STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225573	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sancta Maria Nursing Facility	799 Concord Avenue Cambridge, MA 02138

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43846 Based on observation, record review, and interview, the facility failed to notify the physician of a change in condition related to a 12.6 pound (lbs.) weight gain in one day for one Resident (#328) out of a total sample of 27 residents. Findings include: Review of the facility policy titled Notification of Change in Resident Condition, not dated, indicated Nursing Leadership/Primary Nurse shall notify the resident, consult with the resident's physician and notify family/responsible party when any of the following occurs: i. Examples of Change in Condition that require notification: 2. Change in condition- vital signs, abnormal lab values. If contact is successful, Nursing Leadership/Primary Nurse shall document in the resident's medical record date and time contact was made and information conveyed. If contact is initially unsuccessful, Nursing Leadership/Primary Nurse shall document subsequent attempts to contact resident, physician and family/responsible party in the medical record. - When there is a significant change in treatment required that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment; A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences, such as an adverse drug reaction, or begin a new form of treatment to deal with a problem that has not been used on that resident before. Resident #328 was admitted to the facility in February 2025 with diagnoses that included chronic diastolic congestive heart failure, scabies, end stage renal disease, and toxic encephalopathy. Review of Resident #328's Brief Interview for Mental Status (BIMS), dated 2/14/25, indicated he/she scored an 11 out of a possible 15 indicating he/she as having moderate cognitive impairment. Review of Resident #328's weights indicated: - 2/15/25 161.2 Lbs. - 2/16/25 160.8 Lbs. (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
	225573	A. Building B. Wing	02/26/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/17/25 173.4 Lbs. - 2/18/25 174.5 Lbs. - 2/19/25 174.6 Lbs. - 2/20/25 172.4 Lbs. - 2/21/25 170.8 Lbs. - 2/24/25 167.6 Lbs. - 2/25/25 170.2 Lbs. Review of Resident #328's Congestive Heart Failure (CHF) care plan, dated 2/14/25, indicated Daily weight, record in log, if weight 3# or greater in 2 days or 5# or greater in one week, notify MD/NP (Medical Doctor/Nurse Practitioner). Review of Resident #328's physician order, dated 2/17/25, indicated CHF: Daily weight. Notify MD/NP if weight is > or equal to 3 lbs. (pounds) in 2 days or 5 lbs./week. Review of Resident #328's nursing progress notes 2/16/25 to 2/24/25 failed to indicate that the MD was notified with the 12.6 lbs. weight gain in one day or any weight gain thereafter. Review of Resident #328's MD/NP assessments dated from 2/16/25 to 2/24/25 failed to indicate that the MD or NP assessed the Resident's weight gain. Review of Resident #328's nursing weight change note, dated 2/25/25, indicated both feet noted with 1+ pitting edema. During an interview on 2/25/25 at 2:15 P.M., Charge Nurse #2 said the Resident gained over 10 lbs. last week over many days and the MD should have been notified before today but was not. During an interview on 2/26/25 at 2:20 P.M., the Director of Nursing (DON) said he expects nursing to follow the doctors order and to notify the MD of Resident #328's weight gain and write a progress note.

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	225573	A. Building B. Wing	02/26/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record reviews and interviews, the facility failed to 1) implement a skin integrity care plan for one Resident (#89) and 2) failed to develop a care plan for antipsychotic medication use for one Resident (#27) out of a total sample of 27 residents. Findings include: 1. Resident #89 was admitted to the facility in November 2021 with diagnoses including stroke, hemiplegia and diabetes. Review of Resident #89's most recent Minimum Data Set, dated dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 7 out of a possible 15 which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident #89 is dependent on staff for all functional daily tasks. On 2/24/25 at 8:50 A.M., Resident #89 was observed lying in bed with both heels directly on the mattress. There was no heel protectors observed in the Resident's room. On 2/24/25 at 12:36 P.M. Resident #89 was observed lying in a reclining chair with both heels directly on the footrest of the chair. The Resident was not using any foot protectors. On 2/25/25 at 7:00 A.M., Resident #89 was observed lying in bed with both heels directly on the mattress. There was no heel protectors observed in the Resident's room. On 2/25/25 at 10:04 A.M., Resident #89 was observed in a reclining chair with bilateral heels directly on the footrest and was not wearing bilateral heel protectors. Review of Resident #89's potential for skin impairment care plan last revised 11/8/24, indicated the following intervention: -Bilateral heel protectors to both heels every shift. During an interview on 10/6/25 at 10:06 A.M., Certified Nursing Assistant #1 said he had just completed Resident #89's morning care and was not aware of any heel protectors the Resident should wear on his/her feet. During an interview on 10/6/25 at 10:09 A.M., Nurse #1 said she was unaware of Resident #89's risk of pressure ulcers and any skin protective equipment that is care planned for the Resident. During an interview on 10/6/25 at 10:20 A.M., Unit Manager #1 said Resident #89 has a care plan for bilateral heel protectors and was unaware the Resident did not have the heel protectors in place. Unit Manager #1 said she expects all care plans to be followed. (continued on next page)

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	225573	A. Building B. Wing	02/26/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/25 at 10:37 A.M., the Director of Nursing said he expects all care plans to be followed as written. 2. Resident #27 was admitted to the facility in February 2025 with diagnoses including Parkinson's Disease and toxic encephalopathy. Review of the Brief Interview for Mental Status (BIMS) assessment, dated 2/15/25, indicated Resident #27 scored a 4 out of 15, which indicated he/she had severe cognitive impairment. Review of Resident #27's physician orders indicated the following orders: -Aripiprazole (An antipsychotic medication) oral tablet 5 MG (milligrams), initiated on 2/18/25. -Olanzapine (An antipsychotic medication) oral tablet 2.5 MG (milligrams), initiated on 2/21/25. Review of Resident #27's interdisciplinary care plans failed to indicate a care plan was developed for the Resident's antipsychotic medication use. During an interview on 2/25/25 at 12:22 P.M., Charge Nurse #1 said the Unit Manager is responsible for developing care plans and he was unsure if residents taking antipsychotics should have a care plan developed for this care area. During an interview on 2/25/25 at 12:34 P.M., Unit Manager #2 said residents who are taking antipsychotic medications do not require a care plan to be developed for this care area. During an interview on 2/25/25 at 12:50 P.M., the Director of Nursing said antipsychotic care plans should be developed for any resident who is taking an antipsychotic medication. The Director of Nursing said this type of care plan would be separate from the general psychotropic medication care plan. 52138

