STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225547	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hannah B G Shaw Home	299 Wareham Street Middleboro, MA 02346

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. **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 handle ready-to-eat food (food which does not require cooking or further preparation prior to consumption) to prevent cross contamination. Findings include:Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated, but was not limited to:3-302 Preventing food and ingredient contamination; (A) FOOD shall be protected from cross contamination by: (3) Cleaning equipment and utensils as specified under 4-602.11(A) and sanitizing as specified under S 4-703.11; 4-602.11 Equipment Food-Contact Surfaces and Utensils; (A) Equipment food-contact surfaces and utensils shall be cleaned: (3) Between uses with raw fruits and vegetables and with TIME/TEMPERATURE CONTROL FOR SAFETY FOOD; (5) At any time during the operation when contamination may have occurred. Review of facility's policy titled Food Preparation and Service, Revised November 2022, indicated but was not limited to:-Food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices;-Cross contamination can occur when harmful substances, such as, chemical or disease-causing microorganisms are transferred to food by hands, food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned; -Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness;-Appropriate measures are used to prevent cross contamination. These include cleaning and sanitizing work surfaces and food-contact equipment between uses, following food code guidelines;-Food thermometers used to check food temperatures are clean, sanitized, and calibrated. On 9/10/25 at 12:34 P.M., the surveyor observed Dietary Staff #1 deliver lunch to the [NAME] unit, which consisted of food (in covered holding containers) that would be plated on the unit. Dietary Staff #1 began taking food temperatures with two thermometers from the kitchenette drawer. He inserted each thermometer into a food item. He then took the thermometers out and immediately used them to temp the rest of the food. The thermometers were not cleaned or sanitized between food items. Dietary Staff #1 said this was his process for taking temperatures and he was unaware if any residents on the unit had food allergies. He said he should have cleaned and sanitized the thermometers between use to prevent cross contamination. On 9/11/25 at 11:41 A.M., the surveyor observed Dietary Staff #2 deliver food to the [NAME] unit. Dietary Staff #2 used two thermometers to temp the food. She rinsed the thermometer probes under running sink water between each food item and did not wipe or sanitize the probes between food items. Dietary Staff #2 wiped and sanitized the thermometer probes after completing temperatures of all the food. On 9/11/25 at 11:48 A.M., the surveyor observed Dietary Staff #2 taking food temperatures on the [NAME] unit. She used two thermometers to temp the food. She rinsed the thermometer probes under running sink water between each food item and did not wipe or sanitize the probes between food items. Dietary Staff #2 wiped and sanitized the thermometer probes after completing temperatures off all the food. During an interview on 9/11/25 at 2:15 P.M., the Food Service Director said staff should have cleaned and sanitized the thermometers between each food item to prevent cross contamination.

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review, the facility failed for one Resident (#2), out of a total sample of 15 residents, to ensure the Resident was free from physical restraints. Specifically, Resident #2's wheelchair was replaced with a Broda positioning wheelchair which no longer allowed the Resident to self-propel about the unit.Findings include:Review of the facility's policy titled Use of Restraints, revised April 2017, indicated, but was not limited to, the following:-Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully.-Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls.-When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need of restraints will be documented.-Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including:c. placing a resident in a chair that prevents the resident from rising-Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms.-Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative.-A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record.-Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination.-Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use.Review of the facility's policy titled Fall Management, dated August 2013, indicated, but was not limited to, the following:-Restraints will not be used as a fall prevention intervention.Resident #2 was admitted to the facility in June 2023 with diagnoses including Alzheimer's disease and impulse disorder. Review of the Minimum Data Set (MDS) assessment, dated 6/18/25, indicated Resident #2 was unable to complete a Brief Interview for Mental Status (BIMS) and indicated the Resident was dependent on staff for completion of activities of daily living and was not ambulatory. Further review of the MDS indicated no physical restraints were used but chair and bed alarms were used daily. Review of Resident #2's Comprehensive Care Plan indicated, but was not limited to, the following:-Focus: [Resident #2] is dependent on staff for meeting emotional, intellectual, physical, emotional and social needs r/t (related to) Cognitive deficits and Physical Limitations. [Resident #2] ambulates with staff assistance and also uses a wheelchair for mobility, pedaling around the neighborhood. He/She will require staff assistance to attend activity programs in his/her wheelchair with foot pedals off the neighborhood. His/her vision and hearing are adequate at this time.