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	03/25/2026

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to electronically submit direct care staffing data to Centers for Medicare and Medicaid Services (CMS) for the entire reporting period, Fiscal Year (FY) Quarter 1 2026 (October 1 - December 31) in accordance with the schedule specified by CMS.Findings include:The surveyor requested, but the facility was unable to provide, a policy regarding Payroll Based Journal (PBJ) reporting. Review of the PBJ Staffing Data Report, Fiscal Year Quarter 1 (October 1- December 31) indicated the following:-Failed to submit data for the quarter: Triggered.-One star staffing rating: Triggered.-Excessively Low Weekend Staffing: This metric is suppressed for this facility and quarter.-No RN (Registered Nurse) Hours: This metric is suppressed for this facility and quarter.-Failed to have Licensed Nursing Coverage 24 hours per day: This metric is suppressed for this facility and quarter. During an interview on 3/24/26 at 1:24 P.M., the Administrator said that he was responsible for submitting the PBJ reports and that when he reported for the above quarter, there was an error that he was not aware of, resulting in a missing report for the quarter.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to maintain Enhanced Barrier Precautions (EBP) as indicated for four Residents (#85, #40, #59 and #119) out of a total sample of 29 residents.Findings include: Review of the facility policy titled Enhanced Barrier Precautions, not dated, indicated that Personal Protective Equipment (PPE) staff must don gloves and gowns during high-contact care activities, such as bathing or showering, wound care or dressing changes. Review of the Centers for Disease Control (CDC) website indicated the following, dated June 28, 2024:-Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). 1. Resident #85 was admitted to the facility in January 2026 with diagnoses including kidney failure on dialysis, fall with major injury and pneumonia. Review of the Minimum Data Set, dated [DATE] indicated that Resident #85 was cognitively intact scoring a 15 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #85 required assistance with all activities of daily living. Review of the physician orders indicated an order for enhanced barrier precautions, requires gown and glove use during high contact resident care activities due to increased risk of MDRO (multidrug resistant organism) acquisition due to dialysis catheter. On 3/25/26 at 9:12 A.M., the surveyor observed a sign on the room door indicating that Resident #85 was on enhanced barrier precautions (EBP). On 3/25/26 at 9:12 A.M., the surveyor and the Director of Nursing observed Certified Nurse's Aide (CNA) #1 providing direct contact care to Resident #85. The surveyor also observed that CNA #1 was not wearing a protective gown during the high-contact procedure. During an interview on 3/25/26 at 9:12 A.M., the Director of Nursing said that Resident #85 is on EBP, and the staff should be wearing gowns during high contact care. 2. Resident #40 was admitted to the facility in March 2026 with diagnoses including glaucoma, heart failure and anxiety. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #40 was cognitively intact scoring a 15 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #40 required assist with all activities of daily living. Review of the physician orders dated March 2026 indicated the following order: enhanced barrier precautions, requires gown and glove use during high contact resident care activities due to increased (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risk of MDRO (multidrug resistant organism) acquisition due to chronic LLE (left lower leg) vascular wound. On 3/25/26 at 9:12 A.M., the surveyor observed a sign on the room door indicating that Resident #85 was on enhanced barrier precautions (EBP). On 3/25/26 at 9:12 A.M., the surveyor and the Director of Nursing observed CNA #2 providing direct contact care to Resident #40. The surveyor also observed that CNA #2 was not wearing a protective gown during the high-contact procedure. During an interview on 3/25/26 at 9:16 A.M., the Director of Nursing said that staff were to wear protective gowns whenever providing direct contact care to a resident who had been placed on enhanced barrier precautions. The Director of Nursing said that Resident #40 was on EBP and staff should be wearing gowns during high contact care. 3. Resident #59 was admitted to the facility in March 2026 with diagnoses including surgical wound to right foot, sepsis and congestive heart failure. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #59 was cognitively intact, scoring a 14 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #59 required assistance with activities of daily living. Further review indicated that Resident #59 had a surgical wound. On 3/25/26 at 9:23 A.M., the surveyor observed a sign on the room door indicating that Resident #85 was on enhanced barrier precautions (EBP). On 3/25/26 at 9:23 A.M., the surveyor and Nurse #2 observed Nurse #1 performing a wound treatment to Resident #59's right foot. The surveyor and Nurse #2 also observed that Nurse #1 was not wearing a protective gown during the high-contact procedure. During an interview on 3/25/26 at 9:23 A.M. Nurse #1 said that he should have been wearing a gown during the treatment to Resident #59's foot. During an interview on 3/25/26 at 9:24 A.M. Nurse #2 said that Nurse #1 should have been wearing a gown during Resident #59's wound care. 4. Resident #119 was admitted to the facility in March 2025 with diagnoses including muscle weakness and retention of urine. Review of the Minimum Data Set, dated [DATE], indicated a Brief Interview for Mental Status score of 12 out of 15, indicating moderate cognitive impairment. The MDS further indicated that the Resident had an indwelling urinary catheter On 3/25/26 at 7:59 A.M., the surveyor observed a staff member in the room with the Resident. The staff member said she was providing morning ADL care for the Resident. The staff member did not have a gown on, only gloves. The surveyor observed a sign on the Resident's door that indicated the need for Enhanced Barrier Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident care plan, dated 2/24/25, indicated the following: -Resident requires Enhanced Barrier Precautions= EBP require gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO (Multidrug resistant organism) as well as those at increased risk of MDRO acquisition due to indwelling medical device, even if NOT infected or colonized with a MDRO. -Interventions included: Gown and gloves to be worn during high contact activities: ie: Bathing, Showering, Hygiene, Toileting, Incontinence care, Dressing, Transferring -[Resident] has Indwelling Suprapubic Catheter, 18french 30ml due to Urinary retention/obstructive uropathy, revised 1/28/25. Review of physician's orders indicated the following: -Resident requires Enhanced Barrier Precautions = EBP requires gown and glove use during high-contact resident care activities due to known risk of MDRO acquisition due to suprapubic catheter, dated 2/24/25. During an interview on 3/25/26 at 9:16 A.M., the Director of Nursing said that staff are to wear protective gowns whenever providing direct contact care to a resident who has been placed on enhanced barrier precautions. During an interview on 3/25/26 at 11:38 A.M., the Administrator said that he would expect that staff were implementing enhanced barrier precautions as required.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Advance Directives (written documents that instruct health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) were accurately documented for one Resident (#14) out of a total sample of 29 residents. Specifically, for Resident #14, the facility failed to ensure that Advanced Directives indicated on the MOLST form (Massachusetts Medical Order for Life-Sustaining Treatment form) were consistently documented in the medical record.Findings include: Review of the facility policy titled Advanced Directives, dated 1/20/23, indicated the facility will inform, document, and honor resident preferences regarding advance directives and MOLST orders. All staff will follow valid medical orders reflecting resident wishes. MOLST orders must match facility code status orders. Ensure consistency across all records. Staff must follow MOLST and physician orders. Any discrepancies must be clarified immediately. Definitions: Advanced Directives: Written Healthcare Instructions.MOLST: Medical Order for Life-Sustaining Treatment.DNR/DNI: Orders regarding resuscitation and ventilation. Resident #14 was admitted to the facility in February 2026 with diagnoses that included cognitive communication deficit, major depressive disorder, repeated falls, and traumatic subdural hemorrhage. Review of Resident #14's most recent Minimum Data Set (MDS) assessment, dated 2/22/26, indicated he/she scored a 6 out of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairments. Review of the MDS dated [DATE], indicted the Resident was a DNR (Do Not Resuscitate) and DNI (Do Not Intubate) code status. Review of Resident #14's physician order, dated 2/17/26, indicated DNR/DNI STATUS. Review of Resident #14's Advanced Directives care plan, dated 2/9/26, indicated DNR/DNI. Review of Resident #14's Medical Doctor (MD) progress note, dated 2/10/26, indicated Code Status: DNR/DNI. Review of Resident #14's social services progress note, dated 2/9/26, indicated MOLST reads DNI, DNR. Review of Resident #14's MOLST, dated 2/14/22, indicated DNR only signed by the Resident. During an interview on 3/25/26 at 7:51 A.M., Unit Manager #1 said that if a Resident had a MOLST then it should match the doctors order that was in place. Unit Manager #1 said Resident #14's MOLST only indicated that he/she was a DNR because the DNI spot had been left blank. The Unit Manager reviewed the Residents orders with the surveyor and said the doctors order reads as DNR and DNI. During an interview on 3/25/26 at 9:55 A.M., the Director of Nurses said the physician order should match exactly what was on the Resident's MOLST form. During an interview on 3/25/26 at 11:15 A.M., Social Services #1 said the Residents MOLST should always match the doctors order, so it was consistently documented on what the Residents wishes are.