STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to utilize the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week, as required placing all residents at risk for not having their clinical needs met either directly by the RN or indirectly by the Licensed Practical Nurse (LPN) or Certified Nurse Aides (CNA) that the RN was responsible for overseeing with provision of resident care. Specifically, the facility failed to provide the services of an RN for at least eight consecutive hours a day, seven days a week when no staffing waivers were in place on 4 of 92 days during the period of 7/1/25 through 9/30/25. Findings include:Review of the Facility Assessment, last revised 12/15/25, indicated but was not limited to:-The ratio of registered and licensed practical nurses to aides shall be sufficient to assure professional guidance and supervision in the nursing care of the residents. Facility retains sufficient staffing to maintain a 24-hour licensed nurse (8-hours are RN, 7-days a week). Review of the Payroll Based Journal (PBJ) Staffing Data Report, dated Quarter 4: 2025 (July 1 - September 30), indicated the following:-One Star Staffing Rating Triggered = Star Staffing Rating Equals 1-No RN Hours Triggered = Four or More Days Within the Quarter with no RN Hours Review of the as worked nursing schedule provided by the facility failed to indicate that a RN worked for eight hours in the facility on the following weekend days:-7/6/25-7/13/25-8/3/25-8/16/25 During an interview on 1/15/26 at 9:32 A.M., the Administrator and the Director of Nurses (DON) said the facility did not have any nurse staffing waivers in place. During an interview on 1/21/26 at 12:05 P.M., the Administrative Assistant said she was responsible for staffing and scheduling. She said she was not aware the facility had triggered on the PBJ report for four or more days within the quarter with no RN during Quarter 4 2025. She said if the facility did not have a RN scheduled to work, or the agency did not have an RN available to work, then she would not schedule one. She said she was not aware the facility needed to have a RN on for eight consecutive hours in a 24-hour period seven days a week. During an interview on 1/21/26 at 12:12 P.M., the Administrator said he was aware the facility needed to have eight consecutive hours of RN coverage in a 24-hour period seven days a week. He said during the week the DON fulfills the requirement if there is not an RN scheduled to work, but on the weekends, it is not on his radar to get an RN if there is not one scheduled to work.

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
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on employee record review and interview, the facility failed to complete performance reviews of Certified Nursing Assistants (CNAs) at least once every 12 months and provide regular in-service education based on the outcome of these reviews for five out of five CNA (#1, #2, #3, #4, #5) employee records reviewed. Findings include:Review of five out of five personnel files, of CNAs (#1, #2, #3, #4, #5) who had been employed by the facility for over 12 months, failed to indicate a performance evaluation was completed in 2025. During an interview on 1/21/26 at 12:19 P.M., the Director of Nursing said he has been employed at the facility just over a year. He said since he has been at the facility, he had not completed any annual performance reviews or in-servicing based off the performance review. He said currently the facility does not have a process for annual performance reviews and it was something he had been looking into doing but had not gotten around to it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop, implement and maintain a Quality Assurance and Performance Improvement (QAPI) program which focuses on indicators of outcomes of quality of life, quality of care, and services to residents in the facility. Specifically, the facility failed to show evidence of implementing a data driven QAPI plan for clinical measures, quality of life, and resident choices identified by the facility to improve the resident's quality of life. Findings include:Review of the facility's policy titled Quality Assurance Improvement Plan- [Facility Name], undated, indicated but was not limited to the following:-Our nursing home has a Performance Improvement Program which systematically monitors, analyzes and improves its performance to improve resident/patient outcomes. -Clinical Care-Monitor existing quality improvement/quality measures (QI/QM) results, internal monitors for falls, medication errors, pressure ulcers, incident reports, and infection reports.-QAPI team- Monitor existing data available through resident/family satisfaction surveys, resident/family concerns brought up at Resident Council meetings, concerns from care conferences, informal conversations with residents/family members, and individual rounding with residents and family members.-We will use the performance prioritization sheet to identify areas of improvement and rank them by factors such as prevalence, risk, cost, relevant relevance, responsiveness, feasibility, and continuity period. From this we will determine our process improvement projects (PIPS). -The Steering Committee with the Administration is responsible and accountable for developing, leading, and closely monitoring a QAPI program.-The input given is acted upon and brings QAPI to life in the facility. Concerns are brought up when a certain department or task is not hitting benchmark. The concern is discussed and an action plan developed. If necessary, it will go on a Performance Improvement Project (PIP) Prioritization sheet.-Existing ongoing committees (e.g., staffing stability, falls, Infection control) report their data and activities to the QAPI Steering Committee.The committee maintains a QAPI manual that houses meeting minutes, project [NAME], PIPs, PDSA (Plan-Do-Study-Act) reviews, data, data analysis and sample performance improvement support tools. -The information is analyzed and compared to benchmark and/or targets established by the facility.-Current scores are analyzed against benchmarks that have been set. -Daily interdisciplinary team (IDT) notes are reviewed including adverse events and complaints on a daily basis. We have a mechanism for communicating patterns and trends identified during IDT meetings to the broader QAPI committee. -QAPI teams analyze data regularly as part of their project assignments.-A dashboard or dashboards for individual performance improvement projects are used to communicate progress and outcomes of individual QAPI projects.-Monthly reports/graphs are developed-Department managers and/or the QAPI lead is responsible for cataloging and maintaining these reports.-QAPI Lead is responsible for keeping logs up to date.-A summary of QAPI activities in outcomes will be reviewed and approved by the QAPI Committee. Key information will be posted in public areas of the facility for viewing by Residents, Caregivers, and Families. Written summaries will be available by request.-PIP project [NAME] are developed based on prioritizing process with a minimum of one project charted at a time; more than one may be charted based on the project, available resources, and QAPI committee recommendation.-Results are reported to residents, families, staff, and others verbally or in writing at least one time during Performance Improvement Plan or more often as appropriate.-PIPs are reported by the project lead to the monthly QAPI committee meeting verbally and documented in the meeting minutes.-Once the PIP goals have been met, the PIP will be placed on a permanent tracking log (Department head audit sheets, SDC, training, calendar, etc.) for ongoing but less frequent measurement, to ensure the PIP doesn't get forgotten.