-Focus: [Resident #2] has Functional Abilities Performance deficit in Self-Care and limited physical mobility r/t periprosthetic hip fracture around internal prosthetics left hip (routine healing), osteoporosis, Alzheimer's, Dementia, hx (history) TBI (traumatic brain injury), muscle weakness, dysphagia.Interventions:AMBULATION/LOCOMOTION = N/A The resident requires dependent assistance by 1 staff for locomotion using w/c (wheelchair).-Focus: [Resident #2] is at risk for falls r/t Gait/balance problems, Poor communication/comprehension, Psychoactive drug use, Unaware of safety needs, Wandering/pacing, impulsive behavior, Periprosthetic fracture around internal prosthetics left hip (routine healing), Osteoporosis, hx fallsInterventions:*2 assist with care if unable to leave d/t (due to) safety concern as needed*30 minute safety checks*Anti-rollback system for wheelchair*Anti-tip device for wheelchair*Anticipate and meet the resident's needs*Apply padded hip protector belt as needed/as tolerated*Be sure the resident's call light is within reach and encourage (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance.*Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs.*Encourage the resident to participate in activities that promote exercise, physical activity for strengthening, and maintain mobility.*Ensure floor mats in place while resident is in bed*Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c.*Follow facility fall protocol*Keep bed in lowest position when resident is lying in it.*Pt (physical therapy) evaluate and treat as ordered or PRN (as needed)*The resident needs a safe environment with the bed in low position at night.*The resident uses bed electronic alarm. Ensure the device is in place as needed.*The resident uses chair electronic alarm. Ensure the device is in place and functioning as needed. Review of the Comprehensive Care Plan failed to indicate a restraint/potential restraint was implemented for Resident #2.Review of Resident #2's Nursing Progress Notes indicated, but was not limited to, the following:-11/19/24: Resident continuously moving, pulling seats off chairs and entering residents' bedrooms. Resident settles for lunch however later quickly wheeling all around unit while whistling. Alarm on for safety.-12/8/24: Resident presenting with increased anxiety and agitation in late morning; pushing and pulling at staff, yelling out, aggressively whistling rapidly self-propelling unit in wheelchair and attempting to self-transfer multiple times.-12/10/24: Resident self-propelling around the unit - entering other resident's rooms, pushing/pulling furniture, slamming into other residents' walkers.-12/10/24: Resident self-propelling about unit in wheelchair and while self-propelling was observed to lean too far forward in the wheelchair by the nurse. The nurse ran to assist resident, but was unable to get to Resident quick enough to prevent fall from occurring. Resident landed face forward on floor, sustaining a laceration near left eye, large hematoma to forehead, and abrasions to left hand knuckles. The Resident was sent to the hospital for evaluation.12/11/25: Resident was seen at the hospital due to a fall and returned to the facility with diagnoses including nasal fracture and orbital laceration. -12/12/24: Resident pacing in wheelchair on the unit with nurse.-12/14/24: Broda chair to be ordered by hospice. Physician recommends resident not in wheelchair for self-propelling due to safety concerns. Daughter/health care proxy in agreement.-3/7/25: Resident was agitated and complained of pain. He/she was restless and trying to get out of his/her chair. Ativan (an antianxiety medication) and Morphine (an opioid pain reliever) were given, both with positive effect and no further complaints of pain.-3/17/25: Resident displaying increased signs and symptoms of anxiety/restless and trying to get out of his/her chair. 1:1, verbal redirection with minimal effect.-3/18/25: Resident was showing signs/symptoms of anxiety, restlessness, and was trying to climb out of his/her chair.-3/25/25: As needed Trazodone (an antidepressant medication) and Ativan due to increased agitation, whistling, and trying to leave his/her chair.-3/31/25: Resident was showing signs of agitation and restlessness. Whistling in his/her chair and unable to sit still.-4/1/25: Resident was showing signs of agitation and restlessness. Whistling in his/her chair and unable to sit still.-4/10/25: Resident was showing signs and symptoms of increased restlessness and agitation. Whistling and trying to get out of chair.-4/23/25: Resident was anxious and agitated. Face flushed, whistling and unable to sit still.-4/24/25: Resident was anxious and agitated. Face flushed, whistling and unable to sit still.-4/25/25: Resident showing his/her typical signs of restlessness and agitation. Unable to sit still in chair, face flushed, increasingly loud whistling.