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that appropriate information was communicated to the receiving health care institutions or providers for one Resident (#130) out of a sample of 29 residents. Specifically, the facility failed to contact the Resident's health care provider and elder at-risk services in the community after the Resident provided verbal intent to leave the facility earlier than outlined in the care plan.Findings include:A review of the facility policy titled ?Discharges and Transfers' last updated 9/21/23 indicated the following:-Resident-initiated transfer or discharge means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment.Resident #130 was admitted to the facility in March 2026 with diagnoses including Parkinsons disease.A review of the most recent Minimum Data Set (MDS) dated [DATE] did not indicate a documented Brief Interview for Mental Status (BIMS) score.Further review of the medical record indicated Resident #130 signed his/her own MOLST (Medical Orders for Life-Sustaining Treatment) on 3/11/26 indicating he/she was his/her own responsible party.Review of hospital discharge summary progress notes dated 3/11/26 indicated that Resident #130 presented to the Emergency Department on 3/6/26 with acute delirium resulting in a motor vehicle collision.A review of Nursing progress notes dated 3/11/26 indicated the following:-Resident left AMA tonight. Resident was admitted this evening for a rehabilitation stay. Spouse was not pleased with some aspects of the stay. Resident's spouse was requesting all medications on order to be given to the Resident this evening. The Resident's spouse was informed that there was no in-house pharmacy, and we were awaiting delivery by the pharmacy. Meanwhile, a call was placed to the physician to address the issues. The Resident left before any resolution could be made.During an interview on 3/25/26 at 9:55 A.M., the Director of Nurses said when residents choose to leave the facility AMA, the Social Worker should notify the Resident's primary care provider in the community and notify elder at-risk services in the community.During an interview on 3/25/26 at 10:54 A.M., Social Worker #1 said Residents do have the right to leave the facility AMA. The Social Worker said she did not meet the Resident after he/she was admitted on [DATE]. The Social Worker said she was not aware that the Resident had left the facility AMA. The Social Worker said she expects to be informed when Residents leave AMA so she can call their primary care provider in the community and inform them that the Resident left the facility AMA. The Social Worker said she would also need to call and inform elder services in the community that the Resident may be at risk because the Resident wished to be discharged earlier than outlined in the plan of care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to follow a physician's order for one Resident (#118) out of a total sample of 29 residents. Specifically, the facility failed to ensure multipodus booties were implemented as ordered.Findings include: Review of the facility policy titled Care Plan dated reviewed 2/25/25 indicated the care plan guides the care and treatment provided by all caregivers. Resident #118 was admitted to the facility in January 2026 with diagnoses including liver disease, kidney disease and mild neurocognitive disorder. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #118 was cognitively intact, scoring a 13 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that he/she required extensive assistance with lower body dressing. Review of the physician order dated 2/22/26 indicated an order to offload heels with multipodous boots (pressure relieving boots) every shift. Review of the current care plan indicated a focus of potential for pressure ulcer development r/t decreased strength and endurance, Diabetes, Anemia, HTN with an intervention to off load both heels with multipodus boots when in bed. Further review failed to indicate Resident #118 refused care.On 3/24/26 at 8:41 A.M., the surveyor observed Resident #118 lying in bed. The surveyor also observed a pair of pressure relieving booties on the mattress at the end of the bed. During an interview on 3/24/26 at 8:41 A.M. Resident #118 said that the staff have not put them on yet today. Resident #118 then said that he/she was not able to put the booties on by him/herself. On 3/24/26 at 3:26 P.M., the surveyor observed Resident #118 lying in bed. The surveyor also observed a pair of pressure relieving booties on a chair across from the bed. During an interview on 3/24/26 at 3:26 P.M., Resident #118 said that staff never put the booties on today. When asked if he/she refused to wear the booties or did not like them on, Resident #118 said no. During an interview on 3/25/26 at 8:10 A.M., Certified Nurse's Aide (CNA) #1 said that nurses give report in the morning to let them know what the residents required. CNA #1 said that she wasn't aware that Resident #118 didn't have his/her booties on. During an interview on 3/25/26 at 9:24 A.M. Nurse #2 said that the CNAs were supposed to put the multipodus booties on and physician orders were supposed to be followed. On 3/25/26 at 12:54 P.M., the surveyor observed Resident #118 sitting in a wheelchair without multipodus boots on his/her feet.