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observation, record review and interview, the facility failed to ensure physician orders were implemented for 8 Residents (#42, #328, #133, #54, #48, #89, #27, and #30), out of a total sample of 27 residents. Specifically, 1a. For Resident #42, 1b. Resident #328 and 1c. Resident #133, 1d. Resident #54, 1e. Resident #48 the facility failed to complete weekly skin assessments, as per the physician order. 2. For Residents #89, #27 and #30 the facility failed to follow physician orders as written. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's 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. Review of the facility policy titled Weekly Skin Check Documentation, not dated, indicated it is the policy of the facility to evaluate all resident's skin for evidence of breakdown, wounds, or impaired skin integrity. Those being followed by the wound care team or have weekly wound assessments are still required to have skin checks performed as ordered. Orders for weekly skin checks are placed on admission and assessments are to be documented as ordered. Procedure: 2. Weekly skin check orders are placed in the TAR and scheduled according to the order. 3. Licensed Nursing staff are to acknowledge the weekly skin check order after the weekly skin assessment has been completed. 4. The assessment utilized for weekly skin checks is the N Adv Skin Check Assessment, located in the assessment tab in PCC (electronic medical record). 1a. Resident #42 was admitted to the facility July 2019 with diagnoses that included Alzheimer's disease, aphasia, dysphagia, dementia, and anxiety. Review of Resident #42's most recent Minimum Data Set (MDS) assessment, dated 1/22/25, indicated he/she was assessed by nursing staff to have severe cognitive impairment. Further review of the MDS indicated he/she is at risk for developing pressure ulcers. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #42's physician order dated 6/11/20, indicated Weekly Skin check every Thurs (Thursday) 11-7 (11:00 P.M. to 7:00 A.M.). Review of Resident #42's Braden Scale (Scale for Predicting Pressure Ulcer Risk Evaluation), dated 1/16/25, indicated he/she scored a 13 indicating the Resident is at moderate risk for developing pressure ulcers. Review of Resident #42's at risk for pressure ulcers care plan, dated 8/23/22, indicated Skin assessments weekly and prn (as needed), pay special attention to bony prominences. Review of Resident #42's medical record assessments and nursing progress noted failed to indicate that a completed skin assessment was completed since 1/16/25. During an interview on 2/25/25 at 9:53 A.M., the Director of Nurses (DON) said the weekly skin assessment should be completed under the assessment tab or write a progress note that a full body skin check was done by the nurse. During an interview on 2/25/25 at 10:38 A.M., Charge Nurse #2 said weekly skin assessments should be completed as ordered and the nurse completing them should document the skin check under the assessment tab. 1b. Resident #328 was admitted to the facility in February 2025 with diagnoses that included scabies, end stage renal disease, and toxic encephalopathy. Review of Resident #328's Brief Interview for Mental Status (BIMS), dated 2/14/25, indicated he/she scored a 11 out of a possible 15 indicating moderate cognitive impairment. Review of Resident #328's potential for pressure ulcer development, dated 2/14/25, indicated Skin assessments weekly and prn (as needed), pay special attention to bony prominences. Review of Resident #328's Braden Scale (Scale for Predicting Pressure Ulcer Risk Evaluation), dated 2/14/25, indicated he/she scored a 13 and is at risk for developing a pressure ulcer. Review of Resident #328's physician order, dated 2/17/25, indicated Weekly skin checks on Monday night. Review of Resident #328's medical record assessments and nursing progress noted failed to indicate that a completed skin assessment was completed since admission. During an interview on 2/25/25 at 9:53 A.M., the Director of Nurses (DON) said the weekly skin assessment should be completed under the assessment tab or write a progress note that a full body skin check was done by the nurse. The DON reviewed Resident #328's medical record with the surveyor and the DON said he/she does not have any skin assessments completed since admission. During an interview on 2/25/25 at 10:38 A.M., Charge Nurse #2 said weekly skin assessments should be completed as ordered and the nurse completing them should document the skin check under the assessment tab. (continued on next page)

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	225573	A. Building B. Wing	02/26/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c. Resident #113 was admitted to the facility in December 2024 with diagnoses that included type 2 diabetes, dysphagia, altered mental status, and cognitive communication deficit. Review of Resident #113's most recent Minimum Data Set (MDS) assessment, dated 12/11/24, indicated he/she scored a 11 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. Further review of the MDS indicated he/she is at risk for developing pressure ulcers and had an unhealed pressure ulcer. Review of Resident #113's physician order, dated 12/15/24, indicated Weekly skin checks on Sunday night. Every night shift every Sun for weekly skin check. Review of Resident #113's Braden Scale (Scale for Predicting Pressure Ulcer Risk Evaluation), dated 12/9/24, indicated he/she scored a 13 indicating the Resident is at moderate risk for developing pressure ulcers. Review of Resident #113's medical record assessments and nursing progress noted failed to indicate that a completed skin assessment was completed since 1/27/25. During an interview on 2/25/25 at 9:53 A.M., the Director of Nurses (DON) said the weekly skin assessment should be completed under the assessment tab or write a progress note that a full body skin check was done by the nurse. During an interview on 2/25/25 at 10:38 A.M., Charge Nurse #2 said weekly skin assessments should be completed as ordered and the nurse completing them should document the skin check under the assessment tab. During an interview on 2/26/25 at 9:56 A.M., Unit Manager #2 said weekly skin checks should be completed as ordered and nursing staff should document that under the assessment tab in the electronic medical record. 36431 1d. Resident #54 was admitted to the facility in August 2017 and has diagnoses that include but are not limited to cerebral infarction, hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side, contracture of left upper arm, and contracture, left hand. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #54 scored a 13 out of 15 on the Brief Interview for Mental Status exam indicating he/she as cognitively intact. Further, the MDS indicated Resident #54 had functional limitation in range of motion on both his/her upper and lower extremities on one side and is at risk for developing pressure ulcers/injuries. On 2/24/25 at 7:56 A.M., Resident #54 was observed in bed, with an air mattress mechanism affixed to the footboard. Resident #54 was observed to have his/her left hand held in a fist. Review of Resident #54's physician's orders indicated an order dated 8/13/2019, Weekly Skin check every day shift every Tue (Tuesday), complete skin only assessment. (continued on next page)

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	225573	A. Building B. Wing	02/26/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #54's Braden Scale (Scale for Predicting Pressure Ulcer Risk Evaluation), dated 1/10/25, indicated he/she scored an 11 indicating the Resident is at high risk for developing pressure ulcers. Review of Resident #54's care plan, dated 11/1/2024 indicated Resident #54 has potential for pressure ulcer development r/t (related to) decreased strength and endurance, immobility, incontinence, with the intervention/task, Skin assessments weekly and prn (as needed), pay special attention to bony prominences. Review of Resident #54's medical record assessments failed to indicate a weekly skin assessment was completed in accordance with the physician's order. The last documented weekly skin check was dated 11/12/24. During an interview on 2/25/25 at 3:57 P.M., Nurse #9 said all residents requires weekly skin checks. Nurse #9 said she signed off the weekly skin assessment on the TAR (treatment administration record) for Resident #54 for today. Review of the medical record with Nurse #9 failed to indicate a weekly skin assessment was completed. During an interview on 2/25/25 at 4:24 P.M., Unit Manager (UM) #3 said Resident #54 has an order for a weekly skin check every Tuesday. UM #3 said the nurse should document the weekly skin check on the weekly skin assessment. During an interview on 2/25/25 at 4:38 P.M., the Director of Nursing said signing the TAR off for the weekly skin check is acknowledging the order and that the nurse should be completing a skin assessment in the medical record. 48990 1e. Resident #48 was admitted to the facility in January 2017 with diagnoses including a stage three pressure ulcer and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/12/25, indicated Resident #48 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated he/she was at risk for developing pressure ulcers. Review of Resident #48's active physician's order, initiated 8/1/19, indicated: - Skin check in the evening every Wed (Wednesday) (Document in skin and wound module). Review of Resident #48's Braden Scale (Scale for Predicting Pressure Ulcer Risk Evaluation), dated 2/12/25, indicated he/she was at high risk for developing pressure ulcers as evidenced by a score of 11. Review of Resident #48's plan of care related to potential for pressure ulcer development, revised 9/14/24, indicated: - Skin assessments weekly and prn (as needed), pay attention to bony prominences. (continued on next page)