-4/29/25: Resident was agitated, whistling, face flushed, trying to get out of wheelchair.-5/5/25: Resident was agitated and restless. Whistling, face flushed, unable to sit still. -5/6/25: Resident was agitated and restless. Whistling, face flushed, unable to sit still.-5/20/25: Resident was whistling, face flushed, trying to get out of his/her chair, and showing signs of being uncomfortable.-5/28/25: Resident was whistling, face flushed, trying to get out of her chair-6/19/25: Resident's face was flushed, he/she was making whistling noises, unable to sit still in chair.-6/25/25: Resident was trying to climb out of chair-8/13/25: Resident was restless and agitated, flushed face, whistling, trying to get out of his/her chair.-8/14/25: Resident was agitated and restless, trying to get out of his/her chair, whistling, face flushed, one to one and (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	redirection had no effect.-8/21/25: Resident became agitated, facial flushing, increasingly loud whistling, attempting to get out of chair.-8/27/25: Resident became agitated, facial flushing, increasingly loud whistling, attempting to get out of chair.-8/28/25: Resident became agitated, facial flushing, increasingly loud whistling, attempting to get out of chair.Review of Resident #2's Physician Progress Notes, indicated, but was not limited to, the following: -11/29/24: Patient had a fall. Accidental, no injuries noted. Fall due to patient's poor safety awareness and impulsivity. Patient is very high risk for another fall. -12/12/24: Patient was propelling and fell forward onto his/her face. Sent to hospital. Laceration around eye repaired. Has nasal fractures. Had long discussion with health care proxy (daughter) about patient cannot safely self-propel in wheelchair and we can't allow him/her to be in the wheelchair any longer. There is not enough staff to maintain his/her safety as he/she requires a 1-to-1; He/She is also a danger to other residents as he/she has no awareness of his/her environment. Daughter is in agreement. Daughter to request that patient can be in his/her wheelchair when daughter is in facility and will act as his/her 1-to-1. -12/31/25: Adjusting to loss of wheelchair, taken away due to very significant safety concerns. Status post fall and nasal fracture. Alzheimer's dementia with behaviors. -1/7/25: Continues with intermittent agitation. More falls. Status post fall out of wheelchair and nasal bone fracture. Since taking wheelchair away, less agitated and is adjusting.-3/4/25: Continues with intermittent agitation. More falls. Status post fall out of wheelchair and nasal bone fracture. Since taking wheelchair away, less agitated and is adjusting.-5/1/25: Continues with intermittent agitation. No further falls. Status post fall out of wheelchair and nasal bone fracture. Since taking wheelchair away, less agitated and is adjusting.-7/1/25: Continues with intermittent agitation. No further falls. Status post fall out of wheelchair and nasal bone fracture. Since taking wheelchair away, less agitated and is adjusting.-8/28/25: Wheelchair was taken away due to high risk of injury, status post fall and nasal fractures. -9/2/25: Since taking wheelchair away, less agitated and is adjusting.Review of Resident #2's Interdisciplinary Referral and Rehab Screen, dated 12/12/24, indicated the Resident was status post fall with head strike and hospitalization. Further review indicated hospice was to get the Resident a Broda chair and no decline in mobility was reported.Review of Resident #2's medical record failed to indicate a pre-restraining assessment was conducted or a regular review was done to determine if the Resident was/is a candidate for restraint reduction, less restrictive methods of restraints, or total restraint elimination.On 9/10/25 at 9:05 A.M., the surveyor observed Resident #2 in the unit living room sitting in a Broda chair, slightly reclined with lateral supports in place, feet elevated on footrest, and chair alarm in place.On 9/11/25 at 9:17 A.M., the surveyor observed Resident #2 in the unit living room sitting in a Broda chair, slightly reclined with lateral supports in place, feet elevated on footrest, and chair alarm in place. On 9/12/25 at 10:55 A.M., the surveyor observed Resident #2 in the living room on unit in a Broda chair with feet on footrest, slightly reclined with lateral supports in place and a pillow under his/her head. During an interview on 9/11/25 at 10:00 A.M., CNA #1 said prior to Resident #2's December 2024 fall with nasal fracture, discussion had been had among staff about re-evaluating the Resident's medication regimen and wheelchair because staff felt the Resident may be uncomfortable and was not able to effectively self-propel the way that he/she used to.During an interview on 9/11/25 at 10:00 A.M., Nurse #6 said after Resident #2's fall in December 2024 with nasal fracture, the Resident returned from the hospital in a declined state and was not able to sit comfortable in a standard wheelchair. Nurse #6 said once the Resident started sitting in the Broda chair, he/she appeared more comfortable, and staff saw a reduction in the Resident's behavioral symptoms. During a subsequent interview on 9/12/25 at 11:11 A.M., Nurse #6 said the Resident had a really bad fall resulting in fractures when he/she fell out of his/her