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure that a resident who is unable to carry out activities of daily living received the necessary services needed for two Residents (#24 and #125) out of a total sample of 29 residents. Specifically for Residents #24 and #125 the facility failed to provide supervision or assistance during meals for safety with eating. Findings include:Review of the facility policy titled Care Plan dated reviewed 2/25/25 indicated the care plan guides the care and treatment provided by all caregivers. 1. Resident #24 was admitted to the facility in March 2026 with diagnoses including dysphagia (difficulty swallowing), aspiration pneumonia and blood clots in the left leg. Review of the minimum Data Set assessment dated [DATE] indicated that Resident #24 was cognitively intact scoring a 13 out of 15 on the Brief Interview for Mental Status exam. Further review of the MDS indicated that Resident #24 pockets food in the mouth, coughs or chokes during meals and complains of difficulty when swallowing. Review of the current care plan indicated a focus for at risk for swallowing difficulty due to dysphagia. Further review indicated an intervention of during and/or after each meal if s/s (signs/symptoms) of aspiration are observed such as SOB (shortness of breath), watery eyes, labored breathing, choking, coughing, pocketing food notify the nurse and SLP (speech language pathologist). Further review indicated a focus for activities of daily living with an intervention; the Resident requires assist with eating. Review of the facility document titled Functional Abilities and Goals - admission - V 2 dated 3/5/26 indicated that Resident #24 required supervision/touching assistance with eating. On 3/24/26 at 8:53 A.M., the surveyor observed Resident #24 alone in his/her room eating breakfast. On 3/25/26 at 8:31 A.M., the surveyor observed Resident #24 alone in his/her room eating breakfast. Review of the Speech Therapy (ST) notes dated 3/22/26, 3/23/26 and 3/24/26 indicated that Resident #24 was being treated for dysphagia targeting tolerance of current diet (puree, thin). Further review failed to indicate the level of assistance with eating Resident #24 required. During an interview on 3/25/26 at 8:10 A.M., Certified Nurse's Aide (CNA) #2 said she wasn't aware that Resident #24 was supposed to be supervised at every meal. During an interview on 3/25/26 at 9:24 A.M. Nurse #2 said that she was not aware that Resident #24 was supposed to be supervised with meals. 2. Resident #125 was admitted to the facility in December 2025 with diagnoses including pneumonitis related to aspiration of food, dysphagia (difficulty swallowing) and degenerative disease of nervous system.Review of the Minimum Data Set assessment (MDS) dated [DATE] indicated that Resident #125 is severely cognitively impaired, scoring a 4 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #125 requires substantial/maximal assistance with eating. Further review of the MDS indicated that Resident #125 pockets food in the mouth and coughs or chokes during meals. Review of the current care plan indicated a focus for at risk for swallowing difficulty due to dysphagia. Further review indicated an intervention of during and/or after each meal if s/s of aspiration are observed such as SOB, watery eyes, labored breathing, choking, coughing, pocketing food notify the nurse and SLP (speech language pathologist). Further review indicated a focus for activities of daily living with an intervention to assist the Resident requires assist with eating. Review of the progress notes dated March 2026 indicated that Resident #125 had a history of aspiration pneumonia. During an interview on 03/24/2026 12:31 PM Family member (FM) #1 said that she was here with her son every day for lunch. FM #1 then said that Resident #125 coughed occasionally when eating. She said that Resident #125 was being trained to cough when needed during meals to try and prevent aspiration. During an interview on 3/25/26 at 8:10 A.M., Certified Nurse's Aide (CNA) #2 said that Resident #125 was supposed to be supervised at every meal. During an interview on 3/25/26 at 8:10 A.M., Certified Nurse's Aide (CNA) #1 said that nurses give report in the morning to let them know what the residents required. CNA #1 said that Resident #125 was supposed to be supervised at all meals. During an interview on 3/25/26 at 9:24 A.M. Nurse #2 said that Resident #125 was supposed to be supervised at every meal.

