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	03/04/2026

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

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of Resident Council Minutes, a resident group meeting, interviews, and document review, the facility failed to ensure grievances brought forward from the Resident Council were addressed and promptly resolved to ensure the residents felt their concerns were acted upon timely.Findings include:Review of the facility's policy titled Resident Council, undated, indicated but was not limited to the following:-the purpose of resident council is to provide a forum for residents to have input into the facility operation, discuss concerns, communication and dissemination of information-a resident council response form will be utilized to track issues, and their resolution will be discussed at the next meeting Review of the facility's policy titled: Grievances/Complaints, dated as revised 7/2025, indicated but was not limited to the following:-the resident or persons filing a grievance will be informed of findings of the investigation and actions taken to correct identified problems, by the Administrator within 10 working days of filing the grievance; a written summary will be kept in the grievance book. Review of Resident Council Minutes, dated 9/26/25, indicated but were not limited to:-3:00 P.M. to 11:00 P.M. (3-11) staff are not speaking EnglishReview of the corresponding departmental response form indicated but was not limited to:-Staff not always speaking English on the units - will in-service; in-service with the 3-11 staff ongoing Review of Resident Council Minutes, dated 10/27/25, indicated but were not limited to:-Agency nursing staff continue to not speak EnglishReview of the corresponding departmental response form indicated but was not limited to:Staff continues to not speak English in resident areas - ongoing in-service and audits through Resident Council Review of Resident Council Minutes, dated 11/26/25, indicated but were not limited to: Still having agency staff speaking non-English on unitReview of the corresponding departmental response form indicated but was not limited to:Staff continues to not speak English in resident areas - ongoing in-service and audits through resident council; always having new staff hired and new agency Review of Resident Council Minutes, dated 12/22/25, indicated but were not limited to:-Staff not speaking English on units is getting betterReview of the corresponding departmental response form indicated but was not limited to:Improvement, but staff is not speaking English on the units at times - continue in-service and recommend residents participate in identifying individuals who fail to follow policy Review of Resident Council Minutes, dated 1/28/26, indicated but were not limited to:-Staff continuing to not speak English in resident area (grievance in process)Review of the corresponding departmental response form indicated but was not limited to:Staff continues to not speak English in resident areas - ongoing in-service, new staff are hired and they need to be in-serviced On 2/27/26 at 11:04 A.M., the surveyor held a group meeting with 11 residents in attendance. The residents shared the following information:-9 out of 11 residents in attendance said staff are still not speaking English on the units or in resident areas and they expressed a feeling of the staff speaking negatively about them and trying to be sneaky. This concern remains unresolved since September 2025.- 10 out of 11 residents said they feel unheard by the facility when repeatedly bringing forth concerns and the facility had offered nothing but in-servicing as an attempt to solve concerns, which was ineffective in resolving their concern about staff speaking a foreign language.-9 out of 11 residents in attendance said they don't feel that the facility tries to resolve the issues that they bring forward in Resident Council or provide a plan to resolve the (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	issue. During an interview on 2/27/26 at 12:25 P.M., the Activity Director said she manages the Resident Council meeting minutes and assists the residents with the process. She said when issues arise in Resident Council, she completes the Departmental response form, and it is discussed at morning meeting the next day. She said issues that the residents feel strongly about or are repetitive or severe in nature go directly onto a grievance form. She said the Resident Council had an ongoing unresolved concern about staff not speaking English for many months and she had initiated a grievance for it a few months ago, but the residents continue to voice it as an ongoing concern. She said the grievance was provided to the Administrator who is the grievance officer in the facility. She said the only feedback that she had been able to report to the residents in response to their ongoing concern is in-servicing and she was unaware of any other attempted interventions to solve the Resident Council's concern. She said she agreed with the residents' statement