-The key elements of the program will be reviewed to ensure that they are occurring, that the program is efficient, it is accessible to the community members, and that the results are communicated to the appropriate (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	audience.Review of the facility's quarterly QAPI meeting agenda for 10/22/25, 7/22/25, and 4/23/25, indicated the same agenda with no Performance Improvement Plans identified. During an interview on 1/21/26 at 2:30 P.M., the Administrator said he has a quarterly QAPI meeting at which time they look at everything that happened in the last quarter, including all clinical risk indictors, lab reports, and the pharmacy's comprehensive recommendations, and review the Pharmacy recommendations that are concerning or that have not been completed (referencing review of the meeting agenda). In addition, he said the Department Managers go around the table and discuss what has happened in the last quarter. The Administrator said he completed a QAPI program for missing clothing. He said they implemented labeling the clothes but could not provide any documentation of the PIP, including data collection, analysis, time frame, audits or completion of PIP. The Administrator could not provide examples of completed PIPs which were data driven or ongoing PIPs with measurable goals, data, or audits for any PIPs. The Director of Nursing (DON) said he has not completed any PIPs, and he was not currently working on any PIPs for clinical care, infection control or with any other Department Managers. The DON said he does not have any audits he has performed for the clinical nursing staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record review, observation, and interviews, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed:1. During a respiratory illness outbreak, to implement Transmission-Based Precautions (TBP, an infection control measure to be used in addition to Standard Precautions for patients who may be infected) and to maintain infection surveillance;2. To implement and follow Enhanced Barrier Precautions for residents, including Resident #33;3. For Resident #12, to ensure sanitary practices were used by nursing while preparing and administering medications; and4. To ensure proper cleaning of resident shared equipment between resident use. Findings include:1.Review of the Centers for Disease Control and Prevention, Infection Prevention and Control Strategies for Seasonal Influenza in Healthcare Settings, dated 4/28/25, indicated but was not limited to: -Adhere to Droplet Precautions: Droplet precautions should be implemented for patients with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a patient is in a healthcare facility. Review of the facility's policy titled Policy for Isolation Precautions, undated, indicated but was not limited to the following: -It is the policy of this facility to, when necessary, prevent the transmission of infections within the facility through the use of Isolation Precautions. -Isolation precautions may be instituted by a physician, the infection preventionist, the director of nurses, nurse manager or charge nurse. -A resident may be placed in Isolation Precautions without a physician's order. -Use Droplet Precautions for a resident known or suspected to be infected with microorganisms transmitted by droplets that can be generated by the resident sneezing, coughing, talking, etc., and drop from the air. This includes bacterial infections and some viral infections, including influenza. -Obtain appropriate signage and post outside the doorframe (no resident name or organism name should appear on the signage). Review of the facility's policy titled Infection Prevention and Control Program, undated, indicated by was not limited to: -This program will perform surveillance activities to monitor and investigate cause of infection and manner of spread in order to prevent infections in the facility, maintain a record of infection for each resident who has an infection, analyze clusters or trends of infection, develop specific policies and procedures for standard and transmission based precautions, develop specific policies and procedures for outbreak management and reporting. On 1/15/26 from 7:41 A.M. to 8:17 A.M., the surveyor toured the facility and did not observe any precaution signs posted on the doorframe outside at the entrance of the residents' rooms. During an interview on 1/15/26 at 10:12 A.M., the Director of Nurses (DON) said there was currently (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	no cases of influenza or COVID-19 in the facility or mask requirements for the facility. During an observation with interview on 1/15/26 at 8:07 A.M., the surveyor observed Resident #16 in his/her bed with a moist cough. Resident #16 said he/she has been coughing for about three weeks. During an interview on 1/15/26 at 8:13 A.M., the Activity Director said she (the surveyor) should wear a mask because everyone was coughing and it started about a week ago. During an observation with interview on 1/15/26 at 8:20 A.M., the surveyor observed Resident #7 in his/her room. Resident #7 said he/she had just been in the facility dining room, but the nurse asked him/her to go back to his/her room. Resident #7 said he/she had been sick for about a week and a half with a bad cough and felt like his/her head was going to explode. Review of Resident #15's medical record indicated he/she was hospitalized in January 2026 due to a clinical change in condition including lethargy, low oxygen levels and a fever of 101.0 degrees Fahrenheit (F). Further review of Resident #15's medical record indicated he/she returned to the facility three days later and had been diagnosed with influenza at the hospital. Resident #15's medical record indicated he/she had received two additional doses of Tamiflu (a prescription antiviral medication used to treat and prevent Influenza A and B) (on 1/16/26 and 1/17/26) upon return to the facility. Review of Resident #7's medical record indicated on 1/2/26 he/she presented with symptoms of respiratory illness. Further review of Resident #7's medical record indicated on the following dates he/she continued with symptoms of respiratory illness as indicated: -1/4/26: coughing and sneezing -1/5/26: cold symptoms persisted -1/6/26: intermittent cough noted -1/9/26: Nurse Practitioner #1 indicated he/she had congested cough for approximately one week with a possible flu exposure Review of Resident #27's medical record indicated on 1/2/26 he/she had symptoms of respiratory illness. Further review of Resident #27's medical record indicated on the following dates he/she continued with symptoms of respiratory illness as indicated: -1/3/26: Cold symptoms with cough present -1/4/26: Resident is to start on Tamiflu secondary to cold symptoms. -1/6/26: Continues to have intermittent cough Review of Resident #25's medical record indicated on 1/2/26 he/she presented with flu-like symptoms including congestion. Further review of Resident #25's medical record indicated on the following dates he/she continued with symptoms of respiratory illness as indicated: -1/11/26: Continues to have intermittent cough (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #3's medical record indicated on 1/11/26 he/she presented with a fever of 101.3 degrees F. Further review of Resident #3's medical record indicated on the following dates he/she continued with symptoms of respiratory illness as indicated: -1/12/26: Hospice records indicated he/she had a nasal sound to voice and loose congested cough, had fevers over the weekend, seems to have a cold. Review of Resident #28's medical record indicated on 1/10/26 he/she presented with symptoms of respiratory illness including a cough. Review of the facility's January 2026 ongoing infection surveillance failed to indicate residents being monitored for respiratory symptoms. During an interview on 1/15/26 at 1:54 P.M., Nurse #2 said one resident tested positive for influenza, but he/she was out at the hospital. Nurse #2 said the other symptomatic residents were being treated with Tamiflu even though none of them had tested positive for influenza. During an interview on 1/15/26 at 2:44 P.M., Nurse #7 said many residents were being treated prophylactically for influenza. Nurse #7 said Resident #15 was sent to the hospital and had been diagnosed with the flu. Nurse #7 said Physician #1 had decided to treat his patients because a lot of the residents were having symptoms of respiratory illness. During an interview on 1/21/26 at 10:36 A.M., the Activity Director said residents had been coughing for a little over a week and a half, but at least there was not any flu in the facility. The Activity Director said no residents had