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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. Based on observation, record review and interview, the facility failed to provide treatment and care in accordance with professional standards of practice for one Resident (#41), out of a total sample of 29 residents. Specifically, for Resident #41 the facility failed to ensure wound provider recommendations were implemented for his/her arterial wounds.Findings include:Resident #41 was admitted to the facility in February 2023 with diagnoses that included chronic kidney disease, gout, adult failure to thrive, and falls. Review of Resident #41's most recent Minimum Data Set (MDS) assessment, dated 2/25/26, indicated he/she scored a three out of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Further review of the MDS indicated the Resident had one arterial ulcer. Review of Resident #41's wound care plan, dated 2/26/26, indicated Analgesia as ordered. Monitor/document side effects and effectiveness. Wound MD consult as ordered. Wound care as ordered. Review of Resident #41's Wound Care Provider Program assessment notes, dated 2/24/26, 3/3/26, 3/10/26, 3/17/26, and 3/24/26, indicated the Resident complained of moderate associated pain and had moderate bilateral lower extremity edema. Left heel arterial wound and sacral wound. The Wound notes further indicated:-May apply 4% Lidocaine gel to the wound daily and as needed (PRN) for pain.-LE (lower extremities) elevation and gentle compression therapy with gentle Ace wrap daily.-Offloading discussed.-Plan of care was discussed and coordinated with members of medical team present at bedside. Review of Resident #41's Wound Care Provider Program assessment note, dated 3/17/26, indicated Procedure: Surgical Excisional Debridement of subcutaneous tissue of the left heel. Review of Resident #41's Wound Care Provider Program assessment note, dated 3/24/26, indicated non-palpable pulses bilaterally. Suggest pre-medicating patient 30 minutes prior to wound rounds. Not improved. Review of Resident #41's physician orders failed to indicate any of the above recommendations were put into place. On 3/25/26 at 9:10 A.M., the surveyor observed Unit Manager #1 enter Resident #41's room with treatment supplies to complete his/her dressing changes. On 3/24/26 at 9:00 A.M. and 3/25/26 at 10:56 A.M., the surveyor observed Resident #41 in his/her chair with their feet flat on the ground not offloaded. During an interview on 3/25/26 at 10:56 A.M., Resident #41 said he/she was in pain during dressing changes every day and that it was not an enjoyable experience. During an interview on 3/25/26 at 11:02 A.M., Nurse #3 said Resident #41 had pain in his/her wounds and was on scheduled pain medications at 8:00 A.M., but they have not been given yet. Nurse #3 said the Unit Manager completes the treatments for this Resident and should tell her prior to completing them so she could medicate the Resident before the dressing changes. Nurse #3 was unaware that the dressings were completed and said that the Unit Manager puts in orders for the wound provider recommendations. During an interview on 3/25/26 at 11:06 A.M., Unit Manager #1 said the Resident should be medicated prior to the dressing changes and communication with the nurse did not happen today. He said the Resident did have pain during dressing changes and recommendations should be put in from the wound notes weekly by the Assistant Director of Nurses (ADON). During an interview on 3/25/26 at 11:27 A.M., Nurse Practitioner #1 said she was aware that Resident #41 had pain during wound changes and said she ordered pain medication that she expected to be given prior to the wound changes. Nurse Practitioner #1 said she goes to the facility frequently and expects nursing to put the wound recommendations in timely including the lidocaine, ace wrap and offloading of the lower extremities as she defers to the Wound Provider for wound orders. During an interview on 3/25/26 at 11:33 A.M., the ADON said the provider defers to the wound team and that staff were expected to put in all wound recommendations timely. The ADON said the Resident did have pain in his/her wounds and the plan of care had been communicated to staff for premedicating the Resident. The ADON said usually the Unit Managers puts in the new wound orders the same day as they round with the wound provider, and she helps with the wound orders at times but did not notice the lidocaine, and ace wraps orders were not in place.