wheelchair while self-propelling. She said the Resident was on hospice and shortly after he/she returned from the hospital, hospice decided to put him/her in a Broda chair, probably for safety and comfort. Nurse #6 said the Resident does scoot at times in the chair when he/she is restless but he/she is not capable of getting out of the chair. Nurse #6 said when the Resident is agitated or (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restless, they have interventions, such as as-needed medication, they can use that work for him/her. During an interview on 9/12/25 at 11:47 A.M., Resident Representative #1 said prior to a really bad fall the Resident had in December 2024, the Resident was self propelling in his/her wheelchair about the unit with supervision. Resident Representative #1 said once Resident #2 returned from the hospital, the Resident's physician called her and said the facility would have to take the wheelchair away for safety reasons and the facility did not have the staff to safely allow him/her to be supervised in the wheelchair while self-propelling. Resident Representative #1 said she initially pushed back because she thought of it as if they were restraining Resident #2 and preventing him/her from being able to move and burn off energy, but they continually reminded her that Resident #2 was on hospice and the goal was for safety and comfort, which they could better ensure if the wheelchair was removed. Resident Representative #1 said she was able to compromise with the facility and when she comes to visit, Resident #2 could use the wheelchair and self-propel as long as Resident Representative #1 was there to supervise. Resident Representative #1 said the first few times she came to visit, Resident #2 would sit in the wheelchair and self-propel around for about an hour, but there was a time gap when she couldn't come to visit, and the Resident has now declined so much that he/she likely wouldn't be able to do that anymore anyway. Resident Representative #1 said there was no offer of any other type of chair or device, like a pedal chair that was low where the Resident's feet could still touch the ground, or offer for the Resident to be supervised in the wheelchair for a period of time each day to self-propel and that they just put him/her from the wheelchair directly to the Broda chair once it arrived from hospice. Resident Representative #1 said no alternative options were provided and she did ask about it being a restraint but wanted her parent to be safe, so she compromised.On 9/12/25 at 12:01 P.M., MDS Nurse #1 said she was familiar with Resident #2. MDS Nurse #1 said the facility is restraint-free and there is no documentation or special areas she would look to find information for a resident being restrained because they don't have any. MDS Nurse #1 was asked if Resident #2 could self-propel in his/her wheelchair and she said yes, at one time the Resident could walk and self-propelled in his/her wheelchair but has since moved to a Broda chair. MDS Nurse #1 said she was unaware of the 12/12/24 Physician Progress Note indicating the wheelchair was being removed for safety. MDS Nurse #1 said if the wheelchair was removed with the intention of not allowing the Resident to self-propel any longer, the Broda chair would be considered a restraint since it would prevent the resident from self-propelling like he/she wanted to. On 9/12/25 at 12:37 P.M., the Director of Nursing (DON) said after the Resident's large fall, the physician and herself had a conversation about the Resident's safety and that of other residents on the unit. The DON said she spoke with Resident Representative #1 about it as well. The DON said the intent was to keep the Resident safe and to keep other residents safe as Resident #2 would self-propel and grab at other people. The DON said eliminating the Resident's ability to move in a way he/she would want to would be considered a restraint and that the facility staff cannot remove a resident's ability to do something without assessing or having conversations about it being a potential restraint. The DON said these discussions were had verbally but she did not know if that information made it into the Resident's record. The DON said no restraint assessment was completed, and the Resident's Care Plans were not reflective of the Resident's current status or use of Broda chair. The DON said she spoke with Resident Representative #1 and did not offer other options or other types of chairs. The DON said Resident Representative #1 did agree to the use of the Broda chair and did come in and assist the Resident in the wheelchair at times to self-propel. During a subsequent interview on 9/12/25 at 2:49 P.M., the DON said she couldn't find any evidence the device was considered or evaluated as a restraint or that the risk vs. benefits of the Broda chair's use were provided. She said she did see the Nursing Progress Notes in which the staff indicate at times through the month of August 2025, the Resident would be restless and attempting to get out of the chair. She said the staff told her the Resident does get in the standard wheelchair occasionally, but there is no documentation to support that. During an interview on 9/15/25 at 9:05 A.M., Physician #2, Resident #2's attending physician, (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said he had a lengthy discussion