing/screaming/yelling at people at times with little effect when redirected. 2/3/26: At times cursing/screaming/yelling/coming out of his room with no pants on or topless/ touching people inappropriately with little effect when redirected. 2/4/26: Still cursing/screaming/yelling/coming out of his room with no pants on or topless/touching people inappropriately with little effect when redirected. 2/6/26: Sometimes cursing/screaming/yelling/coming out of his/her room with no pants on or topless/ touching people inappropriately with little effect when redirected. 2/8/26: Resident being sexually inappropriate and attempting to go over this writer's feet with w/c (wheelchair). Resident was redirected and attempted again. 2/9/26: At times cursing/screaming/yelling/coming out of his/her room with no pants on or topless/ touching people inappropriately with little effect when redirected. 2/12/26: Sometimes cursing/screaming/yelling/coming out of his/her room with no pants on or topless/ touching people inappropriately with little effect when redirected. 2/17/26: At times cursing/screaming/yelling/coming out of his/her room with no pants on or topless/ touching people inappropriately with little effect when redirected.The clinical record failed to indicate the physician or behavioral health services were notified of Resident #8's behaviors of touching staff inappropriately.Review of the physicians notes and behavioral health notes failed to include information related to Resident #8's sexual behaviors. During an interview on 2/17/26 12:52 P.M., Nurse #1 said that Resident #8 has behaviors including grabbing female staff's privates/breasts and buttocks. Nurse #1 said that Resident #8 had behaviors of being inappropriate but recently the behaviors have gotten worse. Nurse #1 said that Resident #8 does not attempt to touch other residents, just staff.Review of Resident #8's care plans indicated: Focus: I can and have been socially inappropriate and disruptive to others r/t (related to) intrusive at nurses station, socially inappropriate, initiated 7/29/24.Goal: I will demonstrate only socially appropriate behaviors. I will not disrupt fellow residents or staff by my behaviors through the next review date. 7/29/24. The Resident demonstrates sexually inappropriate behavior toward staff; revised 2/11/26Interventions: Please allow distance when seating me around others to avoid adverse behaviors. Please always approach me in a calm welcoming manner, please assess if my behavior endangers myself or others and intervene as needed. Please avoid an overstimulated area. Loud noises, crowds and other verbally (continued on next page)

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Care Village at Mattapan	405 River Street Mattapan, MA 02126

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aggressive residents may trigger behaviors. Remove me to a quiet place with a calming activity. Please document my behaviors on the behavior monitoring sheet. Please establish limits for inappropriate behaviors. Please explain the consequences of my behavior in a way I will understand. Please monitor me when I am up and keep me where you can observe me for inappropriate behaviors. Re-direct me as needed. Please provide 1:1 sessions with the social worker as needed. Please provide me with psych services as needed. (7/29/24)Although the care plan was updated on 2/11/26 to include Resident #8 had sexually inappropriate behaviors, the care plan failed to indicate specific behaviors Resident #8 was demonstrating and failed to update new interventions to address his/her behaviors. Review of the physician orders included monitoring Resident #8's behaviors of intrusiveness, refusal of care, yelling and swearing, but did not include monitoring for sexually inappropriate behaviors. During an interview on 2/18/26 at 7:42 A.M., Nurse #2 said she is an agency nurse but is aware that Resident #8 has behaviors of grabbing at female staff during care. Nurse #2 said she did not think that Resident #8 attempts to touch other residents. On 2/18/26 at 8:39 A.M., the surveyor was standing in the hallway of the 1st floor unit and observed Resident #8 being wheeled down the hallway by a Certified Nursing Assistant (CNA). Resident #8 reached his/her hand and attempted to touch the surveyor's breast. The surveyor put her hand out to deter the Resident from touching her chest. On 2/18/26 at 8:48 A.M., the surveyor observed Nurse #1 assist Resident #8 with his/her breakfast meal. Resident #8 attempted to touch Nurse #1's genitals and Nurse #1 had to move his/her hand. Resident #8 continuously called Nurse #1 his/her girlfriend and also attempted to kiss Nurse #1. Nurse #1 continuously verbally redirected Resident #8 but his/her behaviors continued. On 2/18/26 at 8:54 A.M., Resident #8 was observed self-propelling in his/her wheelchair out of the dining area. Resident #8 reached his/her hand toward Nurse #2's breasts and Nurse #2 stepped out of the way. Resident #8 said Hey, you're cute you wanna go on a date? During an interview on 2/18/26 at 8:56 A.M., CNA #1 said that Resident #8 grabs female staff during care and she's heard staff yell for help while in his/her room because he/she is trying to touch them. CNA #1 said she did not think Resident #8 attempts to touch residents. During an interview on 2/18/2026 at 9:05 A.M., Nurse #1 confirmed the surveyor's observations and said that Resident #8 tried to touch her genitals and tried to kiss her during the breakfast meal. During an interview on 2/18/26 at 7:59 A.M., the Director of Nursing (DON) said that the facility emails behavioral health services with updates regarding resident needs or increased behaviors.Review of the emails between facility and behavioral health services provided to surveyor dated 1/11/26, 1/12/26, 1/14/26 and 2/14/26 failed to include information related