STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225562	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oc Milford Gardens LLC	10 Veterans Memorial Drive Milford, MA 01757

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **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 severe cognitive impairment and was dependent on staff to meet his/her care needs, the Facility failed to ensures staff consistently implemented and followed their abuse policy, when on 12/13/25 after Nurse #1 was made aware of an allegation that Resident #1 was abused by a staff member, and the following day the Nursing Supervisor was also made aware of the same allegation, however neither of them immediately reported it to facility administration, as required.Findings include: Review of the Facility's Policy titled, Abuse, dated as revised March 2023, indicated that;- the Facility must ensure that alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and exploitation are reported immediately to the administrator and Director of Nurses of the facility utilizing the chain of command,-staff will follow [Facility Name] Policy and Procedure on investigation of abuse, mistreatment, or neglect, and-reporting timeline requirements for all allegations:1.immediate supervisor2. two-hour requirement to report to the Department of Public Health and local law enforcement.Resident #1 was admitted to the Facility in December 2025, diagnoses included dementia, and generalized muscle weakness.Resident #1's Minimum Data Set (MDS) Comprehensive Assessment, dated 12/10/25, indicated he/she had severe cognitive impairment, and was dependent on staff to meet his/her care needs.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted 12/15/25, indicated that the Administrator received report that Resident #1's family member complained about rough handling by Certified Nurse Aide (CNA) #1 during care that caused bruising on his/her arm. The Report indicated that CNA #1 was suspended [on 12/15/25] pending the investigation.Review of the Facility's Internal Investigation Report, undated, indicated that a Police Officer came to the facility on [DATE] and reported that Resident #1's family reported to the Police yesterday (12/14/25), that Resident #1 was handled roughly during care by CNA #1. The Report indicated that CNA #1 was interviewed [12/15/25] and then suspended.During an interview on 01/13/26 at 12:45 P.M., Nurse #1 said that on 12/13/25, she heard Family Member #1 yelling and swearing at CNA #1 saying that he (CNA #1) was abusing him/her (Resident #1) and that he (CNA #1) caused bruises on Resident #1's arms. Nurse #1 said she stepped away from the situation because Family Member #1 was yelling at CNA #1 and she did not want to be involved.There was no documentation to support Nurse #1 notified her supervisor or administrative staff of the altercation between Resident #1's family member and CNA #1 or of the allegation of abuse that the family member made at that time. During a telephone interview on 01/14/26 at 1:01 P.M., which included review of her written witness statement, undated, the Nursing Supervisor said that on 12/13/25, Family Member #1 told her that CNA #1 had not properly cleaned Resident #1.The Nursing Supervisor said that the next day (12/14/25), Family Member #1 told her that she (Family Member #1) wanted to talk to CNA #1 because she thought he (CNA #1) was responsible for bruises on Resident #1's arms. The Nursing Supervisor (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she did not contact the Administrator but had instead put a written statement under his door that day (Sunday 12/14/25).During a telephone interview on 01/29/26 at 11:25 A.M., the Director of Nurses (DON) said the Facility Policy indicates that all staff must immediately report any suspicion or allegation of abuse to their supervisor or administration. The DON said she was not aware of any staff knowing about the allegation of abuse involving CNA #1 and Resident #1 on 12/13/25, but said the weekend Nursing Supervisor was aware of the allegation on 12/14/25 and should have immediately reported to either her (DON) or the Administrator, but she had not.During a telephone interview on 01/28/26 at 3:50 P.M, the Administrator said that it is the policy of the Facility that when any staff member that is made aware of an allegation of abuse, or has a suspicion of abuse, they must immediately report it to their immediate supervisor, and the supervisor must immediately report the allegation or suspicion to Administration. The Administrator said that he was not made aware of an allegation of abuse by staff involving Resident #1 until 12/15/25, when the Police arrived at the Facility and told him.