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	225573	A. Building B. Wing	02/26/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #48's medical record assessments and nursing progress notes failed to indicate that a completed skin assessment was completed since 4/29/24. During an interview on 2/25/25 at 9:50 A.M., Nurse #4 said skin checks should be completed weekly and the nurse completing them should document the skin check under the assessment tab in the medical record. During an interview on 2/25/25 at 9:53 A.M., the Director of Nurses (DON) said the weekly skin assessment should be completed under the assessment tab or write a progress note that a full body skin check was done by the nurse. During an interview on 2/25/25 at 2:02 P.M., the Assistant Director of Nursing (ADON) reviewed Resident #48's medical record. The ADON said there are no skin checks in the medical record since 4/29/24. The ADON said even if it's marked as implemented on the treatment administration record, it's not considered completed unless there is a skin check assessment completed under the assessment tab. During an interview on 2/25/25 at 2:17 P.M., the DON said Resident #48 should have had a skin check completed weekly but was not able to locate one in the Resident's medical record since April 2024. The DON said there was a change in their medical record system, and they were missed. 41456 2a. Resident #89 was admitted to the facility in November 2021 with diagnoses including epilepsy. Review of Resident #89's most recent Minimum Data Set, dated dated dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 7 out of a possible 15 which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident #89 is dependent on staff for all functional daily tasks. On 2/24/25 at 8:50 A.M., and 4:45 P.M., Resident #89 was observed lying in bed with both side rails elevated without padding on either side rail. On 2/25/25 at 07:14 A.M., and 10:04 A.M., Resident #89 was observed lying in bed with both side rails elevated without padding on either side rail. Review of Resident #89's physician orders indicated the following: -Seizure Precautions: Maintain Padded Top Side rails on Bed at all times for injury protection due to Seizures, initiated 4/18/24. During an interview on 10/6/25 at 10:06 A.M., Certified Nursing Assistant #1 said he had just completed Resident #89's morning care and was not aware if the Resident required padded side rails to his/her bed. During an interview on 10/6/25 at 10:09 A.M., Nurse #1 said she was unaware of Resident #89's risk of seizures and examined the Resident's orders. Nurse #1 said the Resident should have padded side rails. She then went into the Resident's room, looked at the Resident's bed and said the padded side rails were not in place. (continued on next page)

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	225573	A. Building B. Wing	02/26/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/6/25 at 10:20 A.M., Unit Manager #1 said Resident #89 has an order for padded side rails on his/her bed. Unit Manager #1 said she was not aware the Resident did not have the padded side rails in place. Unit Manager #1 said she expects all orders to be followed. During an interview on 2/25/25 at 10:37 A.M., the Director of Nursing said he expects all orders to be followed as ordered. 2b. Resident #27 was admitted to the facility in February 2025 with diagnoses including Parkinson's Disease and toxic encephalopathy. Review of the Brief Interview For Mental Status (BIMS) assessment dated [DATE], indicated Resident #27 scored a 4 out of 15, which indicated he/she had severe cognitive impairment. On 2/24/25 at 8:36 A.M., Resident #27 was observed lying in bed with both heels lying directly on the mattress. There were two prevalon boots (heel protecting boots) on the chair next to the bed. Resident #27 was unable to be interviewed regarding the boots. On 2/25/25 at 8:11 A.M., Resident #27 was observed lying in bed with both heels lying directly on the mattress. There were two prevalon boots (heel protecting boots) on the chair next to the bed. A Certified Nursing Assistant (CNA) entered the Resident's room to provide care. When the CNA left the Resident's room at 8:19 A.M., the Resident was still lying in bed without the heel protective boots on. Review of Resident #27's physician orders indicated the following order: -Off-load boots to bilateral heels while in bed, initiated on 2/18/25. Review of the Skin Observation Tool dated 2/24/25 indicated Resident #27 had bilateral heel pressure wounds. Review of the Wound Documentation dated 2/24/25 indicated a recommendation from the wound physician to have soft booties for pressure protection. During an interview on 2/26/25 at 11:53 A.M., CNA #5 said Resident #27's boots are supposed to be on while he/she is lying in bed. During an interview on 2/26/25 at 12:00 P.M., Nurse #7 said she was unaware if Resident #27 had wounds on his/her bilateral heals and said the Resident is supposed to have heel protective boots on while in bed. During an interview on 2/26/25 at 12:05 P.M., Unit Manager #2 said she expects orders to be followed as written. During an interview on 2/25/25 at 10:37 A.M., the Director of Nursing said he expects all orders to be followed as ordered. 2c. Resident #30 was admitted to the facility in September 2022 with diagnoses including Alzheimer's Disease. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #30's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status and the staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #30 is dependent on staff for all functional tasks. On 2/24/25 at 8:55 A.M., Resident #30 was observed with a skin tear to his/her right lower arm. The Resident was not wearing any protective coverings to either arm. On 2/24/25 at 12:35 P.M., Resident #30 was observed sitting in the dining room without any protective coverings to either arm. On 2/25/25 at 7:03 A.M., Resident #30 was observed sitting in the dining room without any protective coverings to either arm On 10/26/25 at 10:28 A.M., Resident #30 was observed sitting in the dining room without any protective coverings to either arm. Review of Resident #30's physician orders indicated the following order: -Every shift -Geri Gloves (a skin protective garment) to both arms, initiated on 9/25/24. Review of nursing notes and the Treatment Administration Record (TAR) failed to indicate Resident #30 refused to wear the geri-gloves. During an interview on 10:32 A.M., Unit Manager #1 said Resident #30 has fragile skin and has an order for geri-gloves for this reason. Unit Manager #1 said Resident #30 often refuses the geri-gloves and if a refusal occurs it would be documented on the TAR. Unit Manager #1 said all orders should be followed as written. During an interview on 2/26/25 at 10:55 A M., the Director of Nursing said all orders should be followed as written. 52138

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225573	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sancta Maria Nursing Facility	799 Concord Avenue Cambridge, MA 02138