required transmission-based precautions due to the illness. During an interview on 1/21/26 at 10:43 A.M., Certified Nursing Assistant (CNA) #2 said a lot of the residents had bad respiratory symptoms last week but none of them had the flu, it was just a cold. CNA #2 said it had been going on for about two weeks and no residents were started on transmission-based precautions. During an interview on 1/21/26 at 10:40 A.M., Nurse #6 said the facility has not had any cases of influenza or COVID-19. Nurse #6 said residents just had respiratory symptoms including cough and congestion. Nurse #6 said no residents had been on started on transmission-based precautions. During an interview on 1/21/26 at 2:27 P.M., Physician #1 said the facility had one or two residents that tested positive for influenza. Physician #1 said Resident #15 tested positive at the hospital and that many of the other residents had cold symptoms including a cough. Physician #1 said he chose to treat his residents prophylactically because the consequences of sudden death were high. Physician #1 said this flu season there was a higher risk because the flu vaccine did not match the influenza going around. Physician #1 said he encouraged the facility to keep a running list of residents and whether they were symptomatic or not because Tamiflu treatment would change from prophylactic dosing to treatment dosing. Physician #1 said the facility had not provided a list of symptomatic residents, but he kept track of it himself. During an interview on 1/20/26 at 3:29 P.M., the DON said recently the facility had a lot of residents with respiratory symptoms but did not have any cases of influenza or COVID-19. The DON said he had no documented surveillance for the respiratory illness outbreak that he completed rounds and observations. The DON said a couple of residents had been tested and documentation was in their (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	medical records, but he did not have a list of those who were tested or symptomatic. The DON said there were no residents who had respiratory symptoms at that time and no residents were or had been on TBP. During an interview on 1/21/26 at 1:19 P.M., the DON said only Resident #15 had been diagnosed with the flu, but the diagnosis had occurred while at the hospital. The DON said he believed Resident #15 had completed treatment for the influenza while at the hospital and so precautions were not initiated. 2. Review of the facility's policy titled Enhanced Barrier Precautions Guidelines, undated, indicated the following: -it is the policy of the facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multi-drug resistance organisms (MDRO). -EBP include gown and glove use during high-contact activities for residents known to be colonized or infected with a MDRO as well as those at risk for MDRO infection (residents with wounds or indwelling medical devices). -It may be acceptable to use gloves only when limited physical contact between the healthcare worker and the resident (i.e. administering medications through feeding tube). On 1/15/26 at 8:00 A.M., the surveyor observed the residents' rooms on the first floor. The surveyor did not observe any signage indicating any of the residents were on EBP. During an interview on 1/15/26 at 8:25 A.M., Resident #33 said he/she was recently admitted to the facility from the hospital and was receiving intravenous (IV) antibiotics for an infection. The surveyor did not observe an EBP sign outside of the room of Resident #33. Review of the medical record indicated Resident #33 was admitted to the facility in January 2026 with a urinary tract infection, a chronic Foley catheter, and IV antibiotics through a PICC line (peripherally inserted central catheter- a long, thin, flexible tube inserted through an arm vein for long term IV therapies). On 1/15/26 at 9:24 A.M., the surveyor observed Nurse #1 and Nurse #2 in the room with Resident #33 and repositioning the Resident in bed. Neither nurse was observed to be wearing a gown or gloves as they touched the Resident and the bed linens. On 1/16/26 at 8:31 A.M., the surveyor observed EBP signs outside of 3 out of 5 resident rooms in the hallway including Resident #33. The EBP sign indicated: -everyone must clean their hands including before entering and when leaving the room -providers and staff must also wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy), wound care (any skin opening requiring a dressing) On 1/16/26 at 8:31 A.M., the surveyor observed Nurse #1 repositioning Resident #33 in bed with no gloves or gown. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/16/26 at 2:25 P.M., Nurse #1 said she was not sure about the EBP sign not being posted outside of the Resident's room on 1/15/26. She said when residents are on EBP the staff only have to wear personal protective equipment (gowns, gloves) when they are providing care to the area in which the person was put on precautions for, such as the catheter for Resident #33. She said the staff did not need to wear PPE when providing any other care to Resident #33. During an interview on 1/20/26 at 3:30 P.M., the DON said if the surveyors did not see EBP signs it might be because the signs had fallen off the wall. He said staff were educated on how to follow EBP and were notified of precautions through the signs placed on resident rooms. 3. Review of the facility's policy titled Administering Medications, last revised December 2012, indicated but was not limited to: -Staff shall follow established infection control procedures for administration of medications as applicable. On 1/20/26 at 8:53 A.M., the surveyor observed Nurse #1 prepare 13 medications for Resident #12. Nurse #1 dropped one pill onto the narcotic book on top of her medication cart. She picked up the pill with bare hands, placed it into the medication cup and administered it to Resident #12. During an interview on 1/20/26 at 4:45 P.M., Nurse #1 said she had made a mistake by administering the medication she dropped onto her narcotic book to Resident #12. She said she should have disposed of the medication, and a new pill should have been administered. During an interview on 1/21/26 at 12:44 P.M., the DON said the top of the narcotic book and medication cart are not considered clean surfaces and the medication should have been discarded and a new pill should have been administered as it is an infection control concern. 4. Review of the facility's policy titled Cleaning and Disinfection of Resident-Care Items and Equipment indicated but was not limited to: -Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control and Prevention) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard. -Reusable items are cleaned and disinfected between residents. Review of the CDC's Considerations for Blood Glucose Monitoring and Insulin Administration, dated 8/7/24, indicated but was not limited to: -If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents. -If healthcare providers use blood glucose testing or insulin administration devices on more than one patient, equipment and supplies may become contaminated. Unsafe practices during assisted monitoring of blood glucose and insulin administration contribute to the spread of hepatitis B virus, hepatitis C virus, HIV, and other infections. Unsafe practices include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses. On 1/20/26 at 8:53 A.M., the surveyor observed the following: -Nurse #1 enter Resident #12's room with a glucometer (a portable medical device that measures the glucose level in a tiny drop of blood) and check his/her blood glucose level. -Nurse #1 exit the room and return the glucometer to the medication cart. Nurse #1 failed to clean and disinfect the glucometer machine prior to returning the glucometer to her medication cart. During an interview on 1/20/26 at 4:45 P.M., Nurse #1 said she should have cleaned and disinfected the glucometer after checking Resident #12's blood glucose level but she did not. During an interview on 1/21/26 at 12:44 P.M., the DON said shared equipment needed to be wiped down between uses for each resident or when returned to the medication cart to prevent the spread of infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observation, interview, and record review, the facility failed to provide services that met professional standards of practice for two Residents (#5 and #12), out of a total sample of 13 residents. Specifically, the facility failed to ensure medications were administered as ordered by the physician. Findings include:Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following:-The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice.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 errors.Review of the facility's policy titled Administering Medications, last revised December 2012, indicated but was not limited to:-Medications shall be administered in a safe and timely manner, and as prescribed.-Medications must be administered in accordance with the orders, including required time frames.-Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified.-The individual administering the medications must check the label THREE (3) times to verify the right resident, right medication, right time, and right method (route) of administration before giving the medication.A. Review of Resident #12's Physician Orders indicated but was not limited to:-Juven (nutrition drink powder designed to support wound healing) mix one packet in 8 ounces of fluid twice daily, dated 1/7/26On 1/20/26 at 8:53 A.M., the surveyor observed Nurse #1 prepare and administer Resident #12's morning medication. Nurse #1 prepared his/her Juven and mixed it with water in a 5-ounce cup.B. Review of Resident #5's Physician's Orders indicated but was not limited to:-Miralax (laxative powder) 17 grams mix with 6 to 8 ounces of thickened liquids, dated 10/24/25On 1/20/26 at 9:53 A.M., the surveyor observed Nurse #1 prepare and administer Resident #5's morning medication. Nurse #1 prepared his/her Miralax 17 grams and mixed it with water in a 5-ounce cup.During an interview on 1/20/26 at 4:45 P.M., Nurse #1 said she thought the cups she had on the medication cart were 8-ounce cups, but they were 5-ounce cups. During an interview on 1/21/26 at 12:44 P.M., the DON said medications must be administered per physician's orders. He said Nurse #1 should have checked the size of the cup and how much fluid it could hold.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to provide wound care as ordered and as recommended to one Resident (#8), in a total sample of 13 residents. Specifically, the facility failed to:a. Carry over wound treatment orders for the bilateral lower extremities to the new electronic medication administration record to ensure treatment was provided for three weeks, andb. Follow the wound consultant recommendations to change the treatment to the lower extremity. Findings include:Resident #8 was admitted to the facility in February 2025. Review of the medical record indicated Resident #8 developed wounds to the bilateral lower extremities in June 2025 and began treatments as recommended by the consultant Wound Nurse Practitioner (NP). a. During an interview on 1/20/26 at 4:40 P.M., the Director of Nurses (DON) said the facility had documented on paper in November 2025 until their change of electronic Medication Administration Record (MAR) and Treatment Administration Record (TAR) were implemented on 12/1/25. Review of the November 2025 TAR for Resident #8 indicated a new treatment was implemented on 11/12/25 for both lower extremities to cleanse with normal saline, pat dry, apply calcium alginate with silver followed by an ABD pad and roll with gauze, then ace wrap, daily. The order was updated on 11/27/25 to change the ABD pad to super absorbent pads. Review of the November TARs indicated treatments were provided as ordered. Review of the December 2025 electronic medical record failed to include any treatment orders were in place for the bilateral lower extremities from 12/1/25 through 12/23/25. Review of the nursing progress notes indicated Resident #8 saw the consultant Wound NP on 12/3/25. Review of the nursing progress note written by Nurse #5 on 12/10/25 indicated Resident #8 had refused wound treatments for two days and refused to see the consultant Wound NP. Review of the nursing progress note written on 12/11/25 indicated Resident #8 refused wound treatment. No further documentation in the progress notes indicated wound treatments were provided to Resident #8 between 12/1/25 and 12/23/25. During an interview on 1/21/26 at 2:40 P.M., Nurse #5 said the facility had switched the MAR/TAR system in December 2025. She said she was not sure why the bilateral lower extremity wound treatments for Resident #8 were not part of the treatment orders. She said she could not know if other staff had attempted wound treatments. She said she was not sure why she had not noticed when the Resident refused treatments that there had not been orders in place. b. Review of the medical record indicated Resident #8 was seen by the consultant Wound NP on 1/7/26. The nursing progress note, written by Nurse #5, indicated the treatment to both legs was changed to cleanse with normal saline, apply Xeroform (a sterile, non-adhering protective dressing consisting of absorbent, fine-mesh gauze impregnated with a petrolatum blend), secure with ABD pad, rolled gauze, and ace wraps. Review of the treatment orders on 1/16/26 failed to include the updated treatment recommendations from 1/7/26. During an interview on 1/21/26 at 3:20 P.M., Nurse #5 said she had entered the nursing progress note regarding the consultant Wound NP visit on 1/7/26 but had not checked to see if the treatment orders had changed. During an interview on 1/21/26 at 2:40 P.M., the physician said he was unaware that the treatment orders were not implemented in December 2025 and that switching electronic medical record systems did not mean that patient care should suffer. He said the facility had a very good wound care team and he follows their treatment recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure pharmacy recommendations from medication regimen reviews (MRR) were reviewed and addressed timely for two Residents (#2 and #27), out of a total sample of 13 residents. Findings include:1. Resident #2 was admitted to the facility in July 2025 with a diagnosis of hyperlipidemia (elevated fats in the blood). Review of the Pharmacy MRR form indicated on 9/25/25 a recommendation was made to the physician regarding medications for Resident #2. Review of the paper and electronic medical record failed to include what the pharmacist recommended and the physician response to the recommendation. On 1/21/26 at 9:00 A.M. the surveyor was provided with a pharmacy consultant Director of Nursing (DON) Summary Report which indicated for the physician to review if Resident #2 needed to continue on a statin (a medication that lowers fat and cholesterol in blood), and if continuing, to consider adding Coenzyme Q10 (a vitamin-like antioxidant). During an interview on 1/21/26 at 9:15 A.M., the DON said he was unable to locate any documentation to indicate the physician had reviewed the pharmacist's recommendation for Resident #2 made in September 2025. 2. Resident #27 was admitted to the facility in July 2023 with diagnoses of anxiety and depression. Review of the Pharmacist's MRR in the medical record indicated on 6/25/25, 7/21/25, and 8/28/25, a recommendation was made to the physician to obtain consents. Review of one pharmacy consultant DON Summary Report created between 8/1/25 and 8/29/25 provided to the surveyor indicated the Resident had current orders for Cymbalta, Trazodone, and Remeron which require consents to be signed and dated yearly. A review of the medical record indicated consents were either incomplete, outdated, due the next month, or were not found in the resident's chart. Review of the medical record indicated Resident #27 had signed consents for Cymbalta dated 7/6/23, Trazadone dated 11/17/23, and Remeron dated 7/20/23. During an interview on 1/21/26 at 11:56 A.M., the DON said he only had one pharmacy recommendation for Resident #27 dated 8/25/25 and it was for consents (see above DON Summary Report). The surveyor reviewed the handwritten MRR form in the medical record indicating in June, July and August 2025 the pharmacist recommended updated consents be obtained. The DON said all consents in the house were reviewed and Resident #27's should be up to date. During an interview on 1/21/26 at 1:38 P.M., the DON said he could not find any additional consents for Resident #27.