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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 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. **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 severe cognitive impairment and was dependent on staff to meet his/her care needs, the Facility failed to ensure that after being made aware of an allegation of abuse that staff immediately reported it to the administration, so it could then be reported to their state agency, timely as required. On 12/13/25, Nurse #1 became aware that Resident #1's family member was angry and alleged that he/she had been physically abused by a Certified Nurse Aide (CNA), however as a result of not immediately reporting the allegation to Administration, the allegation was not reported to the state survey agency until two days later. Findings include:Review of the Facility's Policy titled, Abuse, dated as revised March 2023, indicated the following:-the Facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin, misappropriation of resident property, and exploitation, are reported immediately to the administrator and Director of Nurses of the facility utilizing the chain of command,-all abuse allegations require immediate action, and-the Facility will notify the Department of Public Health (DPH) and local law enforcement no later than two hours after an abuse allegation was received.Resident #1 was admitted to the Facility in December 2025, diagnoses included dementia, and generalized muscle weakness.Resident #1's Minimum Data Set (MDS) Comprehensive Assessment, dated 12/10/25, indicated he/she had severe cognitive impairment and was dependent on staff to meet his/her care needs.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted 12/15/25, indicated that the Administrator received report that Resident #1's family member complained about rough handling by Certified Nurse Aide (CNA) #1 during care that caused bruising on his/her arm. The Report indicated that CNA #1 was suspended [12/15/25] pending the investigation.Review of the Facility's Internal Investigation Report, undated, indicated that a Police Officer came to the facility on [DATE] and reported that Resident #1's family told Police that Resident #1 was handled roughly during care by CNA #1 yesterday (12/14/25). The Report indicated that CNA #1 was interviewed and then suspended.During an interview on 01/13/26 at 12:45 P.M., Nurse #1 said that on 12/13/25, she heard Family Member #1 yelling and swearing at CNA #1 saying that he (CNA #1) was abusing Resident #1 and that he (CNA #1) caused bruises on Resident #1's arms. Nurse #1 said she stepped away from the situation because Family Member #1 was yelling at CNA #1 and she did not want to be involved and said that she did not do anything about it.There was no documentation to support that on 12/13/25, Nurse #1 notified her supervisor or administrative staff of the altercation between Resident #1's family member and CNA #1 or of the allegation of abuse that the family member made at that time. During a telephone interview on 01/14/26 at 1:01 P.M., (which included review of her written witness statement, undated), the Nursing Supervisor said that on 12/13/25, Family Member #1 had told her that CNA #1 had not properly cleaned Resident #1 but did not mention anything about rough care or abuse. The Nursing Supervisor said that the next day (12/14/25), Family Member #1 told her that she (Family Member #1) wanted to talk to CNA #1 because she thought he (CNA #1) was responsible for bruises on Resident #1's arms. The Nursing Supervisor said she did not immediately notify administration.During a telephone interview on 01/29/26 at 11:25 A.M., the Director of Nurses (DON) said that staff are expected to report any suspicion or allegation of abuse to their supervisor or administration immediately, and then administration reports to DPH and the police immediately or within two hours once they are aware of the allegation.During a telephone interview on 01/13/25 at 3:50 P.M., the Administrator said on 12/15/25 he was made aware of the allegation of physical abuse by CNA #1 involving Resident #1 when the Police showed up (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at the Facility with Resident #1's family. The Administrator said the Police told him that Resident #1's family was alleging that CNA #1 was rough during care and caused bruising on Resident #1's arms.The Administrator said he reported to the Massachusetts Department of Public Health immediately on 12/15/25 once he was made aware. The Administrator said he was not aware that other staff were notified about the abuse allegation [Nurse #1 on 12/13/25, Nursing Supervisor on12/14/25] prior to 12/15/25 when the Police showed up at the Facility.The Administrator said it is the expectation and policy of the Facility that all staff report any allegation or suspicion of abuse immediately to their supervisor and Administration. The Administrator said all allegations of abuse must be reported to the Massachusetts Department of Public Health within two hours of when the allegation is made.