to Resident #8's increased behaviors. During an interview on 2/18/26 at 12:02 P.M., the Psychiatric Nurse Practitioner said that she is alerted via email by the facility for any changes in resident behaviors or requests to see residents. The Psychiatric NP said that although she was aware of Resident #8's history of being vocally sexually inappropriate she was not aware of any behaviors of him/her touching female staff. The Psychiatric NP said she would expect to be notified of these kinds of behaviors to review with staff and discuss possible interventions. During an interview on 2/18/26 at 12:56 P.M., the DON said that the provider and behavioral health services should be alerted when a resident is experiencing increasing behaviors. The DON said the social worker is responsible for emailing behavioral health services with updates with resident status and requests for residents to be seen. The DON said she had been told that Resident #8 had been sexually inappropriate and touching staff and would expect staff to monitor those behaviors and to implement interventions to address the behaviors. The DON said she was not aware that the Psychiatric NP was not notified of an increase in Resident #8's behaviors or there was no behavior monitoring for Resident #8's sexually inappropriate behaviors. During an interview on 2/19/26 at 7:49 A.M., the Social Worker said that Resident #8 has varying behaviors and can be sexually inappropriate. The Social Worker said she was told a long time ago that Resident #8 had grabbed a staff person inappropriately but was not aware that the behaviors were re-occurring or escalating. The Social Worker said it is not solely her responsibility to email updates to behavioral health services, but she will do so as things are reported in meetings. The (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Worker said she did email recently for Resident #8 to be seen by behavioral health services but did not include the information related to his/her increased sexual behaviors because she was not aware.During an interview on 2/19/26 at 10:37 A.M., Physician #1 said that when residents are experiencing an increase in behaviors, staff are expected to notify him and behavioral health services. Physician #1 said he was familiar with Resident #8 and was not aware that he/she was having sexual behaviors or touching female staff inappropriately.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview the facility failed to report an allegation of verbal abuse to the State Agency for one Resident (#24) out of 18 sampled residents. Specifically, an allegation of verbal abuse was submitted to the facility on 2/11/26 but not reported to the State Agency until 2/18/26.Findings include:Review of the facility's Abuse Prohibition policy last revised on 2/20/23, indicated:Report the incident immediately to the Director of Nursing and/or Administrator.The Administrator is responsible for ensuring that there has been notification [of] local law enforcement and the State Survey Agency within 2 hours of allegation after identification of alleged/suspected incident.Review of the facility's Grievance Log indicated that on 2/11/26 Family Member #1 reported that a staff member cursed at Resident #24 after he/she asked for help to clean the floor. The Grievance Log Action Taken entry indicated Supervisor cleaned wet floor and educated staff on what needs to happen when resident needs support. The Action Taken entry did not reference a response to the staff cursing at the Resident.Review of the Grievance/Concern Report Form dated 2/11/26 and signed by the Director of Social Services indicated Family Member #1 was talking on speaker phone with Resident #24 that day. The report indicated Family Member #1 said she overheard the Resident ask a housekeeper to clean an area in his/her bedroom. Family Member #1 said she heard the housekeeper then curse.During an interview 2/17/26 at 2:19 P.M., Family Member #1 said that on 2/11/26 during the afternoon she was on speaker phone with Resident #24. Family Member #1 said that a staff member was present during the call. Family Member #1 said he/she heard Resident #24 ask the staff person to clean his/her area, Family Member #1 said she then heard the staff person repeatedly say, Fuck this. Family Member #1 said she told the Director of Social Services that day about the incident. Review of the Health Care Facility Reporting System (HCFRS; an internet gateway to report allegations of abuse and other reportable incidents to the State Agency) on 2/20/26 at 12:03 P.M. indicated the facility did not report the allegation until 2/18/26. The HCFRS report indicated that on 2/11/26 a staff member allegedly verbally abused Resident #24. The facility did not submit the allegation of verbal abuse to the State Agency within the required two-hour time frame.During an interview on 2/18/26 at 8:56 A.M., Consultant #2 said she and the Administrator first learned this morning about the incident involving Resident #24 and a staff member. Consultant #2 said department heads are responsible for immediately informing the Director of Nursing or the Administrator of allegations of abuse. Consultant #2 said the facility is required to report allegations of abuse within two hours to the State Agency.During an interview on 2/19/26 at 7:49 A.M., the Director of Social Services said Family Member #1 called her on 2/11/26 to report that she had been speaking with Resident #24 that day. Family Member #1 told her that she overheard a housekeeper saying fuck you to the Resident.The Director of Social Services said she entered Family Member #1's complaint into the Grievance Log and on the Grievance /Concern Report form. The Director of Social Services said she told the Director of Housekeeping about the incident. The Director of Social Services told the surveyor she did not know