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	03/25/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for one Resident (#3) out of sample of 29 residents. Specifically, the facility failed to ensure that nursing consistently administered oxygen in accordance with the physician's orders. Findings include: Review of facility policy titled Oxygen Administration, updated October 2019, indicated, but was not limited to, the following:-Oxygen shall be administered to a resident by a licensed nurse upon order of the physician.Procedure: -Verify physician order.-Apply cannula/mask as ordered and secure for comfort. Resident #3 was admitted to the facility in March 2026 with diagnoses that included respiratory failure and pneumonia. Review Resident #3's Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating severe cognitive impairment. Further review of the MDS indicated the use of continuous oxygen therapy. On 3/24/26 at 8:25 A.M., the surveyor observed Resident #3 in bed receiving supplemental oxygen at 2.5 liters per minute via nasal cannula, the adjustment controls for the supplemental oxygen were out of reach of the Resident. On 3/24/26 at 12:20 P.M., the surveyor observed Resident #3 in bed receiving oxygen at 2.5 liters per minute via nasal cannula, the adjustment controls for the supplemental oxygen were out of reach of the Resident. On 3/24/26 at 3:15 P.M., the surveyor observed Resident #3 in bed receiving oxygen at 2.5 liters per minute via nasal cannula, the adjustment controls for the supplemental oxygen were out of reach of the Resident. On 3/25/26 at 9:17 A.M., the surveyor observed Resident #3 in bed receiving oxygen at 2.5 liters per minute via nasal cannula, the adjustment controls for the supplemental oxygen were out of reach of the Resident. On 3/25/26 at 12:04 P.M., the surveyor observed Resident #3 in bed receiving oxygen at 2.5 liters per minute via nasal cannula, the adjustment controls for the supplemental oxygen were out of reach of the Resident. Review of Resident #3's active physician's orders indicated the following:- Maintain O2 saturation > 90% below apply 2L O2 via NC (sic), initiated 3/4/26.Further review of the physicians' orders failed to indicate additional instruction regarding Resident #3's supplemental oxygen rate. Review of Resident #3's care plans indicated the Resident used supplemental oxygen due to a recent hospitalization for aspiration pneumonia with respiratory failure and had the following intervention:-Oxygen Settings: O2 via NC (nasal canula) as ordered. Date Initiated: 03/04/2026Review of Resident #3's progress notes failed to indicate a justification for increasing the Resident's oxygen beyond the physician prescribed rate.Review of Resident #3's vitals summary failed to indicate the Residents oxygen saturation had ever dropped below 90%.During an interview and observation on 3/25/26 at 12:06 P.M. Nurse #4 said oxygen should be administered in accordance with the physicians' orders and that nurses check to ensure the correct rate of supplemental oxygen was being administered twice per shift and as needed throughout the day. Nurse #4 said that if a Resident required a different rate of supplemental oxygen than what was ordered that the physician would be notified and the order would be changed. Nurse #4 said that in an emergency the nurse could increase the rate of oxygen, notify the physician and then an order would be put in afterwards which would be documented, however, this was not the case for Resident #3 whose supplemental oxygen should be administered at 2 liters per minute. Nurse #4 observed Resident #3's current oxygen rate with the surveyor, Nurse #4 said the oxygen was being administered at 2.5 liters per minute which was the incorrect rate based on the physician's order. Nurse #4 said the Resident would not be able to adjust the rate him/herself. During an interview on 3/25/26 at 12:14 P.M. Unit Manager #2 said she would expect supplemental oxygen to be administered per the physician's order. Unit Manager #2 said Resident #3 should receive supplemental oxygen at 2 liters per minute and that she doubts the Resident would be able to change the setting him/herself. Unit Manager #2 said if the Residents' oxygen saturation had dropped that the nurse could increase the Resident's rate of supplemental oxygen and notify the physician who would then provide a new order with the new rate; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unit Manager #2 said if the rate needed to be changed, she would expect this to be documented.During an interview on 3/25/26 at 12:24 P.M. the Director of Nurses (DON) said supplemental oxygen should be administered per the physician order. The DON said he would expect Resident #3 to receive supplemental oxygen at a rate of 2 liters per minute based on the Residents physician order. The DON said that if the Residents' oxygen saturation was lower than 90% then a nurse could increase the rate of oxygen to return the Resident to baseline but should also contact the physician and receive a new order with an updated rate; the DON said this would be documented. The DON observed Resident #3's oxygen setting from earlier that day and interpreted the reading as a rate of 2.5 liter per minute and for that reason not reflective of his/her physicians' order. The DON said if the Resident was doing well on a rate of 2.5 liters per minute that the provider should have been contacted and the order formally changed.