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 36431 Based on observation, record review and interview the facility failed to ensure standards of quality of care for 1 Resident (#54), out of a sample of 25 residents. Specifically, for Resident #54 the facility failed to ensure the medical plan of care was implemented by failing to apply an abdominal pad to his/her left-hand and failing to ensure the left-hand discoloration was monitored for wound development. Findings include: Resident #54 was admitted to the facility in August 2017 and has diagnoses that include but are not limited to cerebral infarction, hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side, and contracture of left upper arm, contracture, left hand. Review of the Minimum Data Set assessment, dated 1/15/25, indicated Resident #54 scored a 13 out of 15 on the Brief Interview for Mental Status exam indicating he/she as cognitively intact. Further, the MDS indicated Resident #54 has functional limitation in range of motion on both his/her upper and lower extremities on one side and is at risk for developing pressure ulcers/injuries. Review of Resident #54's active physician orders indicated the following: -Skin check every day shift every Tue (Tuesday) complete skin only assessment date 8/13/2019. -Left hand roll splint after AM care as tolerated for up to 6 hours for contracture management dated 9/8/2021 -Apply abdominal pad to left hand contracture to offload palm from fingers daily. Keep area dry and clean. Until discoloration resolves. Every shift dated 11/15/2024. Review of the MD/NP (medical doctor/nurse practitioner) progress note, dated 11/14/24, indicated: Exam Skin: left middle fingernail with sings (sic) of onchomycosis (sic) (nail fungus) and skin of that finger a bit boggy, area of indentation on palm where the nail rests against the skin due to his/her contracture, no open wounds on fingers or hand. Assessment and Plan Today also noted onchomycosis (sic) of left middle fingernail and some bogginess of the finger pad, as well as indentation on palm skin. No open wounds noted but fingers and palm both at risk for wound formation. Abd pad in contracted hand to protect skin and keep the area dry. Close monitoring for wound development, ensure nails trimmed regularly. During the survey the following observations were made by the surveyor: -On 2/24/25 at 7:56 A.M., Resident #54 was observed in bed. Resident #54 was observed to have his/her left hand held in a fist. There was nothing in Resident #54's left hand to offload the fingers from his/her palm. (continued on next page)

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	225573	A. Building B. Wing	02/26/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/24/25 at 12:39 P.M., Resident #54 was in his/her bed. Resident #54's left hand fingers were folded around a rolled terry cloth towel. No abdominal pad was observed. -On 2/24/25 at 4:08 P.M., Resident #54 was in his/her bed. A blue hand roll was resting on top of his/her fingers. His/her fingers were folded in toward his/her palm, making the palm not visible. There was no abdominal pad present in or around the blue hand roll, nor was the fingers offloaded from his/her palm. During an observation and interview on 2/25/25 at 8:06 A.M., Resident #54 said he/she has pain in his/her left arm and hand. Resident #54 had a blue hand roll in his/her left hand. No abdominal pad was present. During an observation on 2/25/25 at 8:32 A.M., Resident #54 was observed with Nurse #9 and Unit Manager #3. Resident #54 had a blue hand roll and did not have an abdominal pad in his/her left hand. Nurse #9 said an area of discoloration was a small yellowing area on the outer bottom of his/her thumb. Review of Resident #54s care plan, dated 11/1/2024, indicated Resident #54 has potential for pressure ulcer development r/t (related to) decreased strength and endurance, immobility, incontinence, with the intervention/task, Skin assessments weekly and prn (as needed), pay special attention to bony prominences. Review of LTC (long term care) evaluation, dated 1/14/25, indicated Resident #54 had no skin issues. Review of Resident #54's medical record assessments failed to indicate a weekly skin assessment was completed in accordance with the physician's order. The last documented weekly skin check was dated 11/12/24. Review of the Treatment Administration Record (TAR) with the order start date 11/15/24 indicated apply abdominal pad to left hand contracture to offload palm from fingers daily. Keep area dry and clean. Until discoloration resolves and was signed by nursing staff with a check mark and failed to indicate any monitoring of the the discoloration. Review of the TARs dated for December 2024, January 2025, and February through 2/25/25 indicated apply abdominal pad to left hand contracture to offload palm from fingers daily. Keep area dry and clean. Until discoloration resolves and was signed by nursing staff with a check mark and failed to indicate a description or status of the discoloration. The record review did not indicate any care plan, or established monitoring of the discoloration in Resident #54's left hand. During an interview on 2/25/25 at 8:24 A.M., Certified Nursing Assistant (CNA) #5 said Resident #54 is dependent for daily care. CNA #5 said Resident #54's left side is weak, and he/she is unable to open his/her left hand. CNA #5 said she puts a blue hand roll in the Resident's left hand. (continued on next page)

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	225573	A. Building B. Wing	02/26/2025

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Sancta Maria Nursing Facility	799 Concord Avenue Cambridge, MA 02138

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/25 at 3:44 P.M., CNA #4 said she cares for Resident #54 on the 3:00 P.M.-11:00 P.M. shift. CNA #4 said Resident #54 does not always cooperate with care, is unable to use his/her left hand and sometimes she will see the hand roll in the Resident's left hand at the start of her shift. During an interview on 2/25/25 at 4:07 P.M., Nurse #5 reviewed Resident #54's orders and said there is an order for an abdominal pad for his/her left hand. Nurse #5 said she did not know what the discoloration was and that the pad was used for the left-hand contracture. Nurse #5 said she did not know how the skin discoloration was monitored. During an interview on 2/25/25 at 4:53 P.M., the Director of Nursing was told by the surveyor that the Resident was observed without the abdominal pad in his/her left hand and was asked about what the discoloration written in the physician's order was. The Director of Nursing said he did not know about the discoloration or how it was being monitored. During an interview on 2/26/25 at 9:11 A.M., Unit Manager #3 said the doctor gave the order for the abdominal pad for Resident #54 and said the Resident was being treated with an antifungal treatment to his/her hand. Unit Manager #3 said the order for the abdominal pad should be followed and that staff are to report any changes in a resident's skin. Review of the medical record failed to indicate how the discoloration area on Resident's left hand was monitored for wound development.

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	225573	A. Building B. Wing	02/26/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41456 Based on observations, interviews and record review, the facility failed to provide care, consistent with professional standards of practice, to promote healing and prevent new ulcers from developing for one Resident (#428) out of a total sample of 27 residents. Specifically, a.) the facility failed to implement physician ordered pressure ulcer prevention intervention for an air mattress. b.) the facility failed to ensure an air mattress was at the correct settings. c.) the facility failed to follow wound care orders to apply adaptic (a non-adherent wound dressing) to a pressure wound as ordered by the physician. d.) the facility failed to ensure nursing clarified the documented stage of a pressure wound and ensure the wound care treatment order was consistent with professional standards (wound care for a stage two pressure wound was performed instead of wound care for a deep tissue injury). Findings include: Resident #428 was admitted to the facility in February 2025 with diagnoses including hypertension and pressure-induced deep tissue damage of sacral region. Review of the Brief Interview For Mental Status (BIMS) Evaluation assessment, dated 2/20/25, indicated Resident #428 scored a 14 out of 15, which indicated he/she was cognitively intact. a.) The facility failed to implement physician ordered pressure ulcer prevention intervention for an air mattress. On 2/24/25 at 10:15 A.M. Resident #428 was observed lying in bed with his/her family member present in the room. The Resident was observed lying on a standard mattress and the Resident's family member said the Resident had not had an air mattress since admission to the facility. On 2/24/25 at 12:31 P.M., Resident #428 was observed lying in bed on an air mattress. Review of Resident #428's hospital discharge summary indicated Resident #428 was admitted to the facility with a sacral deep tissue injury. Review of Resident #428's physician orders indicated the following order: -Air mattress to bed, set dial to Alternating and 200# (pounds). Check for placement and function every shift, initiated 2/21/25. During an interview on 2/25/25 at 12:50 P.M., the Director of Nursing said Resident #428 was admitted with multiple skin impairments and was prescribed and air mattress on admission. The Director of Nursing said the Resident did not receive the air mattress until 3 days after admission. (continued on next page)