the identity of the housekeeper. The Director of Social Services said the Director of Housekeeping was responsible for investigating the incident and addressing action steps, including informing the Administrator about the incident. The Director of Social Services said she did not know why the Director of Housekeeping did not reference the housekeeper's cursing on the Grievance Log or on the Grievance/Concern Report Form.The Director of Social Services said she then visited Resident #24 to ask how he/she felt about the incident. The Director of Social Services said she was accompanied by another staff person who could translate to English because the Resident spoke primarily Spanish. Through the translator Resident #24 said he/she felt fine and that a housekeeper did not curse at him/her. The Director of Social Serviced said that because Resident #24 denied anyone cursed at him the incident did not need to be reported to the Administrator or Director of Nursing. The Director of Social Services said the Administrator are responsible for monitoring (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	submitted grievances.During an interview on 2/19/26 at 8:04 A.M., the Director of Housekeeping said that on 2/11/26 sometime after 2:30 P.M., the Director of Social Services told him there was a complaint that no one cleaned up puddles in Resident #24's room. The Director of Housekeeping said the Director of Social Services told him she had looked for a housekeeper to mop but she could not find one in the building. The Director of Housekeeping said all the housekeepers had left for the day, so he cleaned the puddles himself. The Director of Housekeeping said no one told him there was an incident or that a housekeeper cursed at the Resident. The Director of Housekeeping said, according to the schedule, Housekeeper #1 was assigned to clean Resident #24's room on 2/11/26 at the time of the incident.The Director of Housekeeping said that if someone told him there was an allegation of abuse, he would have immediately informed either the Administrator or Director of Nursing.During an interview with the Administrator, Consultant #1 and Consultant #2 on 2/19/26 at 9:30 A.M., they said they had been unaware of Family Member #1's allegation until today. They said the allegation did not need to be reported to the State Agency because Resident #24 denied the incident occurred.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview the facility failed to investigate an allegation of verbal abuse for one Resident (#24), out of 18 sampled residents. Specifically, a Family Member reported an allegation of verbal abuse to the facility on 2/11/26, but an investigation did not begin until 2/18/26; approximately seven days later. Findings include:Review of the facility's Abuse Prohibition policy last revised on 2/20/23, indicated:The shift Supervisor/Charge Nurse is identified as responsible for immediate initiation of the reporting process. The Administrator and Director of Nursing are responsible for investigation and reporting.The investigation will begin immediately after reporting the actual or suspected incident.Review of the facility's Grievance Log indicated that on 2/11/26 Family Member #1 reported that a staff member cursed at Resident #24 after he/she asked for help to clean the floor. The Grievance Log Action Taken entry indicated Supervisor cleaned wet floor and educated staff on what needs to happen when resident needs support. The Action Taken entry did not reference a response to the staff cursing at the Resident.Review of the Grievance/Concern Report Form dated 2/11/26 and signed by the Director of Social Services indicated Family Member #1 was talking on speaker phone with Resident #24 that day. The report indicated Family Member #1 said she overheard the Resident ask a housekeeper to clean an area in his/her bedroom. Family Member #1 said she heard the housekeeper then curse.During an interview on 2/17/26 at 2:19 P.M., Family Member #1 said that on 2/11/26 during the afternoon she was on speaker phone with Resident #24. Family Member #1 said that a staff member was present during the call. Family Member #1 said he/she heard Resident #24 ask the staff person to clean his/her area, Family Member #1 said she then heard the staff person repeatedly say, Fuck this. Family Member #1 said she told the Director of Social Services that day about the incident. During an interview on 2/19/26 at 7:49 A.M., the Director of Social Services said Family Member #1 called her on 2/11/26 to report that she had been speaking with Resident #24 that day. Family Member #1 told her that she overheard a housekeeper saying fuck you to the Resident.The Director of Social Services said she entered Family Member #1's complaint into the Grievance Log and on the Grievance /Concern Report form. The Director of Social Services said she told the Director of Housekeeping about the incident. The Director of Social Services said the Director of Housekeeping was responsible for investigating the incident and addressing action steps, including informing the Administrator about the incident. The Director of Social Services said the Administrator are responsible for monitoring submitted grievances.During an interview on 2/19/26 at 8:04 A.M., the Director of Housekeeping said that on 2/11/26 sometime after 2:30 P.M., the Director of Social Services told him there was a complaint that no one cleaned up puddles in Resident #24's room. The Director of Housekeeping said no one told him there was an incident or that a housekeeper cursed at the Resident. The Director of Housekeeping said he did not investigate the incident.During an interview with the Administrator, Consultant #1 and Consultant #2 on 2/19/26 at 9:30 A.M., they said they were made aware of Family Member #1's allegation today and would begin an investigation.