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that residents who were trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Specifically, for Resident #25 the facility failed to determine if the Resident had specific triggers and interventions that might mitigate the response to the triggers should they occur. Findings include:Review of the facility policy titled Trauma Informed Care dated revised January 2023 indicated that the facility must ensure that residents who were trauma survivors received culturally competent, trauma informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Further review indicated that the facility will:1. Identify a resident's past history of trauma. 2. Identify triggers which cause re-traumatization. Resident #25 was admitted to the facility in February 2026 with diagnoses including Post Traumatic Stress Disorder (PTSD), major depression and status post left knee replacement. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #25 is cognitively intact scoring a 14 out of 15 on the Brief Interview for Mental Status exam. Further review indicated a diagnosis of PTSD. Review of the current care plan indicated a focus for Trauma Informed Care failed to indicate triggers that might cause re-traumatization or interventions to mitigate potential reactions to the triggers. Further review failed to indicate if the Resident either refused to discuss his/her PTSD or whether the Resident indicated that there were no triggers he/she was aware of. Review of the social service progress notes failed to indicate Resident #25 had PTSD or that the Resident's PTSD was discussed with the Resident. Review of the medical record failed to indicate Resident #25 was assessed for PTSD and potential triggers. During an interview on 3/25/26 at 9:30 A.M., Resident #25 said that no one has asked her about his/her PTSD since he/she was admitted . Resident #25 then said that the loud talking of the staff at night can bring him/her back to his/her living situation as a child. Resident #25 said that it just makes him/her sad. During an interview on 3/25/26 at 9:58 A.M., the Director of Nursing said that the care plan should include triggers and interventions specific to the Resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure medication was secured in locked compartments for two Residents (#40 and #59) out of a total sample of 29 residents. Specifically,1. For Resident #40 the facility failed to ensure eye drops were secured in a locked compartment.2. For Resident #59 the facility failed to ensure an inhaler was secured in a locked compartment. Findings include:Review of the facility policy titled Medication Storage indicated that all medications are to be safely stored and locked up when not in use. Further review indicated that only authorized staff are to have access to medications. 1. Resident #40 was admitted to the facility in March 2026 with diagnoses including glaucoma, heart failure and anxiety. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #40 was cognitively intact scoring a 15 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #40 required assistance with all activities of daily living. On 3/24/26 at 8:00 A.M., the surveyor observed a bottle of Latanoprost eye drops (used to treat glaucoma) on the windowsill. Review of the medical record failed to indicate that Resident #40 was assessed to safely administer medications. Review of the physician orders failed to indicate an order to self-administer medications. Review of the care plan failed to indicate that the Resident may self-administer medications. During an interview on 3/24/26 at 12:25 P.M., Resident #40 said that someone came in and took the eyedrops from me. They said that I couldn't have them in my room. Resident #40 then said that he/she had brought them in from the hospital at admission to the facility and had had the eye drops in his/her room ever since and no one had said anything about it before. Resident #40 said that he/she had been self-administering the eye drops daily since he/she was admitted . 2. Resident #59 was admitted to the facility in March 2026 with diagnoses including asthma, sepsis and congestive heart failure. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #59 was cognitively intact, scoring a 14 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #59 required assistance with activities of daily living. On 3/24/26 at 8:23 A.M., and 10:35 A.M., the surveyor observed an Advair inhaler (used to treat asthma) on top of Resident #59's bedside cabinet. During an interview on 3/24/26 at 8:23 A.M., Resident #59 said that the nurses leave the inhaler with him/her to use. Resident #59 then said that he/she had been self-administering the medication since he/she was admitted . Resident #59 said that no one has told him/her that the medication needs to be locked up when not using. Review of the medical record failed to indicate that Resident #59 was assessed to safely administer medications. Review of the physician orders failed to indicate an order to self-administer medications. Review of the care plan failed to indicate the Resident may self-administer medications.During an interview on 3/25/26 at 12:00 P.M., Nurse #2 said that residents are not to have medications at the bedside unless they have been assessed to safely self-administer their medications. Nurse #2 said that neither Resident #40 or Resident #59 had been approved to self-administer medications and all medications should be securely locked at all times.