with Resident Representative #1 about the Resident's lack of safety awareness. Physician #2 said Resident #2 had one bad fall with multiple facial fractures, but there were numerous other times when the Resident was self-propelling and staff were able to intervene before any accident or injury occurred. Physician #2 said once Resident #2 sustained his/her injuries in December 2024, he called Resident Representative #1 and met with her on the unit to discuss that Resident #2 was very unsafe and there was not enough staff in place to provide a continuous one to one supervision to the Resident. Physician #2 said he made multiple suggestions, such as transfer to another facility where staff would be able to provide one to one supervision, like a psychiatric facility; leaving Resident #2 in the standard wheelchair and waiting for another accident to happen; or to obtain a Broda chair from hospice to keep the Resident from self-propelling. Physician #2 said Resident Representative #1 did not want to transfer the Resident and did not want the Resident or other residents to be injured, so she agreed to use of the Broda chair. Physician #2 said Resident Representative #1 asked if she would be able to supervise the Resident while self-propelling in the standard wheelchair when she was in to visit and he told her she would have to discuss that with the DON. Physician #2 said both he and Resident Representative #1 felt sad about taking away the Resident's ability to self-propel, but he had little doubt that another accident would happen, possibly involving another resident, if they did not. Physician #2 said he hated taking away the Resident's ability to be mobile, but it became too risky. Physician #2 said it was hard for him to say if the facility staff should have completed a restraint assessment as he felt that he did that and reviewed the risks and benefits with Resident Representative #1.

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on record review and interview, for one Resident (#2), out of a total sample of 15 residents, the facility failed to develop a plan of care accounting for the Resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization. Findings include: Resident #2 was admitted to the facility in June 2023 with diagnoses which included anxiety, depression, Alzheimer's disease, traumatic brain injury (TBI), and post-traumatic stress disorder (PTSD).Review of the Minimum Data Set (MDS) assessment, dated 6/18/25, indicated Resident #2 was unable to complete the Brief Interview for Mental Status (BIMS) and had a diagnosis of PTSD. Further review of the MDS assessment indicated the Resident exhibited physical behavioral symptoms, verbal behavioral symptom, other behavioral symptoms, rejection of care, and wandering.Review of the Social Service admission Assessment, dated 7/5/23, indicated but was not limited to the following:-Resident #2 was in the process of divorcing his/her spouse-Resident #2 had some difficulty adjusting in his/her new environment and presented with mood swings. His/her mood fluctuated and he/she was irritable and easily angered at times and could be combative with care.-Resident #2 appeared comfortable in a quiet environment but could become anxious in loud settings. Review of the Trauma/PTSD Assessment, dated 7/5/23, indicated that Resident #2 was unable to participate in the assessment, but his/her family reported a history of prior assault, which could make the Resident prone to startle easily.Review of the Comprehensive Care Plan indicated but was not limited to the following: FOCUS: [Resident #2] has had behavioral issues at times due to diagnoses of dementia and a history of brain injury and trauma. When [he/she] is restless and anxious, [he/she] can be resistive to care.INTERVENTIONS: -Explain all procedures to the resident before starting and allow the resident time to adjust to changes.-Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed.-Minimize physical touch as much as possible during periods of increased anxiety [sic] or agitation. Respect personal space. Review of Resident #2's Kardex (generated from the electronic health record) and Certified Nursing Assistant (CNA) Care Card failed to indicate information about the Resident's potential trauma trigger as reported by his/her family (Resident's history of prior assault, which could make the Resident prone to startle easily).During an interview on 9/11/25 at 12:53 P.M., CNA #1 said she was not aware of any resident on the unit where Resident #2 resides having a diagnosis of PTSD or any specific trauma triggers. CNA #1 reviewed Resident #2's Resident Care Card with the surveyor, which failed to include information about the Resident's potential trauma trigger as reported by his/her family during completion of the Trauma/PTSD Assessment. CNA #1 said the information could be communicated better between other departments and direct care staff who are providing care to residents.During an interview on 9/11/25 at 1:04 P.M., Social Worker #1 said a trauma assessment is completed for every resident as part of their admission assessment. Social Worker #1 said if she is completing an assessment and a resident feels he/she is through it she would not care plan for PTSD or potential trauma triggers. Social Worker #1 said she has not care planned any resident for a history of trauma. Social Worker #1 reviewed Resident #2's care plans and said she did not see anything specific to the Resident's history of trauma and potential triggers. Social Worker #1 said she is the social worker for the unit on which Resident #2 resides but was not the social worker who did Resident #2's initial assessment when he/she was admitted and could not speak to why his/her care plan did not identify the specific trigger indicated by his/her family related to his/her trauma/physical assault.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225547	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hannah B G Shaw Home	299 Wareham Street Middleboro, MA 02346