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	225573	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sancta Maria Nursing Facility	799 Concord Avenue Cambridge, MA 02138

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b.) The facility failed to ensure an air mattress was at the correct settings. On 2/24/25 at 12:31 P.M., Resident #428 was observed lying in bed on an air mattress. The air mattress was set to level 3 and did not indicate a specific weight setting. On 2/25/25 at 6:53 A.M., 8:20 A.M. and approximately 12:30 P.M., Resident #428 was observed lying in bed on an air mattress. The air mattress was set to level 3 and did not indicate a specific weight setting. Review of Resident #428's physician orders indicated the following order: -Air mattress to bed, Set dial to Alternating and 200# (pounds). Check for placement and function every shift, initiated 2/21/25. During an interview on 2/25/25 at 12:34 P.M., Unit Manager #2 said Resident #428 has a skin impairment on his/her sacral area and requires an air mattress. Unit Manager #2 said the Resident's air mattress should be set to his/her weight and that would be setting number 2. Unit Manager #2 said an air mattress on a firmer setting than what is prescribed for a resident's weight would not be beneficial. During an interview on 2/25/25 at 12:50 P.M., the Director of Nursing said the facility has three different types of air mattresses in the facility and that not all can be set to a resident's weight. The Director of Nursing said Resident #428 has an order to set the mattress specific to his/her weight and the air mattress he/she is on is not the right type. The Director of Nursing said Resident #428's air mattress should be set to setting 2 and was unaware that it had been on setting 3 for the past two days. The Director of Nursing said an air mattress on a firmer setting would not be as beneficial and could potentially cause worsening of a wound. 48990 c.) The facility failed to ensure Charge Nurse #1 followed wound care orders when he did not apply adaptic (a non-adherent wound dressing) to a pressure wound as ordered by the physician. Review of facility policy titled 'Dry Clean Wound Dressings', undated, indicated: - Steps in the Procedure: 17. Apply the ordered dressing and secure with tape or bordered dressing per order. Review of Resident #428's active physician order, initiated 2/21/25, indicated: - Wound Care - Cleanse Coccyx Stage 2 pressure wound with Vashe (a type of wound cleanser) or any antibacterial wound cleanser. Pat dry, apply Adaptic, then Calcium Alginate and then cover with dry protective dressing, every day shift. On 2/26/25 at 9:14 A.M., the surveyor observed Charge Nurse #1 perform a wound dressing change to Resident #428's coccyx. Charge Nurse #1 cleansed a large, discolored area of intact skin on his/her coccyx with antibacterial wound cleanser. Charge Nurse #1 patted the area dry and then applied calcium alginate followed by a dry protective dressing. Charge Nurse #1 failed to apply adaptic. (continued on next page)

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	225573	A. Building B. Wing	02/26/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 2/26/25 at 9:37 A.M., Charge Nurse #1 said he was unaware the physician had ordered adaptic, and that he applied only calcium alginate followed by a dry protective dressing. Charge Nurse #1 reviewed the active physician order and said he should have applied adaptic but did not. During an interview on 2/26/25 at 9:42 A.M., Unit Manager #2 said Resident #428 had a physician's order for adaptic followed by calcium alginate and a dry protective dressing. Unit Manager #2 said Charge Nurse #1 should have been implemented adaptic as ordered by the physician or else clarified the order if there were any concerns. During an interview on 2/26/25 at 1:50 P.M., the Director of Nursing (DON) said Charge Nurse #1 should have implemented adaptic, in addition to the calcium alginate and dry protective dressing, because that was the physician order or else clarified the order if there were any concerns. d.) The facility failed to ensure nursing clarified the documented stage of a pressure wound and ensure the wound care treatment order was consistent with professional standards (wound care for a stage two pressure wound was performed instead of wound care for a deep tissue injury). Review of facility policy titled 'Dry Clean Wound Dressings', undated, indicated: - Report other information in accordance with facility policy and professional standards of practice. Review of the facility policy titled 'Notification of Change in Resident Condition', dated 1/13/25, indicated Nursing Leadership/Primary Nurse shall notify the resident, consult with the resident's physician and notify family/responsible party when any of the following occurs: i. Examples of Change in Condition that require notification: - When there is a significant change in treatment required that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment; A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences, such as an adverse drug reaction, or begin a new form of treatment to deal with a problem that has not been used on that resident before. Review of Resident #428's hospital discharge paperwork, dated 2/20/25, indicated: - Wound care on discharge: Sacral DTIs (deep tissue injuries): BID (twice daily): cleanse with soap and water, pat try, apply triad paste (a paste used on wounds). Review of Resident #428's assessment titled 'N Adv - Clinical Admission', dated 2/20/25, indicated there was a sacrococcygeal pressure ulcer/injury that was present on admission without any exudate (drainage). This assessment failed to indicate the stage of this pressure wound. Review of Resident #428's active physician order, initiated 2/21/25, indicated: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225573	A. Building B. Wing	02/26/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Wound Care - Cleanse Coccyx Stage 2 pressure wound with Vashe (a type of wound cleanser) or any antibacterial wound cleanser. Pat dry, apply Adaptic, then Calcium Alginate and then cover with dry protective dressing, every day shift. On 2/26/25 at 9:14 A.M., the surveyor observed Charge Nurse #1 perform a wound dressing change to Resident #428's coccyx. The Resident had a large, discolored area of intact skin on his/her coccyx, which Charge Nurse #1 said was a deep tissue injury. Charge Nurse #1 said this was not a stage two pressure wound. Charge Nurse #1, who had provided Resident #428's wound care the previous four days, said each time he had performed this wound dressing change the wound has looked the same. Charge Nurse #1 cleansed the discolored area of intact skin on his/her coccyx with antibacterial wound cleanser. Charge Nurse #1 patted the area dry and then applied calcium alginate followed by a dry protective dressing. Review of Resident #428's treatment administration record, dated 2/22/25, 2/23/25, 2/24/25, and 2/25/25, indicated the following physician order documented as completed by Charge Nurse #1: - Wound Care - Cleanse Coccyx Stage 2 pressure wound with Vashe (a type of wound cleanser) or any antibacterial wound cleanser. Pat dry, apply Adaptic, then Calcium Alginate and then cover with dry protective dressing, initiated 2/21/25. During a follow-up interview on 2/26/25 at 9:37 A.M., Charge Nurse #1 said the coccyx wound treatment order was for a stage two pressure wound. Charge Nurse #1 said during each wound dressing change he had completed the wound had not been a stage two pressure wound, but always a deep tissue injury with intact skin. Charge Nurse #1 said he was not aware if calcium alginate or adaptic were appropriate treatments for intact skin or deep tissue injuries. Charge Nurse #1 said this should have been clarified, but it's not his job. Charge Nurse #1 said it was Unit Manager #2's job to clarify orders with the physician if they don't match during the weekly wound rounds. During an interview on 2/26/25 at 9:42 A.M., Unit Manager #2 said on admission she reviewed Resident #428's hospital discharge paperwork for wound care orders. Unit Manager #2 said the hospital discharge paperwork recommended triad paste, which they do not use in the facility, so she called the physician and asked for an alternative treatment. Unit Manager #2 said she never visualized the wound herself, but since triad is usually for stage two pressure wounds, she told the physician Resident #428 had a stage two pressure wound on his/her coccyx. Unit Manager #2 said the physician ordered adaptic and calcium alginate for a stage two pressure wound. Unit Manager #2 said she would have expected Charge Nurse #1 to clarify the order when he first noted the wound status did not match the treatment order. Review of Resident #428's hospital discharge paperwork and admission paperwork, both dated 2/20/25, failed to indicate Resident #428 had a stage two pressure wound. The hospital discharge paperwork, dated 2/20/25, indicated sacral deep tissue injuries. During an interview on 2/26/25 at 11:15 A.M., the Regional Nurse Consultant said adaptic and calcium alginate are not appropriate wound treatments for intact skin or deep tissue injury and Charge Nurse #1 should have stopped the dressing change with the surveyor and clarified the wound treatment orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225573	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sancta Maria Nursing Facility	799 Concord Avenue Cambridge, MA 02138