that issues are not always resolved through the Resident Council process as they should be in a timely manner and that the process needed work to resolve the Resident Council concern for staff not speaking English on the units. Review of the facility's Grievance Book from February 2025 to March 2026 indicated but was not limited to the following:-9/26/25: Resident Council concern of: Employees not speaking English on the unitsInvestigation: provide in-services to staff starting 9/26/25Resolution: survey Resident Council regarding this issue at next meeting (21 working days after the initiation of the grievance)The grievance form failed to indicate the grievance was resolved, a date of resolution, or that the plan was communicated to the Resident Council within 10 working days, in accordance with the facility practice/policy. During an interview on 3/4/26 at 12:03 P.M., the Staff Development Coordinator provided all in-services completed in the facility from August 2025 to March 4, 2026, for review.Only one in-service was completed regarding staff speaking a foreign language in resident areas on 9/26/25.The facility could not provide the survey team with any follow up education on this topic by the time of exit. During an interview on 2/27/26 at 1:11 P.M., the Administrator said he is the grievance official for the facility and reviews all concerns brought forth by the Resident Council. He said the concern of staff speaking a foreign language in resident areas may never be resolved as it is a behavior and changing other people's behavior is an ongoing situation that may not be fixed at all. He said he was not aware that the residents felt unheard by the facility in regard to this ongoing concern. He said the facility was attempting to in-service staff on the issue and he wasn't aware that there was no ongoing improvement. He said the facility had initiated audits and considered a performance improvement plan for this unresolved concern, but again there is potential the issue will remain unresolved. He said he should probably have communicated more detailed interventions and attempts to resolve the concern with the Resident Council, and he can see how this lack of communication would make the residents feel like the process was not working as intended.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews, and record review, the facility failed to ensure one Resident (#28), out of a total sample of 23 residents, received care and treatment in accordance with professional standards. Specifically, the facility failed to obtain a physician's order and/or include a left heel boot in the plan of care. Findings include: Review of the facility's policy titled Resident Mobility and Range of Motion, undated, indicated the care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. And the care plan will include type, frequency, and duration of interventions. Review of the facility's policy titled Charting and Documentation, undated, indicated but was not limited to the following:-All services provided to the resident, progress toward care plan goals, or any changes on the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.-The following information is documented in the medical record: Treatments or services performed.-Documentation of procedures and treatments will include specific details including date/time provided, assessment data, how the resident tolerated the procedure/treatment. Review of the Lippincott Manual of Nursing Practice, 11th Ed. (2019) indicated: Scope of Practice, Licensure, and Certification: The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. The National Council of State Boards of Nursing and the National League of Nursing have developed standards that guide each State Board in the development of their licensure requirements and scope of practice rules. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice dated as revised April 11, 2018, indicated but was not limited to the following:Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Resident #28 was admitted to the facility in December 2025 with diagnoses which included cerebral infarction (CVA/Stroke), hemiplegia (paralysis on one side) and hemiparesis (weakness on one side) following a CVA affecting left non-dominant side, and a fractured left heel. Review of the Minimum Data Set (MDS) Assessment, dated 1/4/26, indicated he/she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. Additionally, Resident #28 had a CVA with hemiparesis and was at risk for pressure ulcers. Review of the Physician's Orders indicated but were not limited to the following:-Left CAM boot (hard orthotic boot to immobilize and protect foot/ankle while allowing limited walking during recovery from injuries like fractures) on for transfers and when out of bed (OOB) every day and evening shift for fractured left heel and toes. (12/30/25)-Apply left resting hand splint per patient's tolerance daily and remove daily to assess skin for skin integrity. (1/12/26) Review of the Comprehensive Care Plan indicated but was not limited to the following:-Resident has Activities of Daily Living (ADL) self-care performance deficit functional limitations, limited mobility. (12/29/25)-Apply left resting hand splint per patient's tolerance daily and remove daily to assess for skin integrity. (2/27/26)-Resident has potential for skin breakdown due to decreased mobility and impaired circulation. (12/25/25) The surveyor made the following observations:-2/25/26 at 4:00 P.M., Resident lying in bed with soft left heel boot on.