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on records reviewed and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment for one Resident (#26) from a total sample of 15 residents. Specifically, the facility failed to ensure respiratory equipment including oxygen tubing and bilevel positive airway pressure (bipap-medical device used to treat breathing disorders) equipment was properly maintained and stored in a clean and sanitary manner to decrease the risk of potential contamination and infection.Findings include:Review of the facility's policy titled Equipment Changing, undated, indicated but was not limited to the following:-All respiratory therapy equipment must be changed in order to prevent nosocomial infections (infections acquired in healthcare settings).-The equipment should be marked with the date that it was changed.-All equipment should be changed on a weekly basis as well as needed (PRN) if it becomes soiled or falls on the ground. This equipment includes but is not limited to: -air entrainment masks (medical device used to deliver a precise, controlled concentration of oxygen to a patient by mixing room air with a high-velocity oxygen stream) -corrugated tubing (flexible, disposable, single-patient-use tube that connects the BiPAP machine to the patient's mask, delivering pressurized air for breathing support) -oxygen tubingResident #26 was admitted to the facility in April 2024 and had diagnoses including chronic obstructive pulmonary disease (a lung disease that causes long-term damage to the airways and lungs leading to breathing difficulties). Review of the Minimum Data Set assessment, dated 12/26/24, indicated Resident #26 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 14 out of 15 and received oxygen therapy.Review of Resident #26's physician's orders indicated but was not limited to the following:-Change oxygen (O2) tubing weekly on Sunday 11-7, every Sunday (11/5/23)-Apply bipap mask every evening, attach with supplemental O2 at 1.5Liters/minute every evening shift; settings are as follows: Avaps-AETidal Volume 350Max Pressure 24Pressure Support minimum 6 maximum 12EPAP minimum 5 and maximum 12; Respiratory rate 15 per minute FI02 1.5 litersO2 to be run in conjunction with bipap at 1.5L/min (4/12/24)Review of Resident #26's August 2025 Medication Administration/Treatment Administration records (MAR/TAR) indicated he/she utilized bipap treatments as ordered by the physician and oxygen tubing was changed on 9/7/25.During an observation with interview on 9/10/25 at 9:53 A.M., the surveyor observed Resident #26 resting in bed. An oxygen concentrator was noted in the Resident's room with oxygen tubing attached to the concentrator and connected to a bipap machine placed on a bedside table. The oxygen tubing was labeled as having been last changed on 8/27/25 at 9:00 P.M. A bipap mask was noted to be connected to the corrugated tubing and resting on top of the bipap machine exposed to the environment, was not dated, and was not covered with a plastic bag. Resident #26 said he/she uses the bipap machine only at night and does not use oxygen regularly.On 9/11/25 at 1:05 P.M., the surveyor observed Resident #26 lying in bed watching television. Oxygen tubing was attached to the concentrator and connected to a bipap machine that was on a bedside table. The oxygen tubing was labeled as having been last changed on 8/27/25 at 9:00 P.M. A bipap mask was noted to be connected to the corrugated tubing and resting on top of the bipap machine exposed to the environment, was not dated, and was not covered with a plastic bag.During an interview on 9/11/25 at 1:27 P.M., Nurse #2 reviewed Resident #26's medical record and said the Resident's oxygen tubing used for the bipap machine is supposed to be changed every week on Sunday and labeled with the date it was changed. She said the tubing was signed off as having been changed on 9/7/25.During an interview with observation on 9/11/25 at 1:33 P.M., Nurse #2 said the tape secured to the O2 tubing was dated 8/27 at 9:00 P.M. and it should have been changed on 9/7/25 and was not. Nurse #2 noted the bipap mask lying on top of the machine uncovered with the corrugated hosing connected. She said nursing is supposed to remove the hose, clean it and hang it to dry every morning and did not do that. She said the mask should be stored in a plastic bag when not in use and was not.During an interview on 9/12/25 at 10:16 A.M., the Director of Nursing (DON) said (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #26's oxygen tubing should have been changed as ordered, the hose removed from the bipap unit and cleaned, and the mask should have been placed in a plastic bag and not left on top of the bipap unit uncovered.