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **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 severe cognitive impairment and was dependent on staff to meet his/her care needs, the Facility failed to ensure that Resident #1 and other residents on his/her unit were protected from potential further abuse by a staff member, when although Nurse #1 and the Nursing Supervisor were made aware of an allegation of physical abuse by a family member on 12/13/25 and 12/14/25, neither of them reported the allegation as required which resulted in the staff member continuing to care for and interact with the residents, and as well as a two day delay in facility initiating an investigation into the allegation.Findings include: Review of the Facility's Policy titled, Abuse, dated as revised March 2023, indicated that when any allegations of abuse, mistreatment, neglect, misappropriation of resident property is observed, reported or suspected by an employee, the following steps will be implemented:-immediately protect the residents from alleged abuse, and-immediately suspend the employee pending an investigation.Resident #1 was admitted to the Facility in December 2025, diagnoses included dementia, and generalized muscle weakness.Resident #1's Minimum Data Set (MDS) Comprehensive Assessment, dated 12/10/25, indicated he/she had severe cognitive impairment, and was dependent on staff to meet his/her care needs.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted 12/15/25, indicated that the Administrator received report that Resident #1's family member complained about rough handling by Certified Nurse Aide (CNA) #1 during care that caused bruising on his/her arms. The Report indicated that CNA #1 was suspended (12/15/25) pending the investigation.Review of the Facility's Internal Investigation Report, dated 12/15/25, indicated that a Police Officer came to the facility on [DATE] and reported that Resident #1's family reported to the Police yesterday (12/14/25), that Resident #1 was handled roughly during care by CNA #1. The Report indicated that CNA #1 was interviewed and then suspended.During an interview on 01/13/26 at 12:45 P.M., Nurse #1 said that on 12/13/25, she heard Family Member #1 yelling and swearing at CNA #1 saying that he (CNA #1) was abusing Resident #1, and that he (CNA #1) caused bruises on Resident #1's arms. Nurse #1 said she removed herself from the situation because Family Member #1 was yelling at CNA #1 and she did not want to be involved, so she did nothing about it.There was no documentation to support Nurse #1 notified her supervisor or administrative staff of the altercation between Resident #1's family member and CNA #1 or of the allegation of abuse that the family member made at that time. During a telephone interview on 01/14/26 at 1:01 P.M.,(which included review of her written witness statement, undated), the Nursing Supervisor said that on 12/13/25, Family Member #1 told her that CNA #1 had not properly cleaned Resident #1 but did not mention anything about abuse.The Nursing Supervisor said that the next day (12/14/25), Family Member #1 told her that she (Family Member #1) wanted to talk to CNA #1 because she thought he (CNA #1) was responsible for bruises on Resident #1's arms. The Nursing Supervisor said she did not immediately report the allegation to administration.There was no documentation to support that the Nursing Supervisor initiated and investigation into Family Member #1's allegation of abuse, including have CNA #1 removed from the schedule, pending an investigation.During a telephone interview on 01/29/26 at 11:25 A.M., the Director of Nurses (DON) said that on 12/15/25 the Administrator informed her about the allegation of abuse involving Resident #1 and CNA #1. The DON said any time an allegation of abuse is made against a staff member, that the accused staff member must be suspended from the Facility immediately in order to protect the resident involved, as well as other residents.The DON said because a staff member (Nursing Supervisor) was made aware of the allegation on 12/14/25, that she should have immediately reported the allegation to administration, but she did not. The DON said CNA (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 should have been suspended on 12/14/25 but had not suspended until 12/15/25. The DON said that as far as she knew, the Nursing Supervisor was the first staff member to be aware of the allegation.During a telephone interview on 01/28/26 at 3:50 P.M. the Administrator said that CNA #1 was not working at the Facility on 12/15/25 when he (Administrator) became aware that CNA #1 had been accused of physical abuse involving Resident #1, so he called CNA #1 and requested a statement and suspended him pending an investigation. The Administrator said any staff member accused of abuse should be suspended immediately, and until the Facility's investigation is complete.