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 1:50 P.M., the Director of Nursing (DON) said adaptic and calcium alginate are not appropriate wound treatments for intact skin or deep tissue injury and Charge Nurse #1 should have clarified the physician order when he first noted the wound status did not match the treatment order. Refer to F726. 52138

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225573	A. Building B. Wing	02/26/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36431 Based on record review and interview the facility failed to ensure for 1 Resident (#92) out of a total sample of 27 residents, that 72-hour neurological checks were conducted after Resident #92 sustained unwitnessed falls. Findings include: Review of the facilities policy titled, Falls Management, last updated October 2023, indicated the facility will utilize resident/patient related information made available upon admission and ongoing to determine resident/patient at risk for fall status. Procedure: A fall risk evaluation will be conducted by the nurse on duty/supervisor on any resident/patient sustaining a fall with or without injury. Once the resident/patient is clinically evaluated as being stable, vital signs, neurological signs, range of motion, and evaluation of cognitive status will be documented. Neurological checks, to be documented on the neurological flow sheet for 72 hours in the following circumstances, resident/patient states that he/she hit head, physical evidence resident hit head, and unwitnessed fall. Resident #92 was admitted to the facility April 2022 and has diagnoses that include but are not limited to legal blindness, repeated falls, cataracts, acute on chronic systolic heart failure and cognitive communication deficit. Review of Resident #92's Minimum Data Set (MDS) assessment, dated 12/18/24, indicated that he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she as having intact cognition. Review of Resident #92's care plans indicated a care plan with the focus: Resident #92 is at risk for falls D/T (due to) unsteady gait, decreased balance, generalized weakness and impaired mobility due repeated falls, legally blind, poor safety awareness, use of antidepressant and antianxiety medications, diuretic medication, opioid use for pain, confusion, oxygen use, incontinence, date initiated 1/2/2024. Review of the following fall risk evaluations indicated Resident #92 was at risk for falls: 9/23/24 comprehensive, 10/8/24 quarterly,10/8/24 other, 11/7/24 other, 12/3/24 quarterly,12/4/24 admission,12/16/24 other,12/18/24 quarterly, 12/22/24 other, 12/24/24 other, 2/5/25 quarterly, 2/6/25 other, 2/19/25 other, and 2/21/25. Review of the incident reports provided to the surveyor by the Director of Nursing indicated Resident #92 sustained 12 falls between 9/6/2024 through 2/21/2025. Of the 12 falls, 10 were not witnessed. Review of the 10 not witnessed fall incident reports, indicated 6 did not include 72-hour neurological assessment low sheets. Review of the incident reports indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225573	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sancta Maria Nursing Facility	799 Concord Avenue Cambridge, MA 02138

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Fall date 9/8/24, at 5:31 P.M., Fall was not witnessed. Fall occurred bedside. An initial Neurological focused evaluation was conducted. Review of the incident report failed to indicate a 72-hour neuro flow sheet was completed. -Fall date 10/6/24, 06:00 (6:00 A.M.) fall was not witnessed. Fall occurred in Resident's room. Resident was attempting to self-toilet at the time of the fall. Further review of the incident report failed to indicate 72-hour neurological checks were conducted. -Fall 11/7/24 at 5:45 P.M., Fall was not witnessed. Fall occurred in the bathroom. An initial focused neurological focused evaluation was completed, no further 72-hour neurological flow sheet was completed. -Fall 11/13/25, at 7:36 P.M., fall was not witnessed. Fall occurred in the Resident's room. A neurological focused evaluation was conducted. Further review failed to indicate a 72-hour neurological flow sheet was completed. -Fall date 12/22/24, at 6:30 A.M., Fall not witnessed. Fall occurred in the bathroom. Initial neuro check conducted; no further 72-hour neurological flow sheet was completed. -Fall 2/19/25, 12:00 P.M., Fall was not witnessed. Fall occurred in Resident's room. Further review failed to indicate a 72-hour neurological check was completed. During an interview on 2/26/25 at 11:20 A.M., Unit Manager #3 said Resident #92 is at high risk for falls and has had multiple falls. Unit Manager #3 said all falls Resident #92 has sustained are reviewed and the care plan revised. Unit Manager #3 said all falls that are not witnessed require 72-hour neuro checks that are documented on paper neuro flow sheets. Unit Manager said once completed the neurological flow sheets are given to the Director of Nursing as part of the incident report. During an interview on 2/26/25 at 11:44 A.M. The Director of Nursing said neuro checks were required on falls with head strikes or falls that are not witnessed. The DON said the Neurological checks are completed on paper and that the nursing staff and Unit managers are responsible to ensure the neuro checks are conducted. The DON said he was not entirely sure where the missing neuro checks were for Resident #92.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225573	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48990 Based on interviews, record review, staff education review, and Facility Assessment review, the facility failed to ensure the nursing staff were trained and demonstrated the competencies and skill sets necessary to provide the level and types of care and services needed as outlined in the Facility Assessment. Specifically, the facility failed to ensure licensed nursing staff were trained and demonstrated competency related to wound care. Findings include: According to the Board of Registration in Nursing, 244 CMR 9.00: Standards of Conduct, a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Review of the comprehensive Facility Assessment Tool, updated and reviewed August 2024, included but was not limited to the following: - Services and Care We Offer Based on our Residents' Needs: Skin integrity: Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds.) - Staff training/education and competencies: Ongoing staff training and education is provided to all departments within the facility specific to each discipline. We also provide annual training along with annual competencies that are required for all departments in the facility according to DPH regulations. - Annual Competencies for Nurses (subject to change): Clean Dressing Change. Review of the summarized Facility Assessment Tool, updated and reviewed February 2025, included but was not limited to the following: - Services and Care We Offer Based on our Residents' Needs: Skin integrity: Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). Weekly wound rounds with physician. - Staff training/education and competencies: Additional full day staff orientation, depending on position, for specific skill and competencies. Annual Education Fair and Core Competency evaluations. - Competencies: Specialized Care - wound care/dressings. (continued on next page)