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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 secure medications for one of two medication storage areas. Specifically, the second floor medication cabinet was unlocked and medications were accessible to staff, residents and visitors.Findings include:Review of the facility's policy Storage of Medications (undated) indicated:Medications and biologicals are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to licensed personnel, pharmacy personnel or staff members lawfully authorized to administer medications.Medication rooms, carts and medication supplies are locked when not attended by persons with authorized access.On 2/18/26 at 7:48 A.M. the surveyor observed the second floor medication cabinet unlocked, located at the nursing station. An open padlock hung from its clasp and there were no other means to lock the cabinet. The surveyor observed a refrigerator inside the cabinet, and it was unlocked. The surveyor opened the refrigerator door and observed:5 vials of various insulin types3 insulin pens1 bottle of probiotics3 squeeze bottles of ophthalmic solutions 1 respiratory inhalerNo narcotics were in the refrigerator.During the observation there were no licensed staff at the nursing station or in sight of the medication cabinet. A nurse administering medications was located around the corner in the hallway, but not in sight of the medication cabinet and was unaware the surveyor had opened the cabinet.Between 7:48 A.M. and 10:20 A.M. the surveyor observed that the medication cabinet remained unlocked and the padlock hung from its hasp. During this time licensed and non-licensed staff entered and exited the nursing station but did not lock the cabinet.During an interview on 2/18/26 at 10:20 A.M., the surveyor showed Consultant #1 the unlocked medication cabinet. Consultant #1 proceeded to lock the cabinet. Consultant #1 said the medication cabinet should never be unlocked unless a nurse was present.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 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 ensure two of two nourishment kitchens were maintained in a clean, sanitary condition and failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety.Findings include:Review of the facility policy titled Nutrition Services, undated, indicated but was not limited to the following: 4. To minimize the risk of foodborne illness, the time that potentially hazardous foods remain in the danger zone (41 Fahrenheit (F) to 135 F) will be kept to a minimum. Foods that are left without a source of heat (for hot foods) or refrigeration (for cold foods) longer than 2 hours will be discarded. Review of the facility policy titled Food Safety, dated August 2011 indicated but was not limited to the following:It is the policy of this facility that to follow the food protection guidelines as defined in the Hazard Analysis Critical Control Point (HACCP) system to reduce the risk of food contamination and foodborne illness.b. Food Storage: Minimize exposure of potentially hazardous foods to room temperature. Refrigerator units must be maintained at ,41 [NAME] (F) and freezers ,0 F or a temperature to keep food frozen solid. On 2/19/26 at approximately 5:20 A.M., the surveyor made the following observations in the first-floor nursing unit:-One Resident was observed reaching into a gray cooler while holding a plastic cup and removed the half-filled cup with clear water. The Resident began to sip water from the cup. The surveyor opened the cooler and saw about two inches of water at the bottom of the gray cooler. -One clear pitcher containing apple juice, approximately one quarter full was observed on a metal cart underneath two coolers behind the nurse's station. The pitcher was labeled Date 2/18/26. Use By 2/20/26. The pitcher containing the apple juice and was not on ice and was placed directly on the metal cart. The internal temperature of the apple juice at the time of the observation was measured at 76 degrees F.During an interview on 2/19/26 at 5:25 A./M., Certified Nursing Assistant (CNA) #3 said if residents are thirsty, we use the coolers for ice and water and said apple juice is stored on the metal cart and is used for residents. During an interview on 2/19/26 at 5:30 A.M., Nurse #5 said the gray cooler was filled with ice and the clear pitcher of apple juice was delivered around 7:00 P.M., on 2/18/26 and had been used for residents during the overnight shift. Nurse #5 said the dietary department delivers the cooler of ice and apple juice and said they do not store the juice on ice. Nurse #5 said residents should not be accessing the coolers and drinking from the gray cooler that had melted ice in it and said residents need to ask the nurse for water. During an interview on 2/19/26 at 5:35 