| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225545 | A. Building<br>B. Wing | 11/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Regalcare at Courtyard-Medford | 200 Governors Avenue<br>Medford, MA 02155 |

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 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assure that each resident?s assessment is updated at least once every 3 months.<br><br>Based on records reviewed and interviews for one of three sampled residents (Resident #2), the Facility failed to ensure that they completed a quarterly Minimum Data Set (MDS) assessment as required in a timely manner.Findings include:Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual indicated for Quarterly Assessments:The MDS completion date (item Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD + 14 calendar days).Resident #2 was admitted to the Facility in 03/2022, diagnoses include Alzheimer's Disease, bipolar disorder, hypertension and diabetes mellitus.Review of Resident #2's Medical Record indicated that his/her last completed Quarterly MDS had an Assessment Reference Date (ARD) of 08/13/25.Further review of Resident #2's medical record indicated that his/her quarterly MDS, with an ARD of 11/11/25, had not been completed within 14 days of the ARD date (due to be completed by 11/25/25).During a telephone interview on 12/03/25 at 3:23 P.M., the MDS Nurse said the facility has been behind in completing multiple MDS assessments. The MDS Nurse said that she only works remotely for about seven to ten hours per week for the Facility and can only complete so many.During a telephone interview on 12/03/25 at 3:31 P.M., the Regional Clinical Director said that she was currently responsible for overseeing and assisting the Facility with the MDS process.The Regional Clinical Director said that she was aware that the MDS's for the Facility have been behind for some time and said she has been working on getting the Facility back into compliance.During an interview on 11/28/25 at 3:08 P.M., the Director of Nurses (DON) said that he was aware that there are many MDS's that are incomplete and are being completed late.The DON said that the Facility's expectation was to have all MDS's completed in a timely manner as required, and in accordance with the RAI Manual. |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 225545 | A. Building<br>B. Wing | 11/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Regalcare at Courtyard-Medford | 200 Governors Avenue<br>Medford, MA 02155 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was independent with eating, the Facility failed to ensure they maintained a complete and accurate medical/clinical record, including but not limited to his/her Comprehensive Nutrition Assessment and Nurse Progress Notes.Findings include:Review of the Facility Policy titled Charting and Documentation, dated as last revised 04/2022, indicated that the Medical Record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.The Policy indicated that the documentation in the medical record will be objective, complete and accurate.Resident #1 was admitted to the Facility in 06/2023, diagnoses include history of a traumatic Subarachnoid Hemorrhage (SAH, life threatening emergency caused by bleeding between the brain and its covering membranes) frontal lobe contusions secondary to multiple falls, hypertension and dysphagia.Review of Resident #1 Care Plan titled Activities of Daily Living (ADL), dated as last reviewed 08/27/25, indicated that he/she was able to eat independently after staff set up (helper set-up or cleans up, resident completes the activity).Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 10/08/25, indicated that he/she was independent (completes the activity by themselves with no assistance from a helper) with the task of eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident).Review of Resident #1's Comprehensive Nutritional Evaluation, dated 10/31/25, indicated that he/she required to be fed by the staff.Review of Resident #1's two previous nutrition evaluations dated 08/12/25 and 05/12/25, indicated that he/she feeds self no assist.During a telephone interview on 11/28/25 at 2:15 P.M., the Registered Dietician (RD) said that she had completed Resident #1's Nutritional Assessment remotely while covering for the Facility's regular dietician.The RD said after looking at his/her ADL's and functional ability for eating, she must have accidentally checked off the wrong box on the Nutrition Assessment. The RD said that Resident #1 is independent with eating and said she made a documentation error.Review of Resident # 1's Nurse Progress Notes, dated 11/19/25, written by Nurse #1, indicated that Resident #1 was dependent with eating.During an interview on 11/28/25 at 12:42 P.M., Nurse #1 said that he has taken care of Resident #1 many times and said that he/she is independent for eating, at times the CNA's may provide him/her with a set-up, but Resident #1 is able to eat his/her meals independently.Nurse #1 said that he was not aware that he documented Resident #1 as dependent with meals in his/her latest progress note and said he made an error when checking off the level of assistance that he/she required with eating.During an interview on 11/28/25 at 3:08 P.M., the Director of Nurses (DON) said that he did not realize that there was conflicting documentation in Resident #1's medical record until he had submitted the reportable to the Department of Public Health.The DON said that it is the Facilities expectation that all medical record entries, including but not limited to ADL documentation, Nurse Progress Notes and Nutritional Assessments are complete and accurate. |