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	225573	A. Building B. Wing	02/26/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/25 at 1:11 P.M., the Administrator said both the above referenced Facility Assessment Tools are current, but one is more comprehensive and the other is a summary. The Administrator said both should be followed. Throughout the recertification survey (2/24/25 through 2/26/25) the surveyors identified multiple concerns regarding wound care including: - failure to implement wound treatments following physician's orders. - failure to obtain new treatment orders for a pressure wound when the wound status changed and current treatment order was no longer appropriate. - failure to complete weekly skin checks. The surveyor reviewed staff education files for wound competencies for three licensed nurses who provided wound care during the recertification survey. - 0 out of 3 nurses had evidence of wound care competencies completed since hire. During an interview on 2/26/25 at 1:21 P.M., the Assistant Director of Nursing (ADON) said she was responsible for staff competencies and training. The ADON said she was unaware wound or wound dressing competencies were required annually or upon hire. The ADON said if wound or wound dressing competencies are indicated as required on the Facility Assessment, then they should have been completed. The ADON said she has not done any wound related competencies that include return demonstration since she started the position in September 2024. The ADON said she was unable to locate any wound competencies for the three licensed nurse files requested since they were hired. During an interview on 2/26/25 at 1:50 P.M., the Director of Nursing (DON) said wound care competencies should completed as indicated in the Facility Assessment.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 15016 Based on record review and interview, the facility failed to ensure the pharmacist completed a Monthly Medication Review (MMR) for one Resident (#8), out of 27 sampled residents. Findings include: Resident #8 was admitted to the facility in November 2024, and had diagnoses that included bipolar disorder, schizophrenia and diabetes type II. Review of Resident #8's physician orders, dated February 2025, indicated they included, but were not limited to, the following medications: - Trazodone (antidepressant) 150 milligrams (mg) one tablet one time per day. - Zoloft (antidepressant) 100 mg two tablets one time per day. - Risperidone 0.5 mg (antipsychotic) one tablet two times per day. - Metformin (antidiabetic medication) 500 mg one tablet two times per day. Review of Resident #8's MMRs, performed by the pharmacist, from November 2024 through January 2025, indicated an MMR was not completed for December 2024. During an interview on 2/25/25 at 8:22 A.M., the Director of Nursing (DON) said Resident #8's MMRs, located in the electronic and paper records, did not include a review for December 2024. The DON said he would try to locate the missing MMR. As of the last day of survey, the DON had not provided a copy of the December MMR.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43846 Based on observations, interviews and policy review, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically, 1. The facility failed to ensure treatment carts and medication carts were locked while a nurse was not present on the fourth floor. 2. The facility failed to ensure nursing staff secured medications in the medication cart prior to leaving the cart unattended on the fourth and fifth floor units. Findings include: Review of the facility policy titled Medication Administration and Charting Policy, dated as revised November 2024, indicated Medication carts must always remain locked, unless the nurse who is administering the medication is in direct control of the medication cart. If the medication cart is left unattended it must be locked. Review of the facility policy titled Mediation Storage, not dated, indicated it is the policy of the facility to store all medications in a safe and orderly manner. Unlocked medication carts are not left unattended by the nurse with carts keys. 1. On 2/24/25 from 7:37 A.M. to 7:46 A.M., the surveyor observed the treatment cart unlocked and unsupervised on the 4th floor unit. The surveyor observed a resident and staff members walking by the unlocked treatment cart multiple times. On 2/24/25 at 8:12 A.M., the surveyor observed a medication unlocked and unsupervised on the 4th floor unit. No staff were present. During an interview on 2/26/25 at 9:06 A.M., Unit Manager #2 said she expects nursing staff to lock the medication carts and treatment carts when the nurse is not present at the carts. On 2/26/25 at 9:30 A.M., the surveyor observed a 4th floor treatment cart unlocked in the hallway. The nurse was not within sight line of the treatment cart. The surveyor observed multiple prescription topical medications within this treatment cart. During an interview on 2/26/25 at 9:34 A.M., Unit Manager #2 came within view of the treatment cart and locked it. Unit Manager #2 said the treatment cart should have been locked when not within the nurses' view. 2. On 2/25/25 at 12:00 P.M., the surveyor observed a Trelegy inhaler on top of a medication cart on the 4th floor. The nurse was not present at the cart or in the hallway. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/25 at 9:06 A.M., Unit Manager #2 said medications should never be left unattended on top of the medication cart. 15016 On 2/25/25 at 9:27 A.M., during the medication pass on the fifth floor unit, the surveyor observed Nurse #1 remove a blister pack of Escitalopram 5 milligram tablets (antidepressant) from the medication cart drawer and place the pack on top of the cart. Nurse #1 then told the surveyor she needed to leave and get additional medications from the medication room. Nurse #1 then locked the medication cart and walked down the hallway and around a corner. The surveyor observed there were 13 tablets of Escitalopram in the blister pack. No other nursing staff were within eyesight of the cart. On 2/25/25 at approximately 9:31 A.M., Nurse #1 returned to the medication cart. Nurse #1 then unlocked the cart and returned the blister pack of escitalopram to the cart drawer and then locked the cart. Nurse #1 said she should not have left the Escitalopram unsecured and unattended on top of the medication cart while she was getting additional medications from the medication storage room.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 48990 Based on observations, interviews and record review, the facility failed to provide adaptive equipment for one Resident (#37) out of a total sample of 27 residents. Specifically, the facility failed to ensure Resident #37 was provided with a two handled cup for use during his/her drinks and liquids to maximize intake. Findings include: Review of the facility policy titled 'Adaptive Equipment Policy', undated, indicated: - As a part of our ongoing effort to make our residents' health the top priority, the facility will comply with the below guideline to assure the oversight of any adaptive equipment administered to a resident in the center. This will ensure that once issued all equipment in place, is maintained to quality standards, and is continuously appropriate and available to the resident. - Upon identifying a specialty therapy equipment piece should be issued: a. While the resident is on services: The treating therapist shall provide education to the resident and any staff members and caregivers who may be involved in the oversight of the piece of equipment. ii. It is the responsibility of the therapy department to care plan and/or to assure nursing is aware of any care plan to be written for the use of the adaptive feeding equipment iii. It is the responsibility of the therapy department to assure the center specific communication process to the dietary department occurs if it involves the equipment to be provided at meal times. (i.e., completing a pink communication slip and providing this to the dietary department). b. Upon discharging the resident from services: i. The rehab department must ensure therapy to nursing communication has occurred to include any language to be added to the care plan. Resident #37 was admitted to the facility in June 2024 with diagnoses including hemiparesis (one-sided muscle weakness) following a stroke. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/18/24, indicated Resident #37 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. This MDS also indicated Resident #37 required set up and clean up assistance with eating. Review of Resident #37's occupational therapy progress note, dated 2/3/25, indicated she was providing therapy to maximize performance with self-feeding. The note also indicated: (continued on next page)