A.M., Dietary Staff #3 said the coolers are filled with ice and water and pitchers with apple juice are delivered to the unit on the cart for the staff to use. On 2/19/26 at approximately 6:12 A.M., the surveyor observed the following in the nourishment room on the first-floor nursing unit: -The kitchenette floor was stained throughout the room and had dark brown and black build up along the edges and along the bottom of the cabinets with dried pieces of food and crumbs scattered across the floor. The floor in front of the refrigerator had numerous food stains and dried spilled substances along the side and directly in front of the refrigerator and was sticky. The door frame had a brown dried liquid stain along the top. There were crumbs along the edge of the room along with dead bugs and dust.-The inside cabinet above the sink had pink and brown stains on the bottom shelf, multiple dried food crumbs and one old brown and black banana. There were crumbs along the edge of the cabinet shelves along with dead bugs and dust.-The microwave was placed on top of a broken piece of plaster that had brown, yellow, red, and, rust colored stains across the bottom. The microwave had cracked, chipped and peeling edges along the inside and dark brown buildup located inside with dried food and spilled yellow substance along the inside and buildup of crumbs and debris. There were crumbs under the microwave along with dead bugs and a sticky substance along the handle.-Multiple (continued on next page)

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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 - Few	opened packages crackers and condiment packets were observed between refrigerator and wall and located behind the microwave.On 2/19/26 at approximately 6:15 A.M., the surveyor observed the following in the nourishment room on the first-floor nursing unit:-The inside of the refrigerator felt warm to touch and there was condensation observed along the back and sides. Food containers were wet and there was no thermometer located inside of the refrigerator. Review of the Facility Refrigerator/Freezer Temperature Log dated February 2026, posted on the front of the refrigerator was missing 12 temperatures and was left blank. Further review of the temperature log indicated temperatures above 38 degrees F was recorded on five out of 19 days with the last documented temperature on 2/18/26 in the morning and was 40 degrees F. -The surveyor observed cartons of milk and dietary supplements inside of the refrigerator that felt warm to the touch and had condensation on the outside. The internal temperature of the milk at the time of the observation was measured at 50 degrees F.On 2/19/26 at approximately 5:40 A.M., the surveyor observed the following in the nourishment room on the second-floor nursing unit:-The floor was stained with dark brown and black build up along the floor and edges of the door frame. The door frame was cracked and chipped with brown dried liquid stains along the sides. There were two soiled pest traps in the corners of the nourishment room, one in each corner with dead bugs inside. There were pieces of trash inside and surrounding both pest traps.During an interview on 2/19/26 at 9:14 A.M., Dietary Staff #1 who is the temporary covering Food Service Director, said cold beverage brought to the nursing units must be labeled, dated and on ice. Dietary Staff #1 said apple juice should not be left out for hours at room temperature and should be under 41 degrees. Dietary Staff #1 said refrigerator temperatures must be checked twice daily and reported if temperatures fall out of safe storage range. During an interview on 2/19/26 at 9:17 A.M., Dietary Staff #2 said dietary staff are responsible for checking the nourishment room refrigerator temperatures and said he was unaware of the temperatures not being checked and said staff should report temperatures that are above 38 degrees. Dietary Staff #2 said he would expect the dietary staff to clean out the refrigerator and microwave daily and report any issues to housekeeping if further cleaning is necessary. During an interview on 2/19/26 at 7:51 A.M., the Director of Maintenance said he was not aware of the refrigerator temperatures not working and said he does not have an open work order to replace the thermometer in the refrigerator.During an interview on 2/19/26 at 8:17 A.M., the Director of Housekeeping said housekeeping staff should be cleaning the nourishment rooms daily. During an interview on 2/19/26 at 9:05 A.M., Consultant #1 said it is her expectation that staff are checking the nourishment rooms daily and are storing food appropriately. Consultant #1 said she would expect the refrigerators to be in good working order and temperatures to be monitored and reported if out of safe range.