STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225536	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Healthcare at Harrington House	160 Main Street Walpole, MA 02081

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 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 records reviewed and interviews for one of three sampled residents (Resident #1), who had reported to nursing at breakfast time and again at lunch time, that he/she was unable to grasp his/her utensil which was a change for him/her, the Facility failed to ensure nursing notified his/her Physician and Health Care Proxy (Family Member #1) in a timely manner of his/her change in condition. Resident #1 was subsequently transferred to the Hospital Emergency Department (ED) around dinner time for evaluation of his/her complaints and was admitted .Findings include:Review of the Facility Policy titled Notification of Changes, dated as last revised 10/2025, indicated to promptly inform the resident, consult with the resident's physician, and notify, consistent with his/her authority, the resident's representative when there is a change requiring notification.The Policy indicated the Facility must consult with the resident's physician and notify the resident's legal representative when there is a significant change in the resident's physical, mental or psychosocial condition and circumstances that require a need to alter treatment.Resident #1 was admitted to the Facility in March 2024, diagnoses include paraplegia (partial or complete paralysis of the lower half of the body), diabetes mellitus, a chronic stage four (IV) pressure injury, obstructive uropathy with a chronic indwelling catheter (flexible tube inserted into the bladder to drain urine) in place, and a history of bilateral Deep Vein Thrombosis (DVT's).Review of Resident #1's Annual Minimum Data Set (MDS) dated [DATE], indicated that his/her Brief Interview for Mental Status (BIMS) score was a 15 out of 15, indicating he/she was cognitively intact (13-15 indicates cognitively intact, 8-12 indicates moderately impaired cognition, and 0-7 indicates severe cognitive impairment).During an interview on 07/01/26 at 1:49 P.M., Resident #1 said on 05/11/26 right after breakfast he/she informed his/her nurse (later identified as Nurse #1), that he/she was unable to hold any utensils in his/her right hand. Resident #1 said Nurse #1 asked him/her to squeeze both of his/her hand, Resident #1 said he/she did. Resident #1 said at lunchtime he/she had to ask for a sandwich because he/she still could not grasp and hold his/her utensils and was unable to eat the lunchtime meal that had been served because it required utensils.Resident #1 said after returning from lunch another nurse and the head nurse (later identified as the Unit Manager and the Director of Nurses), came to him/her room and asked him/her to squeeze his/her hands as well as some other things to evaluate him/her.Resident #1 said he/she heard the Director of Nurses (DON) say they were going to do a telehealth appointment with his/her provider, however Resident #1 said that did not happen.Resident #1 said his/her daughter (Family Member #1, Health Care Proxy, HCP) came in to visit at suppertime, and he/she informed her that he/she had been having difficulty since breakfast grasping his/her utensils. Resident #1 said as soon as his/her daughter looked at him/her, she thought he/she was having a stroke, the evening nurse (later identified as Nurse #2) then called the Physician, Emergency Medical Services (EMS) and then he/she was sent out to the Hospital.During a telephone interview on 06/30/26 at 2:12 P.M., Family Member #1 said on 05/11/26, she had gone to visit her parents (Resident #1 and roommate are married) and said when she walked into their room, she was not looking directly at Resident #1 because he/she was watching television and his/her face was not (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visible.Family Member #1 said Resident #1 informed her he/she was having trouble all day grasping items and that he/she said he/she had reported it right after breakfast and then again after lunch to his/her nurse. Family Member #1 said, prior to arriving at the facility around dinnertime to visit with Resident #1, she had not been notified by nursing that he/she had reported earlier that day that he/she was not able to hold his/her utensils.Family Member #1 said she looked at Resident #1's face and noticed he/she had right sided facial drooping and knew something was wrong. Family Member #1 said Nurse #2 assessed Resident #1 right away, called the Physician, EMS, and Resident #1 was transferred to the ED.Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated he/she had suffered an acute Cerebral Vascular Accident (CVA) with right upper extremity weakness and right facial droop with associated dysarthria (difficulty with articulation).During a telephone interview on 07/01/26 at 2:10 P.M., Nurse #1 said on 05/11/26 Resident #1 reported to him that he/she was unable to grasp his/her utensils during breakfast. Nurse #1 said Resident #1 could eat independently after being set-up and said not being able to grasp his/her utensil was a change from his/her baseline.Nurse #1 said he assessed Resident #1, asked him/her to squeeze both hands (equal strength noted) and said he told Resident #1 he would have occupational therapy evaluate him/her for the potential need for weighted utensils.Nurse #1 said later that afternoon, another staff member asked him to assess Resident #1 again, specifically checking his/her face for right facial drooping. Nurse #1 said he asked Resident #1 to smile and said the left side of his/her face went up however the right side did not go up when he/she smiled.Nurse #1 said that he had not called the Physician after his first evaluation because he felt Resident #1's hand grasps were equal. Nurse #1 said after the second assessment, he felt since Resident #1's face was asymmetrical (opposite side do not match) to begin with, and he could not tell if his/her inability to fully smile was new or his/her baseline.Nurse #1 said he should have notified Resident #1's physician and Family Member #1 (HCP) upon the discovery of a significant change in his/her baseline condition.During an in-person interview on 07/01/26, the Unit Manager said on 05/11/26, after breakfast, Resident #1 informed her he/she was unable to use his/her motorize electric wheelchair because his/her right hand was feeling funky and he/she could not grasp the joystick (controls motion and movement of wheelchair). The Unit Manager said she observed Resident # 1 not being able to engage his/her motorize wheelchair because of his/her right-hand weakness and he/she needed to have his/her wheelchair pushed manually by staff.The Unit Manager said she informed Nurse #1 of her discussion with Resident #1 and asked Nurse #1 to assess him/her. The Unit Manager said she also informed the Director of Nurses (DON) and asked her to assess Resident #1 as well.The Unit Manager said if she had been Resident #1's nurse, she would have assessed him/her herself and notified his/her physician and Family Member #1 (HCP) of the changes.During a telephone interview on 07/02/26, Resident #1's Nurse Practitioner (NP) said after his/her second report of right-hand weakness and any concern about facial drooping, nursing staff should have called to inform the providers of Resident #1's changes. The NP said something was clearly going on with him/her and said she would have had nursing send Resident #1 to the ED at that time. During an interview on 07/01/26 at 3:38 P.M., The Director of Nurse (DON) said on 05/11/26, sometime after lunch, she was asked to assess Resident #1 by the Unit Manager because he/she had reported that he was unable to independently use his/her motorize electric wheelchair.The DON said that she reported her assessment of Resident #1 to the Unit Manger and said perhaps they could do a telehealth visit with his/her provider.The DON said that she was not aware Resident #1 had reported he/she was unable to use his/her right-hand during breakfast due to being unable to grasp the utensils.The DON said if she had been aware of Resident #1's initial complaint of not being able to hold the utensils, reported to Nurse #1, she would have asked if he (Nurse #1) had informed the physician of the resident's change.The DON said it is the Facility's expectation that nursing must notify the residents physician and responsible party of changes in status in a timely manner.