-2/26/26 at 1:13 P.M., Resident lying in bed with soft left heel boot on.-2/27/26 at 1:20 P.M., Resident lying in bed with soft left heel boot on. During an interview on 2/25/26 at 4:00 P.M., Resident #28 said he/she wears the CAM boot when out of bed and the soft boot while in bed every day. The Resident said someone from Occupational Therapy (OT) gave it to him/her, and he/she has had it for a while. Resident #28 said the staff never put the soft boot on correctly and OT did some education of how to put it on, but staff still don't do it right. Review (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the OT treatment notes failed to indicate he/she had a soft heel boot or any treatment plan for a soft heel boot. During an interview on 2/27/26 at 1:23 P.M., Certified Nursing Assistant (CNA) #2 said Resident #28 has had the soft boot for a while, at least a few weeks, and he/she wears it in bed every day. She said the CNA Assignment sheet doesn't say anything about a brace, so if we have questions then we ask the nurse. She said there is no other place they can get resident specific care information and they do not have a Care Card or anything like that to give instructions. During an interview on 2/27/26 at 1:25 P.M., Nurse #4 said there is no written communication tool for the CNAs. She said if they have questions about a brace or splint they must ask the nurse. She said the nurses get information when things change from therapy and there would be a physician's order for any brace or splint, so the nurse would know when they should be applied and removed. During an interview on 2/27/26 at 1:30 P.M., Rehab Staff #1 said if a resident has a splint or brace given by OT then they enter the order in the computer and the nurse gets it approved by the physician. She said we do an education sheet with the staff and keep that form in the binder in the Rehab Office. She said soft boots usually do not come from OT and was unsure who gave it to Resident #28. She was unable to provide an education form for any splint/brace/boot education that may have been done as there was nothing for Resident #28 in the binder. During an interview on 2/27/26 at 1:33 P.M., the Director of Rehab said the therapists will enter the orders in the computer and nursing completes the order and updates the care plan. She said Resident #28 wears the CAM boot out of bed because of the heel and toe fractures. She said it comes off in bed, but she was unaware of a soft boot. She said when therapy does education with a device it is documented on this Transition of Care from Rehab to Nursing form and she did not have one for Resident #28. She said he/she came to the facility with the CAM boot but was unsure where the soft boot came from. During an interview on 2/27/26 at 1:42 P.M, Rehab Staff #2 said she did not provide Resident #28 with the soft boot. She said Resident #28 has asked her to put it on him/her sometimes and he/she does wear it in bed. During an interview on 3/3/26 at 10:13 A.M., Nurse #3 said there should be an order for any device, so the nurses know when to put it on and when to remove it. She said Resident #28 has two devices for the left leg. She said the CAM boot has an order in the computer, but the soft boot does not, and it should. She said she was going to check with therapy because the Resident does wear it every day. During an interview on 3/3/26 at 12:55 P.M., the Director of Nurses (DON) said sometimes there may not be an order for a brace/splint, but it should at least be in care plan if it's not an order. She said staff are educated by therapy on how to put them on/off and the schedule of what to do should be documented somewhere so staff know what to do, but there was nothing about the soft boot on the care plan or in the orders. During an interview on 3/3/26 at 1:55 P.M., Unit Manager (UM) #2 said there probably should have been an order for the soft boot, as staff would look in the orders to find out when to put braces/splint on and when to take them off. He said the order for the CAM boot has been there, but the order for the soft boot is new, it was not there previously, and Resident #28 has been wearing it in bed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure one Resident (#59), out of a total sample of 23 residents, was provided an environment as free of accident hazards as possible and received adequate supervision and assistance to prevent accidents. Specifically, the facility failed to ensure person-centered interventions were developed and implemented related to the root cause of the falls to mitigate the risk of future falls and/or injury resulting in five falls in three months after he/she had sustained a fall with fracture and had a change in mobility and continence. Findings include: Review of the facility's policy titled Falls-Clinical Protocol, undated, indicated but was not limited to the following:-While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause.