STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225548	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Tewksbury	10 Erlin Terrace Tewksbury, MA 01876

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, for one of three sampled residents (Resident #1), whose Plan Of Care indicated he/she required an assist of two for transfers, the Facility failed to ensure staff consistently implemented and followed his/her Care Plan interventions related to transfers, when on 04/20/26 Certified Nurse Aide (CNA #7) transferred Resident #1 by himself, and did not get another staff person to assist with the transfer. Findings include:Review of the Facility Policy and Procedure titled Resident ADL Guide/Kardex, dated 12/2023, indicated its purpose to ensure that Certified Nurse Aides are provided with a complete and updated reference source for resident care needs upon admission and throughout length of stay. The Policy and Procedure indicated ADL Kardex are to be reviewed and updated at Case Management/Care plan meetings.Review of Resident #1's clinical record indicated his/her diagnoses included Hemiplegia and Hemiparesis (severe or complete paralysis/loss of voluntary movement on one side) following Cerebral Infarction affecting right dominant side, repeated falls, and abnormal posture.Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 03/11/26, indicated he/she had severe cognitive impairment, and was dependent on staff for transfers from chair to bed.Review of Resident #1's ADL Care Plan, dated as initiated on 12/14/24 with an estimated goal date of 02/27/26, indicated that he/she required a two person stand pivot assist with all transfers.During a telephone interview on 05/05/26 at 2:20 P.M., CNA #7 said the resident care Kardex (utilized by the CNA's) provides specific information on the care needs of the residents. CNA #7 said according to Resident #1's Kardex on 04/20/26, Resident #1 required a two person assist with transfers. CNA #7 said on 04/20/26 at about 9:30 P.M. he transferred Resident #1 from the wheelchair to the bed without the assistance of a second person. CNA #7 said he stood Resident #1 up, and with the assistance of a walker, pivoted and sat him/her onto the bed without incident. CNA #7 said he did not get a second person to assist him, because he did not feel it was needed. At the time of the Survey the facility was unable to provide a copy of Resident #1's care Kardex that was in effect on 04/20/26, that would have indicated to the CNAs what level of staff assistance he/she required.During a telephone interview on 05/05/26 at 2:08 P.M., Nurse #2 said on 04/20/26 at about 9:30 P.M. CNA #7 called nursing staff into Resident #1's bedroom to report an area of ecchymosis (bruising) to his/her right upper arm. Nurse #2 said it was not known to her, if Resident #1 was transferred by CNA #7 alone or with assistance. During a telephone interview on 05/05/26 at 3:45 P.M., the Administrator said CNAs are expected to review the summary of their resident's care needs through the Kardex (which was based on their Plan of Care) in order to provide care and services as required, and that CNA #7 should have gotten another staff member to assist him with Resident #1's transfer.Review of Resident #1's Plan of Care, updated 04/30/26, indicated he/she had impaired mobility related to history of stroke with right side hemiparalysis. Resident #1's Plan of Care interventions indicated staff were now required to transfer him/her with mechanical lift and two assists. During a conference call telephone interview on 05/06/26 at 1:07 P.M., with the Administrator and the Director of Social Services, the Administrator said that he was unable to generate Resident #1's CNA Kardex that was in effect on 04/20/26. The Administrator emailed a copy of Resident #1's Kardex to the Surveyor (on 05/06/26) that was currently in effect. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator said Resident #1 was being transferred at the time of survey (04/30/26) using the mechanical lift with two staff members as reflected in his/her Plan of Care, but that the CNA's Kardex had not been updated to reflect that a mechanical lift was now required for transfers. The Administrator said the Kardex's were not automatically updated within the electronic medical system when changes are made to the Plan of Care.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, for two of three sampled residents (Resident #1 and Resident #2), the facility failed to ensure they reviewed and revised their Comprehensive Care Plans following the completion of their Minimum Data Set assessment.Findings include:Review of the Facility Policy and Procedure titled Care Plan Policy, revised May 2025, indicated the following:-The Care Planning/Interdisciplinary Team develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain.- The resident's comprehensive care plan is developed within seven days of the completion of the resident's comprehensive assessment (MDS). - Each resident comprehensive care plan is designed to reflect treatment goals, timetables and objectives that are measurable. - The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans when there is a significant change in the resident's condition, the desired outcome is not met, when readmitted to the facility from a hospital stay and at least quarterly.1. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment indicated it had been completed with an Assessment Reference Date (ARD) of 03/11/26. Further review of Resident #1's medical record indicated his/her Care Plan Meeting occurred on 02/19/26 (prior to MDS assessment completion) and that the Care Plan was checked off as having been updated. Review of Resident #1's Comprehensive Care Plans indicated it identified Problems/Strengths, Goals (with an Estimated Date), and Interventions, which included but were not limited to the following concern areas:- Cognitive loss and risk of decline in communication (initiated 12/20/24) - Vision impairment (initiated 12/16/24)- Risk of decline in communication (initiated 01/03/25)- Bladder and bowel incontinence (initiated 12/20/24)- Risk of alterations in mood state (initiated 01/03/25)- Mechanically altered diet (initiated 03/10/25)- Skin breakdown (initiated 12/20/24)- Psychotropic medication (initiated 12/20/24)- Alteration in activities of daily living (initiated 12/14/24)- Hard of hearing (initiated 03/14/25)- Risk of Falls (initiated 12/16/24)Although the Care Plan Meeting on 02/19/26 indicated the Care Plans were updated, Resident #1's Care Plan had an Estimated Date for Goals to be met as 02/27/26. 2. Review of Resident #2's Annual MDS assessment indicated it had been completed with an ARD of 03/27/26. Further review of the medical record indicated Resident #2's Care Plan Meeting occurred on 03/19/26, prior to the MDS assessment completion, and that the Care Plans were checked off as having been updated.Review of Resident #2's Comprehensive Care Plans indicated it identified Problems/Strengths, Goals (with an Estimated Date), and Interventions, which included but were not limited to the following concern areas:- Cognitive loss and risk of decline in communication (initiated 07/08/22)- Hearing deficits (initiated 07/08/22)- Bladder and bowel incontinence (initiated 07/08/22)- Long term placement (initiated 09/15/25)- [NAME] for alterations in mood state (initiated 09/15/25)- History of behaviors (initiated 09/15/25)- Risk for Falls (initiated 08/24/23)- At risk for potential nutrition problem (initiated 07/01/22)- At risk for skin breakdown (initiated 07/08/22)- Alteration to activities of daily living (initiated 07/05/22)Although the Care Plan Meeting on 03/19/26 indicated the Care Plan was updated, Resident #2's Care Plan had an Estimated Date for Goals to be met as 03/19/26. During a telephone interview on 05/08/26 at 3:10 P.M., the MDS Coordinator said the Care Plan Meeting should not occur prior to the completion of the MDS. The MDS Coordinator said the Care Plans are reviewed to ensure they are accurate to the resident, that interventions are appropriate to the resident and that goals are realistic and attainable. The MDS Coordinator said Resident #1's and Resident #2's estimate goal dates should have been noted about 90 days from the Care Plan meeting date and were not.