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	225573	A. Building B. Wing	02/26/2025

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Pt (patient) was able to self-feed with built up handles MI (meaning minimum assistance) from table to mouth with 100% accuracy. Pt noted preference for two handled cup. Therapist noted 100% accuracy with two handle [sic] cup. Therapit [sic] ordered two handle cup with all meals. Review of Resident #37's physician telephone order, dated 2/3/25, indicated: - Two handled cup with drinks at all meals. Review of a dietary communication slip for Resident #37, dated 2/3/25, indicated: - Two handled cup with drinks at all meals. Review of Resident #37's active physician's orders and care plan on 2/25/25 at 8:30 A.M. failed to indicate two handled cups should be provided. On 2/24/25 at 8:55 A.M., the surveyor observed Resident #37 eating breakfast. The meal slip on the tray indicated apple juice in a two handled cup should be on the breakfast tray. There was a carton of apple juice with a straw on the tray, which was not in a two handled cup. There was no two handle cup available on meal tray. On 2/24/25 at 12:25 P.M., the surveyor observed Resident #37 eating lunch. The meal slip on the tray indicated chicken soup in a two handled cup should be on the lunch tray. There was a bowl of chicken soup on the tray, which did not have any handles. There was no two handle cup available on meal tray. Resident #37 said it takes him/her a lot longer to drink the soup because the cup he/she likes with the handle hasn't been given to him/her in a while. Resident #37 said he/she likes when the two handled cups come because it's a lot easier to drink liquids. Resident #37 said his/her soup was now cold because it took him/her so long to eat it and requested the surveyor ask staff to heat up the soup. On 2/25/25 at 8:14 A.M., the surveyor observed Resident #37 eating breakfast. The meal slip on the tray indicated orange juice should be on the tray, without any instructions for the orange juice to be in a two handled cup. There was a carton of orange juice with a straw on the tray, which was not in a two handled cup. There was no two handle cup available on meal tray. Resident #37 said he/she wished it was in a cup with two handles because he/she was having trouble drinking it. During an interview on 2/25/25 at 2:36 P.M., the Director of Rehab (DOR) and the Food Service Director (FSD) said occupational therapy recommended a two handled cup with drinks for all meals on 2/3/25 and showed the surveyor the dietary communication slip indicating this was communicated to the kitchen. The DOR said therapy issued a two handled cup to Resident #37 which was being stored in the Resident's room. The DOR said staff on the floor was supposed to make sure it was provided to the Resident for all drinks and liquids and that the staff was supposed to clean it between uses. The DOR said this plan had been in place until an order they had placed for a larger quantity of two handled cups to be available in the kitchen. The DOR said the larger quantity order had been delivered and given to the kitchen today (2/25/25). (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/26 at 8:54 A.M., Certified Nurse Assistant (CNA) #2 said the nurses check the meal slip to ensure everything and adaptive eating equipment is on the tray before it is delivered. CNA #2 said she was unaware Resident #37 required a two handled cup. CNA #2 said Resident #37 had a two handled cup in his/her room, but they do not transfer any drinks or soups into it, and he/she has not been using it. During an interview on at 2/26/25 at 8:56 A.M., Unit Manager #3 said nurses are responsible to check the meal slip to ensure everything and adaptive eating equipment, including two handled cups, are on the tray before it is delivered. Unit Manager #3 said if the two handled cups were indicated on the meal slip and were not available, the nurse should have called the kitchen to obtain the two handled cup or clarified the need for them with the therapy department. Unit Manager #3 said she was unaware Resident #37 had a two handled cup in his/her room, but that it shouldn't be stored there because they were not able to sanitize it on the unit. Unit Manager #3 went to Resident #37's room and confirmed there was a two handled cup being stored in his/her room. Unit Manager #3 located Resident #37's physician telephone order, dated 2/3/25, indicating two handled cup with drinks at all meals and said the physician telephone order had not been transcribed into the active physician's orders but should have. During an interview on 2/26/25 at 10:46 A.M., the Director of Nursing (DON) said nurses are responsible to check the meal slip to ensure everything and adaptive eating equipment, including two handled cups, are on the tray before it is delivered. The DON said if the two handled cups were indicated on the meal slip and were not available, the nurse should have called the kitchen to obtain the two handled cup or clarified the need for them with the therapy department. The DON said staff should have ensured the two handled cup, which was stored in his/her room, was provided to Resident #37.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41456 Based on observations, record reviews and interviews, the facility failed to maintain accurate medical records for two Residents (#89 and #30) out of a total sample of 27 residents. Findings include: 1a. Resident #89 was admitted to the facility in November 2021 with diagnoses including epilepsy. Review of Resident #89's most recent Minimum Data Set, dated dated dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 7 out of a possible 15 which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident #89 is dependent on staff for all functional daily tasks. On 2/24/25 at 8:50 A.M., and 4:45 P.M., Resident #89 was observed lying in bed with both side rails elevated without padding on either side rail. On 2/25/25 at 07:14 A.M., and 10:04 A.M., Resident #89 was observed lying in bed with both side rails elevated without padding on either side rail. Review of Resident #89's physician orders indicated the following: -Seizure Precautions: Maintain Padded Top Side rails on Bed at all times for injury protection due to Seizures, initiated 4/18/24. Review of the Treatment Administration Record for 2/24/25 and 2/25/25, indicated the nursing staff had marked the order as complete, indicating the padded siderails were present on Resident #89's bed. During an interview on 2/26/25 at 10:55 A.M, the Director of Nursing said orders should not be marked as complete if not done b. Resident #30 was admitted to the facility in September 2022 with diagnoses including Alzheimer's Disease. Review of Resident #30's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status and the staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #30 is dependent on staff for all functional tasks. On 2/24/25 at 8:55 A.M., Resident #30 was observed with a skin tear to his/her right lower arm. The Resident was not wearing any protective coverings to either arm. On 2/24/25 at 12:35 P.M., Resident #30 was observed sitting in the dining room without any protective coverings to either arm. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #30's physician orders indicated the following order: -Every shift -Geri Gloves (a skin protective garment) to both arms, initiated on 9/25/24. Review of the Treatment Administration Record (TAR) indicated the nursing staff had marked the order as complete on 2/24/25, indicating Resident #30 had worn the geri-gloves. During an interview on 10:32 A.M., Unit Manager #1 said Resident #30 has fragile skin and has an order for geri-gloves for this reason. Unit Manager #1 said Resident #30 often refuses the geri-gloves and if a refusal occurs it would be documented on the TAR. Unit Manager #1 said all orders should be followed as written and not marked as complete if not done. During an interview on 2/26/25 at 10:55 A.M, the Director of Nursing said orders should not be marked as complete if not done.