-Examples of risk factors include musculoskeletal abnormalities, gait and balance disorders, weakness, environmental hazards, and medical conditions.-The staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risk of clinically significant consequences of falling. Review of the facility's policy titled Care Plans-Comprehensive, dated as last revised 7/2023, indicated but was not limited to the following:-Each resident's comprehensive care plan is designed to incorporate risk factors associated with identified problems.-Care plan interventions are designed after careful consideration of the relationship between the resident's problem area(s) and their causes.-The Care Planning/Interdisciplinary Team (IDT) is responsible for the review and updating of care plans when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly. Resident #59 was admitted to the facility in December 2024 with diagnoses which included mild cognitive impairment, protein calorie malnutrition, spinal stenosis, repeated falls, and fracture of the right femur. Review of the Minimum Data Set (MDS) Assessment, dated 12/23/25, indicated he/she scored 8 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had moderate cognitive impairment, had orthopedic surgery to repair a fracture, did not have any falls since the last assessment, used a wheelchair, was occasionally incontinent, not on a toileting program, and required supervision/touching assistance with transfers and toileting. During an observation with interview on 2/25/26 at 9:55 A.M., the surveyor observed Resident #59 sitting in his/her wheelchair self-propelling around their bedroom. The Resident said he/she fell and broke their hip a while ago and had a few other falls because he/she was clumsy. Review of the Comprehensive Care Plan indicated but was not limited to the following:PROBLEM: Resident is a risk for falls/recent falls.INTERVENTIONS: Low Bed, Divert Resident with alternate activities, encourage to sit in chair instead of on the edge of the bed, obtain resident input, reposition items as needed, therapy eval for multiple falls, call for assistance and encourage to attend activities. PROBLEM: Resident is frequently incontinent of urine with potential for improved control or management of urinary elimination.INTERVENTIONS: Provide access to the bathroom, provide privacy and comfort, and provide verbal cues and physical assistance as needed. PROBLEM: Resident is at risk for decreased ability to perform Activities of Daily Living (ADLs) related to fall with hip fracture and surgical repair.INTERVENTIONS: Resident requires staff participation with bathing, dressing, transfers, and toileting needs. Review of the Resident Care Card/Kardex indicated but was not limited to the following:-Transferring: Resident requires staff participation.-Dressing: Resident requires staff participation.-Bathing/Showering: Resident requires staff participation.-Personal Hygiene: Resident requires staff participation.-Bladder/Bowel: Resident requires staff participation. Review of the medical record indicated Resident #59 had a fall on 10/8/25 resulting in a hip fracture. He/she had subsequent falls on 11/13/25, 12/25/25, 12/29/25, 1/14/26, and 1/18/26. Review of the Incident Reports indicated but were not limited to the following: FALL 10/8/25 at 3:30 A.M., Resident #59 heard a noise at night (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and jumped out of bed, resulting in a fall with a hip fracture.-Prior to this fall he/she was independent with transfers and ambulation and was continent of their bowel/bladder.-He/she was transferred to the hospital. FALL 11/13/25 at 7:00 P.M., Resident #59 called for help and was found in the bathroom on the floor and stated they had to use the bathroom. -On 11/17/25 the Falls Care Plan was updated to Divert Resident by giving alternative objects or activities as needed. FALL 12/25/25 at 6:45 P.M., Resident #59 was sitting on the bathroom floor barefoot and told staff they were trying to transfer off the toilet and slid to the floor.-Therapy eval was ordered for multiple falls and self-transferring. FALL 12/29/25 at 6:30 A.M., Resident #59 called for help and was observed sitting on the floor next to the bed. He/she stated they had to go to the bathroom and slid out of wheelchair. The wheelchair was not locked and moved back during the transfer.-Falls Care Plan was updated to reposition items as needed to location within visual field. FALL 1/14/26 at 3:30 A.M., Resident #59 observed sitting on the floor. They were trying to use the bathroom, did not lock the wheelchair, and fell self-transferring from the bed to the chair.