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, records reviewed, and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5% when two out of three nurses observed during a medication pass made three errors out of 28 opportunities, resulting in a medication error rate of 14.29%. Those errors impacted one Resident (#12), out of four residents observed. 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 prescribers. Review of the facility's policy titled Administering Medications, last revised December 2012, indicated but was not limited to:-Medications shall be administered in a safe and timely manner, and as prescribed.-Medication must be administered in accordance with the orders, including required time frames.-Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified.-The individual administering the medications must check the label THREE (3) times to verify the right resident, right medication, right time, and right method (route) of administration before giving the medication. For Resident #12, Nurse #1 failed to administer:-the correct dose of Allopurinol (treats chronic gout by lowering uric acid),-Folic Acid (used for preventing and treating low blood levels of folate)-Vitamin D3 (a critical fat-soluble vitamin that promotes calcium absorption for bone health, supports immune function, and maintains muscle/nerve health)-Pyridoxine (Vitamin B6, a water-soluble vitamin essential for protein metabolism, red blood cell production, and nervous/immune system function)On 1/20/26 at 8:53 A.M., the surveyor observed Nurse #1 prepare and administer medications to Resident #12 including:-Allopurinol 100 milligrams (mg) tab Nurse #1 omitted the following medications:-Folic Acid 400 micrograms (mcg)-Vitamin D3 5000 units-Pyridoxine 100 mg Review of Resident #12's Physician's Orders indicated but was not limited to:-Folic Acid 400 mcg, give one tablet daily at 9:00 A.M., dated 1/7/26-Vitamin D3 5000 units, give once a day at 9:00 A.M., dated 1/7/26-Allopurinol 100 mg, give 50 mg daily at 9:00 A.M., dated 1/7/26-Pyridoxine 100 mg, give one table daily at 9:00 A.M., dated 1/7/26 Additionally, during the medication pass the surveyor observed a bottle of Vitamin D3 1000-unit tablets in the medication cart. During an interview on 1/20/26 at 9:40 A.M., Nurse #1 said the facility did not have Vitamin D3 5000 units, Folic Acid 400 mg, and Pyridoxine available. During an interview on 1/20/26 at 4:45 P.M., Nurse #1 reviewed Resident #12's Allopurinol order, she said she had overlooked that the order said to administer Allopurinol 50 mg and administered Allopurinol 100 mg this morning. She said she should have administered Allopurinol 50mg as ordered by the Physician. Nurse #1 said the medication cart contained a bottle of Vitamin D3 1000 units tablets. She said she could have administered five 1000 units tablets, but she did not. During an interview on 1/21/26 at 12:44 P.M., the Director of Nursing said Nurse #1 should have given Resident #12 five tablets of Vitamin D3 1000 units to equal Vitamin D3 5000 units. He said medications must be administered as ordered by the Physician and follow the five rights (right patient, right drug, right dose, right route, and right time).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observation and interview, the facility failed to ensure all drugs and biologicals were stored in a safe and secure manner as required. Specifically, the facility failed to ensure multidose vials of medications were labeled with a date opened and a use by date per manufacturer's guidelines in one of one medication carts and in one of one medication rooms.Findings include:Review of the facility's policy titled Administering Medications, last revised December 2012, indicated but was not limited:-When opening a multi-dose container, the date opened shall be recorded on the container.-Insulin pens will be clearly labeled with the resident's name or other identifying information. Review of the facility's policy titled Medication Storage in the Facility, last revised in January 2018, indicated but was not limited to:-When the original seal of a manufacturer's container or vial is broken the container or vial is initially broken, the container or vial will be dated. The nurse shall place a date opened sticker on medication and enter the date opened and/or new date of expiration.-Medications and multidose containers may be used until the manufacturer's expiration date or for the length of time allowed by state regulations, whichever is less.-The date opened and/or the triggered expiration date should be recorded on the label for such purposes affixed to the vial. Review of the Center for Disease Control and Prevention's (CDC) Considerations for Blood Glucose Monitoring and Insulin Administration, dated 8/7/24, indicated but was not limited to:- Insulin pens should be assigned to an individual person and labeled appropriately. Review of the CDC's Preventing Unsafe Injection Practices, dated 3/26/24, indicated but was not limited to:- Limit the use of multi-dose vials and dedicate them to a single patient whenever possible. Reused multi-dose vials should be kept and accessed in a designated clean medication preparation area, away from immediate patient treatment areas.- Multi-dose vials are labeled by the manufacturer and typically contain an antimicrobial preservative to help limit the growth of bacteria. The preservative does not have an effect on viruses, nor does it provide complete protection against bacterial contamination.- The United States Pharmacopeia (USP) General Chapter 797 recommends the following: - Once a multi-dose vial is opened (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer states another date for that opened vial. The beyond-use-date should never exceed the manufacturer's original expiration date. On 1/15/26 at 1:57 P.M., the surveyor completed a review of the medication storage room with Nurse #7 and observed the following in the refrigerator:-One open multidose vial of Tubersol (used to aid in diagnosing of tuberculosis infection), dispense date 1/23/25. Manufacturer's guidelines indicated that once open use within 30 days. On 1/15/26 at 2:09 P.M., the surveyor completed a review of the medication cart with Nurse #2 and made the following observations:-One opened multidose vial of Lantus Insulin (a long-acting insulin), dispense date 10/20/25, laying in a box with lancets, glucose test strips, and alcohol wipes, uncapped without a resident's name, date opened, and expiration date.-One opened multidose vial of Humalog Insulin (rapid-acting insulin), laying in a box with lancets, glucose test strips, and alcohol wipes, uncapped, without a resident's name, date opened, and expiration date.-Two opened Tresiba Insulin (long- acting insulin) pens without a resident's name, date opened, and expiration date.-One opened Aspart Insulin (fast-acting insulin) pen without a resident's name, date opened, and expiration date.-Two opened Lispro Insulin (fast-acting insulin) pens without a resident's name, date opened, and expiration date.