-Falls Care Plan was updated to obtain resident input on strategies to anticipate needs and to prevent future falls. They reported they need to position the wheelchair properly next to the bed prior to transfer. FALL 1/18/26 at 9:30 P.M., Resident #59 was observed sitting on the floor next to the bed. They said they were transferring to the wheelchair and slid to the floor.-Falls Care Plan was updated to include floor mats. The intervention was discontinued the next day at the resident's request. Review of the Therapy Evaluation and Treatment notes indicated but were not limited to the following:-Occupational Therapy (OT) Discharge summary, dated [DATE], indicated he/she required supervision with all aspects of ADLs. Specifically, supervision or touching assistance with toileting and transfers.-Physical Therapy (PT) Discharge summary, dated [DATE], indicated he/she needed one assist to transfer, ambulate daily, and required supervision or touching assistance for toilet transfer and bed to chair transfers.-PT Evaluation and Plan of Treatment, dated 12/30/25, indicated he/she was ambulating with contact guard assist with walker when discharged from PT but has not walked with staff since discharge on [DATE]. At time of discharge, he/she required supervision level for transfers and contact guard for gait. Presenting today with decreased balance, standing tolerance, impaired safety awareness/insight, and decreased tolerance secondary to minimal mobility since discharge.-PT Discharge summary, dated [DATE], indicated he/she needed 24-hour care and required supervision with all transfers, and supervision/touching assistance for bed to chair and toileting transfers. Review of the Toilet Transfer, Toilet Hygiene, Toilet Use, and Bed/Chair Transfer documentation log for 2/1/26 though 3/3/26 indicated he/she was coded as Independent/No assistance from a helper greater than 50% of the time. The surveyor made the following observations:-2/27/26 at 9:51 A.M., Resident #59 was sitting in his/her wheelchair self-propelling around the unit. He/she approached the nurses' station and stood up at the desk without locking the wheelchair brakes.-2/27/26 at 10:52 A.M., Resident #59 was sitting in his/her wheelchair self-propelling around the unit. He/she told the Activities staff they needed to use the bathroom and then wheeled past the desk in the direction of their room and asked a staff member if they could get into their bathroom now. The staff member told the Resident he/she could get into the bathroom in their room, and then she walked away in the other direction. Resident #59 proceeded to self-propel to their room unassisted to use the bathroom.-3/3/26 from 9:08 A.M. until 10:01 A.M.: At 9:08 A.M., Resident #59 was in the bathroom inside their bedroom. Resident #59 exited the bathroom at 9:59 A.M., seated in the wheelchair, self-propelling to the other side of the room. The Resident was barefoot, dragging a towel from the wheelchair, carrying three hangers and a pair of socks. The Resident told the roommate they had to go back into the bathroom to clean up the mess from getting ready. At 10:01 A.M., the Resident was sitting in the wheelchair putting their socks on. Throughout the observation, no staff entered the bathroom to assist Resident #59 with toileting, dressing, or cleaning up the bathroom after he/she was done. During an interview on 3/3/26 at 10:14 A.M., Nurse #3 said when a resident falls, they complete the assessments, incident report, and then the care plan is updated with a new intervention related to the fall. She said the Director of Nurses (DON) is notified (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and they review the falls at risk meeting. During an interview on 3/3/26 at 1:55 P.M., Unit Manager #2 said after a fall the incident report and assessments are done and then the nurse should be updating the care plan. He said Resident #59 is stubborn and falls all the time, but in reviewing the incident reports he would expect interventions to be related to toileting and transfers. He said he/she requires assistance with toileting and transfers, and he/she should not be toileting self or left in the bathroom alone, and staff should not be telling him/her they can go alone. During an interview on 3/3/26 at 1:10 P.M., the DON said after a fall the post fall and risk management is done. She said they try to figure out the cause of the fall and anyone who is clinical can update the care plan. The surveyor reviewed the five falls with the DON and the intervention added if any at the time of the fall. The DON said the fall on 11/13/25 was related to toileting and transfers and the intervention does not address that. She said at the time she thought maybe the self-toileting was a behavior. She said after the fall on 12/25/25 was also related to toileting and nothing was added until they fell again on 12/29/25 attempting to transfer to use the bathroom and a therapy eval was ordered, but the toileting was not addressed. She said Resident #59 had two more falls in January. She said the fall on 1/14/26 the intervention was added to obtain resident input and wheelchair positioning was added to the care plan. The DON said the care plan indicates