-One open Lispro Insulin pen, dispense date 10/11/25 without a date opened and expiration date. During an interview on 1/15/26 at 2:19 P.M., Nurse #2 said all insulin must be labeled with a resident's name, date opened, and expiration date. She said once the insulin is opened, regardless of if it is a multidose vial or an insulin pen, it was only good for 28 to 30 days after opening and per manufacturer's instructions. She said she did not know to which residents the two multiuse vials of insulin and five insulin pens belonged to. She said the two multidose vials of insulin should have been (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stored in an individual bag since they are opened. She said she did not have to administer insulin today (1/15/26) therefore she had not checked the insulin for proper storage and labeling. During an interview on 1/21/26 at 12:38 P.M., the Director of Nursing said once insulin was opened it was only good for 28 to 30 days or per manufacture's guideline. He said multidose vials of insulin must be stored in an individual bag for infection control purposes and to prevent cross contamination. He said all insulins must be labeled with a resident's name, date opened, and expiration date. He said the Tubersol was only good for 30 days once opened and should have been labeled with a date opened and use by date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure food and liquids were prepared and served in a form designed to meet the individual needs for three Residents (#34, #25, and #5), out of a total of 13 sampled residents. Specifically, the facility failed:1. For Residents #34, to follow the physician ordered therapeutic diet of minced moist (ground) and follow the downgrade from thin liquids to nectar thick liquids resulting on three occasions to be served the wrong diet consistency: a. Resident was served a whole hot dog while on a minced moist diet. b. Resident was served thin liquids at breakfast after the Resident's diet was downgraded the previous day to nectar thick liquids. c. Resident was served regular (thin) water resulting in Resident stating he/she choked.2. For Resident #25, who was on a mechanical soft diet related to swallowing difficulties, to serve him/her the therapeutic alternative to a whole baked potato; and3. For Resident #5, to serve nectar thick liquids during medication administration putting him/her at risk for aspiration (inhaling foreign material (like food, liquids, or vomit) into the lungs).Findings include:Review of the facility's policy titled Therapeutic Diet, revised November 2015, indicated but was not limited to the following: -Therapeutic diets shall be prescribed by attending physician. Mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered therapeutic diets. Examples of therapeutic diets include: Altered consistency diets. - The physician's diet order should match the terminology used by food services. -Routine menus are planned by the Food Services Manager and approved by a registered dietitian for nutritional accuracy. The Food Service manager will establish and use a tray identification system to ensure that each resident receives his or her diet as ordered. Review of the facility's policy titled Dietary Notification Policy of Diet Changes, dated 7/27/09, indicated but was not limited to the following: -Purpose of this diet slip policy is to assure (sic) that the kitchen is alerted to the diet change timely. Having the diet written out also makes it clearer for the kitchen staff who are responsible for implementing the change. -Procedure: -A Dietary Notification Slip is to be sent to the kitchen before the diet can be changed. A phone call can be made to the kitchen to alert the staff if it is close to the meal delivery time, but this call must be followed by a dietary slip. -When writing the new diet on the slip please include the ENTIRE diet on the slip, not just the texture change or the therapeutic change. -Speech therapist cannot write out a diet slip and bring it to the kitchen. The nurse must obtain an order then she/he will bring it to the kitchen. Resident #34 was admitted to the facility in January 2026 with diagnoses which included cerebral infarction (stroke), aphasia (impaired ability to speak), and dysphagia (difficulty swallowing, indicating a disruption in the process of moving food or liquid from the mouth to the stomach). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #34's Physician's Orders indicated: -Minced and moist, thin liquids. Special instructions: small single sips, every shift. Effective 1/10/26 through 1/15/26 -Minced and moist, Nectar thick liquids. Special instructions: small single sips, every shift. Effective 1/15/26 open ended. -May omit dietary restrictions on special occasions. No, Effective 1/10/26 opened ended. Review of the Nursing Note, dated 1/15/26 at 3:49 P.M., indicated Resident #34 had a new order per Nurse Practitioner #1 to be placed on nectar thick liquid due to coughing episodes until cleared by Speech. During an interview on 1/15/26 at 5:11 P.M., Nurse #1 said when Resident #34 came from the hospital he/she was on puree diet and they upgraded Resident #34 today to a minced moist diet and nectar thick liquids. During an interview on 1/15/26 at 5:15 P.M., the Director of Nursing (DON) said if the diet was changed today from thin liquids to nectar thick liquids. The DON said the staff should have sent a communication slip to the kitchen when the Nurse Practitioner changed the diet. The surveyor reviewed the Kitchen communication book with Nurse #1 and there was no diet slip filled out for Resident #34 on 1/15/26. The DON said to Nurse #1, let's make sure we send the change in diet to the kitchen now. a. On 1/15/26 at 5:02 P.M., the surveyor observed Resident #34's dinner tray and diet slip and made the following observations: -Review of diet slip indicated Resident #34 was prescribed a mechanical soft diet (minced moist) and thin liquids. -Resident #34 was served a whole hot dog in a bun. -Resident #34 was served with nectar thick milk, apple juice, and orange juice. During an interview on 1/15/26 at 5:11 P.M., Nurse #1 said Resident #34 has orders for minced moist diet which should be chopped up in small pieces. Nurse #8 said it should be something soft they can chew. Nurse #1 and Nurse #8 both said Resident #34 should not be given a whole hot dog. Nurse #1 said when Resident #34 came from the hospital he/she was on puree diet and they upgraded Resident #34 today to a minced moist diet and nectar thick liquids. During an interview on 1/15/26 at 5:15 P.M., the Director of Nursing (DON) said if Resident #34 was admitted with minced moist diet (mechanical soft), the Resident should not have received a whole hot dog. b. On 1/16/26 at 8:43 A.M., the surveyor observed Resident #34's breakfast tray and made the following observations: -Review of diet slip indicated Resident #34 was prescribed a mechanical soft diet and thin liquids. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident was served thin liquids including milk, coffee, and cranberry juice. c. On 1/16/26 at 9:41 A.M., the surveyor heard Resident #34 yelling. The surveyor entered the room after Nurse #4 and observed a cup of water which had been thrown across the room. During an interview on 1/16/26 at 9:42 A.M., Resident #34 said he/she choked; it went down the wrong way. During an interview on 1/16/26 at 9:42 A.M., Nurse #4 checked her report sheet and said Resident #34 was not on Nectar thick liquids. Nurse #4 checked Resident #34's current orders and said Resident #34 has orders for nectar thick liquids. She said she was never told in report the Resident was changed to nectar thick liquids yesterday. Nurse #4 said she checked Resident #34's breakfast tray this morning and he/she was served nectar thicks liquids. The surveyor shared their findings with Nurse #4 which showed Resident #34's breakfast tray had thin liquids, and the meal ticket indicated thin liquids. Nurse #4 said the ticket should be corrected. After the surveyor notified the facility, on 1/15/26 at 5:15 P.M., that Resident #34's diet was downgraded from thin liquids to nectar thick liquids by the Nurse Practitioner on 1/15/26 at 3:49 P.M., the facility continued to serve Resident #34 thin liquids on 1/16/26 on two occasions. 2. Resident #25 was admitted to the facility in April 2023 with a diagnosis of dysphagia. Review of the Care Plans indicated Resident #25 required an altered consistency diet related to chewing issues and would be evaluated by speech therapy in 2024. The interventions included monitoring for and reporting episodes of choking and to cue to slow down if eating too quickly. Review of the current Physician's Orders indicated Resident #25 had a diet consistency of mechanical soft (foods that are naturally soft, mashed, ground, or finely chopped to require minimal chewing) and an order for aspiration precautions to be maintained through 1 to 1 assist with meals. Review of the Speech Therapy evaluation, dated 1/12/26, indicated Resident #25 had dysphagia, required supervision at mealtimes and needed assistance with feeding. On 1/16/26 from 12:15 P.M.