he/she needed staff participation, which is assistance, so that intervention does not address the issue of toileting and transfers either because they require assistance with both. After the fall on 1/18/26 floor mats were added but then resolved the next day because they did not work for the Resident. She said after they were resolved nothing else was added. The DON said she can see now how the interventions do not address the cause of the fall and a way to try and prevent future falls because all five falls were around toileting and transfers The surveyor reviewed the medical record with the DON which indicated Resident #59 was independent and continent of urine prior to the fall with hip fracture and since then they have required assistance. The MDS indicated occasional incontinence, and they have had five falls related to toileting with no toileting interventions implemented. The DON said she didn't realize the Resident was continent prior to the hip fracture so maybe the toileting was not a behavior and said they would need to start a diary. The surveyor reviewed the observation from 2/27/26 when staff advised Resident #59 he/she could go to the bathroom and from earlier in the morning when he/she was in the bathroom for 55 minutes alone. The DON said she would expect staff to assist Resident #59 with toileting and transfers and not tell them they could go alone or leave them in the bathroom for an hour alone.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations and interviews, the facility failed to ensure activity of daily living (ADL) care was provided to maintain good personal grooming for one Resident (#63), in a total sample of 23 residents. Specifically, the facility failed to ensure nail care was performed for Resident #63. Findings include: Review of the facility's policy titled Activities of Daily Living (ADL), undated, indicated residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, and personal hygiene. Resident #63 was admitted to the facility in January 2026 with diagnoses which included intervertebral disc degeneration and weakness. Review of the Minimum Data Set (MDS) Assessment, dated 2/16/26, indicated he/she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) Assessment, indicating he/she was cognitively intact and was dependent on staff for assistance with ADLs. Review of the Comprehensive Care Plan indicated Resident #63 had an ADL self-care performance deficit due to weakness and degenerative disc disease.During an interview on 2/25/26 at 8:49 A.M., Resident #63 said he/she had a pair of toenail clippers, the big ones, that he/she used for fingernails because the little ones are too hard to manipulate. The Resident said the staff took them and put them somewhere; staff said they could not be in his/her room. The Resident said since then he/she has been asking to have their nails cut and no one will do it. The Resident said he/she was unsure where the nail clippers are now because staff took them before he/she moved units. Resident #63 said they have asked multiple nurses and Certified Nursing Assistants (CNAs) to cut them, and no one will do it.The surveyor made the following observations of Resident #63 sitting in their room:-2/25/26 at 8:49 A.M., nails on both hands long and dirty with dark substance underneath the nails.-2/26/26 at 9:45 A.M. and 1:17 P.M., nails on both hands long and dirty with dark substance underneath the nails.-2/27/26 at 9:12 A.M., nails on both hands long and dirty with dark substance underneath the nails.-3/3/26 at 10:03 A.M., nails on both hands clean and trimmed. Review of the shower schedule indicated Resident #63 was scheduled for a shower on Thursdays on the 7-3 shift. (2/26/26 was a Thursday) During an interview on 2/27/26 at 11:20 A.M., CNA #1 said every Resident is showered weekly. He said they do the shower and weight, and the nurse does the rest. During an interview on 2/27/26 at 1:12 P.M., Nurse #1 said Resident #63 cannot cut their own nails. She said the CNAs or a nurse will do it. She said they are cut whenever they are long, dirty, or if someone asks. During an interview on 2/27/26 at 1:15 P.M., Unit Manager (UM) #1 said she recalled Resident #63's nail clippers being locked in the cart but was unsure where they were now since he/she moved units. She thought they moved with him/her. She said the CNAs do nail care weekly on the shower day and as needed if they are long, dirty, or if the resident asks. During an interview on 3/3/26 at 10:07 A.M., Nurse #3 said nail care should be done on the shower day and whenever it is needed. During an interview on 3/3/26 at 1:00 P.M., the Director of Nurses (DON) said nail care should be done on shower days, as needed if they are dirty, and when a resident asks. She said if a resident asked for fingernails to be trimmed she would expect it to be done as soon as possible that day. During an interview on 3/3/26 at 2:00 P.M., UM #2 said nail care should be done on the shower day. He said staff can cut fingernails but not toenails. He said he would expect nails to be clean and trimmed if requested.

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	03/04/2026

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

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and interviews, the facility failed to ensure staff provided appropriate care and services for one Resident (#12) with a Gastrostomy tube (G-tube: a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition, fluids, and medication), out of 23 sampled residents. Specifically, the facility failed to ensure enteral feedings (provide nutrition directly into gastrointestinal tract) were administered via G-tube in accordance with physician's orders.Findings include:Review of the facility's policy titled Enteral Tube Feeding via Continuous Pump, dated as revised 7/2025, included but was not limited to:- The purpose of this procedure is to provide a guideline for the use of a pump for enteral feedings.- Preparation: Verify that there is a physician's order for this procedure.- General Guidelines: Check the enteral nutrition label against the order before administration. Check the following information: Resident name, ID, and room number; type of formula; date and time formula was prepared; route of delivery; access site; method (pump, gravity, syringe); and rate of administration (milliliters (mL)/hour).-Steps in the Procedure:-Verify placement of tube-When correct tube placement has been verified, flush tubing with at least 30ml warm water (or prescribed amount).- Initiate Feeding: On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order. Resident #12 was admitted to the facility in January 2026 with diagnoses including cerebral infarction (type of stroke caused by a blockage in an artery that restricts blood flow to the brain) and aphasia (difficulty speaking).Review of the Minimum Data Set (MDS) assessment, dated 1/8/26, indicated Resident #12 had a Brief Interview for Mental Status (BIMS) score of 10 of 15, indicating he/she was moderately cognitively impaired. Review of Section K: Swallowing/Nutritional Status of the MDS assessment indicated Resident #12 was receiving nutritional support through a feeding tube and he/she received 51% or more of total calories through the feeding tube. The assessment also indicated the Resident was averaging 501 cubic centimeters (cc) per day or more of fluid intake.Review of Resident #12's current Physician's Orders indicated but were not limited to:- Start Date 1/8/26: NPO (nothing by mouth) - tube feeding only diet: NPO texture, NPO consistency.-Start Date 1/21/26: Enteral Feed Order Up 12:00 P.M., Down 10:00 P.M., Jevity 1.5 Cal Administer continuous via Pump 150 milliliters per hour (ml/hr).-Start Date 1/21/26: Free Water: 80ml/hr while running tube feeding Up 12:00 P.M., Down 10:00 P.M.-Start Date 1/12/26 Check placement of feeding tube prior to each use.Review of Resident #12's Nutrition Assessment, dated 1/14/26, indicated the Resident was receiving tube feeding through G-tube placement. The Dietitian documentation indicated recommendations were made to adjust the tube feeding to 150 ml/hour x 10 hours. On 2/26/26 at 12:58 P.M., the surveyor observed Resident #12 resting in bed. The enteral feeding pump was placed on a pole next to the bed without any feeding, water, or tubing present.On 2/26/26 at 1:26 P.M., the surveyor observed Resident #12 resting in bed. The enteral feeding pump was placed on a pole next to the bed without any feeding, water, or tubing present.During an observation with interview on 2/26/26 at 1:29 P.M., the surveyor observed Nurse #6 seated behind the nursing station having a snack. Nurse #6 said she has not hung Resident #12's tube feeding yet because she is running late and has had many interruptions on her medication pass. She said the tube feeding runs in very slowly so it should not be a problem for the Resident that it is late.On 2/26/26 at 1:43 P.M., the surveyor observed Nurse #6 enter Resident #12's with a feeding bottle, bag of water, and tube feeding supplies. Nurse #6 hung the feeding and programmed the pump at a rate of 150 ml/hour and programmed the water flush with rate of 80 ml/hour. She flushed the feeding tube with 60ml/water via a piston syringe (device used to inject fluids) and then connected the feeding tubing to the G-Tube and started the pump. Nurse #6 did not check residual aspirate (volume of fluids withdrawn from the stomach to assess digestion and gastric emptying), or placement of the feeding tube prior to the start of the feeding. On 3/2/26 at 1:26 P.M., the surveyor observed Resident #12 (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resting in bed with enteral feeding running. Written on the bottle in black marker was the date of 3/2/26, time of 12:00P.M., and a rate of 50ml/hr. The feeding pump was programmed at 80ml/hr. The water flush was also programed for 80ml/hr.On 3/2/26 at 4:25 P.M., the surveyor observed Resident #12 resting in bed with enteral feeding running. Written on the bottle in black marker was the date of 3/2/26, time of 12:00P.M., and a rate of 50ml/hr. The feeding pump was programmed at 80ml/hr. The water flush was also programed for 80ml/hr. During an interview on 3/2/26 at 4:33 P.M., Unit Manager (UM) #1 