-12:38 P.M., the surveyor observed Resident #25 having lunch in the main dining room. The meal plate contained a cut up piece of fish and a whole baked potato (skin on) with a slit at the top and sour cream in the slit, the inside of the potato was not visible to the Resident. Review of the facility's therapeutic menu with breakdowns indicated a for residents with mechanical soft diets, a baked potato should be provided mashed with a fork. During an interview on 1/20/26 at 1:50 P.M., the Food Service Director said for residents on a mechanical soft diet she will usually serve the residents mashed potatoes instead of a baked potato. She said Resident #25 should not have gotten a baked potato on 1/16/26. 3. Resident #5 was admitted to the facility in January 2019 with diagnosis including dementia. Review of the most recent Minimum Data Set (MDS) Assessment, dated 1/14/26, indicated Resident #5 had a severe cognitive deficit as evidenced by staff interview. Further review of his/her MDS assessment indicated Resident #5 was on a mechanically altered diet (a diet which required a change (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in texture of food or liquids). Review of Resident #5 Physician Orders indicated but was not limited to: -Nectar thick liquids (easily pourable and flows from a spoon more slowly like a thicker cream soup), dated 12/4/25 -Miralax (laxative powder) 17 grams mix with 6 to 8 ounces of thickened liquids, dated 10/24/25 On 1/20/26 at 9:53 A.M., the surveyor observed during medication administration Nurse #1 prepare Resident #5's Miralax and mix it with water. Nurse #1 administered the Miralax mixed with water to Resident #5. Nurse #1 failed to thicken Resident #5's water to a nectar consistency prior to administering his/her medication. During an interview on 1/20/26 at 4:45 P.M., Nurse #1 said Resident #1 was on nectar think liquids. She said Resident #1 was supposed to drink nectar thick liquids at all times, but she did not thicken the water she used for the Miralax. She said she thought the Miralax would act as a little bit of a thickener. During an interview on 1/21/26 at 1:04 P.M., the Director of Nursing said Miralax was not a thickening agent. He said the water used for Resident #5's Miralax should have been thickened to a nectar thick consistency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure the main kitchen and 2nd floor kitchenette maintained sanitary conditions. Specifically, the facility failed to:1. Substitute pasteurized eggs (in-shell or liquid eggs gently heated between 130 degrees Fahrenheit (F) to 140 F to kill salmonella and bacteria without cooking them, making them safe for raw or undercooked recipes) for raw shell eggs when serving undercooked poached eggs to residents, placing them at risk for Salmonella Enteritidis (a virulent organism that may be present in raw shell eggs);2. Ensure open-refrigerated, ready-to-eat time/temperature controlled for safety, foods were labeled with the date of opening; and3. Ensure the second-floor kitchenette was regularly cleaned and did not contain expired foods. Findings include:1. Review of ServSafe Manager, 6th edition, indicated if you mainly serve high-risk populations, such as those in hospitals and nursing homes, use pasteurized eggs or egg products when serving dishes that are raw or undercooked. On 1/15/26 at 8:50 A.M., the surveyors observed the residents having poached eggs (eggs cooked outside the shell in simmering water, resulting in a tender, set white and a soft, runny yolk) for breakfast. Review of the Fall/Winter 4-week cycle menu indicated on Fridays on Week 3 the residents were served poached eggs on toast. During an interview with observation on 1/15/26 at 11:54 A.M., the Food Service Director (FSD) said she was using pasteurized eggs. The FSD and surveyor observed an open case of eggs in the refrigerator not labeled as pasteurized. The FSD said she had opened the case this morning and had used these eggs for poached eggs. Review of the facility food delivery orders for November 2025, December 2025 and January 2026 indicated raw shell eggs (not pasteurized) were ordered on 11/17/25, 12/11/25, and 1/8/26. During an interview on 1/20/26 at 9:23 A.M., the FSD said the poached eggs were the only undercooked eggs that were on the 4-week cycle menu. She said the poached eggs should have been made with pasteurized eggs. 2. Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised January 2023, indicated but was not limited to the following:3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.(B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. On 1/15/26 at 7:30 A.M., the surveyor observed two white plastic containers in the refrigerator with worn labels indicating fruit salad. The surveyor opened one of the containers which contained a plastic bag with a light-yellow powdery food substance with a small scoop with a handle resting in the food. During an interview on 1/20/26 at 9:25 A.M., the FSD said the first bucket contained grated parmesan cheese. She said she does not know when the plastic bag was opened as it was not labeled. She said the open parmesan cheese can usually last about 20 days. The surveyor and FSD observed the order sticker to indicate the item was delivered to the facility on [DATE]. The second bucket was opened and contained a plastic bag with a white shredded cheese. The FSD said this was mozzarella cheese and was stuck together from being pushed down into the bucket. The surveyor and FSD observed the order sticker date to indicate the mozzarella cheese was delivered to the facility on [DATE]. She said the bags of parmesan cheese and mozzarella should have been dated when opened. During an interview with observation on 1/20/26 at 9:25 A.M., the surveyor observed opened containers of lemon and cranberry thickened liquids with manufacturer (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	directions stating, after opening, may be kept up to seven days under refrigeration. The FSD said she was not sure when the items were opened because they were not labeled with the open date. The surveyor and the FSD also observed the following opened items that were not labeled: large jug of relish, large jug of mayonnaise, large jug of Caesar salad dressing, nine-pound container of Dijon mustard and a jar of mint jelly which had changed color at the top of the jelly to a darker color with spots. The surveyor and the FSD were unable to find dates on any of the containers. The surveyor and the FSD peeled off a sticker from the top of the mint jelly and found a best by date of 11/22/24. During an interview on 1/20/26 at 9:40 A.M., the FSD said all of the dietary staff know that the refrigerated items need to be labeled when opened to ensure food safety. She said it was the responsibility of all staff to be labeling the items, and she was responsible for the oversight of the staff. 3. On 1/20/26 at 9:13 A.M., the surveyor observed the second-floor kitchenette with the following:-food residue on the microwave handle, small pieces of orange substance in the microwave-cabinets to have a visible residue around the handles-refrigerator: one homemade marmalade dated as expiring June 2025 and two yogurts with a use by date of 1/13/26; and a brown spilled substance in the bottom drawer During an interview on 1/20/26 at 9:45 A.M., the FSD said the microwave and cabinets should be cleaned by housekeeping staff. She said the Dietary staff should be checking the refrigerator for expired foods every day to discard expired foods. During an interview on 1/21/26 at 11:48 A.M., Housekeeper #1 said she was the housekeeper on the second floor. She said she was not responsible for wiping down the cabinets, the microwave, or the refrigerator. During an interview on 1/21/26 at 12:24 P.M., the Maintenance Director said he was responsible for the maintenance and housekeeping staff. He said the housekeeping staff should be cleaning the second-floor kitchenette including the cabinets, microwave, and refrigerator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on record review and interview, the facility failed to ensure staff notified the Physician in a timely manner recommendations for a medication change from the consulting Psychiatric (Psych) Nurse Practitioner (NP) for one Resident (#27), out of a sample of 13 residents. Specifically, the facility failed to notify the Physician of recommendations to increase Cymbalta (an antidepressant medication) from 60 milligrams (mg) to 90 mg. This delay resulted in Resident #27 not receiving an increased dose for 41 days.Findings include:Resident #27 was admitted to the facility in July 2023 with diagnoses of anxiety and depression. Review of the Psych NP's progress note, dated 10/20/25, indicated but was not limited to:-Chief complaint- Please document using patient's own words why they are Here: Sad-Mood: Depressed-Recommendations: Mood. Cymbalta 60 mg daily. Sad mood. Consider increasing to 90 mg daily.