said she prepared and administered Resident #12's feeding because she is the nurse providing care today. The Surveyor and UM #1 reviewed Resident #12's physician's order and observed Resident #12's feeding pump together. The pump was set to 80ml/hr with a rate written on the bottle of 50ml/hr. UM #1 said the pump should be set to 150ml/hr per the physician's order. UM #1 said she did not check the order prior to administering the feeding. She said she is not sure why she wrote a different rate on the bottle than what she set the pump at. UM #1 said both rates are incorrect.During an interview on 3/3/26 at 10:36 A.M., Nurse #6 said she did not check placement of Resident #12's feeding tube the other day because she is not required to do so. Nurse #6 reviewed the physician's order to check placement prior to use and said she did not realize Resident #12 had an order to do so.During an interview on 3/3/26 at 10:50 A.M., the Dietitian said Resident #12 was receiving bolus feedings when she first came to the facility. She said Resident #12's family requested the feedings be changed to continuous because the Resident was saying he/she was hungry. The Dietitian said she is not notified by nursing if the feeding is administered late or at the wrong rate. She said she monitors the Resident's nutritional status by his/her weekly weights.During an interview on 3/3/26 at 4:02 P.M., the Assistant Director of Nursing (ADON) said all nurses must demonstrate competency of caring for a G-tube prior to having a resident with one on their assignment. The ADON said the competency consists of checking the tube for placement and residual.During an interview on 3/4/26 at 9:18 A.M., the Director of Nursing (DON) said enteral feeding should be given at the time ordered to ensure the Resident is receiving adequate nutrition. She said all physician's orders should be double checked prior to setting up the feeding to ensure it is given at the ordered rate. The DON said her expectation is for placement of the feeding tube to be checked prior to use if there is a physician's order to do so.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure staff maintained accurate medical records for one Resident (#5), out of a total sample of 23 residents. Specifically, the facility failed to ensure nursing staff accurately documented the use of an as needed (PRN) medication on the medication administration record (MAR).Findings include:Review of the facility's policy titled Administering Medications, last revised 7/2025, indicated but was not limited to:-The individual administering the medication initials the resident's Medical Administration Record (MAR) on the appropriate line after giving each medication and before administering the next ones.-As required or indicated for a medication, the individual administering the medication records [sic] in the resident's medical record: -the date and time the medication was administered. Resident #5 was admitted to the facility in January 2026 with diagnoses including osteoarthritis and pressure ulcer of the sacral (base of the spine) region. Review of the Minimum Data Set assessment (MDS), dated [DATE], indicated Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating he/she was cognitively intact. Further review indicated Resident #5 had received an opioid (a strong prescription pain reliever) medication during the review period. Review of Resident #5's Physician's Orders indicated but was not limited to:- Oxycodone tablet (opioid pain reliever) 5 milligrams (mg), give 1 tablet by mouth every 4 hours as needed for pain, give one tab for moderate pain of 4-6 and two tabs for severe pain 7-10 (start date: 1/18/2026) Review of the MAR indicated Resident #5 received Oxycodone 21 times from 2/7/26 to 3/3/26. Review of the Narcotic Book (a record book used in healthcare settings to track and document the administration and handling of controlled substances) indicated Resident #5 had received his/her Oxycodone 38 times from 2/7/26 to 3/3/26. Further review of Resident #5's MAR indicated the use of his/her Oxycodone had not been documented 17 out of 38 times (44.7% of the time). During an interview on 3/3/26 at 3:03 P.M., Nurse #5 said when a resident receives a PRN medication that is a narcotic, it should be documented the time it is given in the MAR and in the narcotic book. During an interview on 3/3/26 at 4:09 P.M., Unit Manager (UM) #1 said when a PRN medication is administered it must be documented on the MAR. She said if it is a narcotic, it must be signed out of the narcotic book as well. UM #1 and the surveyor reviewed Resident #5's Oxycodone MAR and narcotic book together. She said she administered Oxycodone to Resident #5 and got busy and forgot to document on the MAR. She said the documentation did not match as it should and is inaccurate. During an interview on 3/4/26 at 9:18 A.M., the Director of Nursing (DON) said it was her expectation for nurses to document all narcotic PRN medication administration on the MAR as well as in the narcotic book. She said the MAR reflects what has been given to the Resident and if it is not documented it could potentially lead to a medication error.