-Psych NP is in a consultative role; recommendations are given to facility prescriber. Review of an email from the Psych NP to the Director of Nursing (DON) and Director of Social Services (SS), dated 10/20/25, indicated the Psych NP emailed Resident #27's progress note to the facility the same day of service on 10/20/25.Review of Nursing Notes, dated 12/1/25 at 2:58 P.M., indicated New Psych recommendations reviewed with Physician (MD) #1. MD agrees with recommendations and suggests to increase as follows: Duloxetine (Cymbalta) 60 mg orally (po) daily to Duloxetine 90 mg po daily. Monitor Moods. Review of the Medication Administration Records (MAR) for 10/20/25 through 11/30/25 indicated Resident #27 received Duloxetine 60 mg daily.Review of the MAR for December 2025 indicated starting 12/2/25 Resident #27 started receiving Duloxetine 90 mg daily. During an interview on 1/20/26 at 2:08 P.M., the DON said if a resident is seen by the Psych NP, her notes are emailed to him and the Director of SS. Once the notes are received, the physician is notified and then the family. The DON was not sure what day the Psych NP note was emailed over, but whenever the note was received, it should have been acted upon right away. The DON said a month is a long time for the physician to be notified. During an interview on 1/20/26 at 2:25 P.M., the Director of SS reviewed her emails and said the Psych NP note for Resident #27's visit on 10/20/25 was received on 10/20/25. The Director of SS said when she receives the Psych NP notes, she prints them and gives them to the DON. During an interview on 1/20/26 at 2:27 P.M., the DON said he is now aware the Psych NP note was received in the building on 10/20/25. He said the physician should have been notified right away, over a month is a long time. He is not sure what the delay was in this case. During an interview on 1/21/26 at 2:27 P.M., Physician #1 said if the Psych NP makes recommendations, he should be made aware of them timely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. Based on interviews and record review, the facility failed to ensure laboratory services were provided for one Resident (#2), out of a sample of 13 residents. Specifically, the facility failed to ensure a urinalysis with culture and sensitivity were obtained according to the physician's orders. Findings include:Resident #2 was admitted to the facility in July 2025 with a diagnosis of failure to thrive. Review of the Nursing Progress Note, dated 11/12/25, indicated Resident #2 was seen by the physician the previous evening with an order to collect urine and send for culture and sensitivity. Review of the Physician Progress Note, dated 11/11/25, indicated Resident #2 was complaining of urinary tract infection symptoms again. Review of the Interim Physician's Order Sheet included an order, dated 11/11/25, for a urinalysis and a urine culture and sensitivity. Review of the paper and electronic medical record on 1/15/26 failed to include results from a urinalysis in November 2025. Review of the Physician Progress Note, dated 11/29/25, indicated Resident #2 complained of dysuria (painful burning urination) again. During an interview on 1/20/26 at 9:03 A.M., the Director of Nurses (DON) said he had contacted the laboratory (lab) and found that they did not have the urine specimen from November 2025. He said he was able to locate a lab slip in the electronic laboratory system which indicated specimen requires recollection and a new order placed if results are needed with a reason given no specimen collected. The DON said he was not sure if he had ever heard from the laboratory about the specimen not being collected, but they should have contacted him. He said there was no indication the facility had reached out to the lab to follow up on the urinalysis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed, the facility failed to timely notify the physician of an abnormal X-ray for one Resident (#1), out of 13 sampled residents. Specifically, the facility waited eight days to inform the physician of an X-ray result of osteomyelitis (an infection in the bone) to the right heel. Findings include:Resident #1 was admitted to the facility in October 2025 with deep tissue pressure injuries (intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft) to the bilateral heels. Review of the medical record indicated Resident #1 was seen by the consultant Wound Nurse Practitioner on 12/26/25 following a recent hospitalization. The Wound Note indicated the heels had worsened and there was a concern for osteomyelitis with a recommendation to X-ray both heels. Review of the Interim Physician's Order Sheet included an order to X-ray both heels on 12/29/25. Review of the results, dated 12/29/25 at 8:35 A.M., indicated Resident #1 had right heel osteomyelitis, with a handwritten note indicating the results were reviewed with the Physician on 1/6/26. Review of the nursing Progress Notes from 12/29/25 through 1/6/26 failed to mention the X-ray or the results. During an interview on 1/21/26 at 12:41 P.M., the contracted radiology services said the X-rays of the bilateral heels were taken on 12/29/25 at 7:30 A.M. and the results were ready on 12/29/25 at 8:35 A.M. and faxed to the facility at 8:37 A.M. He said after faxing the results, the facility was added to a call list and contacted with the results. He said in addition, the facility can always contact the company for the results. During an interview on 1/21/26 at 12:53 P.M., the Director of Nurses (DON) said he was not aware that X-ray results for osteomyelitis could be determined the same day and had never experienced this before. He said he would have to review this further. During an interview on 1/21/26 at 2:28 P.M., the Medical Director, who was the primary physician for Resident #1, said he expected to be contacted right away with the X-ray results. During an interview on 1/21/26 at 3:17 P.M., the DON said he had reviewed the information and found the X-ray results were sent to the facility on [DATE] and the physician was not aware until 1/6/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on interview and observation the facility failed to ensure one Resident (#2), out of 13 sampled residents, was referred to hospice services for an evaluation.Findings include:Resident #2 was admitted to the facility in July 2025 with diagnoses of failure to thrive and a lung mass. Review of the medical record indicated on 12/10/25 a nurse received a call from a hospice agency indicating they were looking for a physician's order for Resident #2 to be evaluated by hospice, and the nurse contacted the physician. Review of the paper medical record included an order written on 12/10/25 by the physician for Resident #2 to be evaluated by hospice and to treat if indicated based on the Resident's diagnoses of failure to thrive and having a lung mass. Review of the paper and electronic medical record on 1/15/26 failed to include any information regarding Resident #2 being referred to hospice services as indicated. During an interview on 1/20/26 at 10:36 A.M., the Director of Nurses said he did not know if there was a hospice referral completed in December 2025. During an interview on 1/20/26 at 4:15 P.M., the Social Worker said she had been out of the facility in December 2025 and was not aware of the nursing note regarding hospice or the order in the medical record. During an interview on 1/21/26 at 11:00 A.M., the Social Worker said she had reached out to the hospice agency and had found that the family of Resident #2 had called to request services on 12/7/25 and that was why the hospice agency had contacted the facility on 12/10/25 for a physician's order. The Social Worker said no one from the facility had gotten back to the hospice agency and the physician's order for a hospice evaluation for Resident #2 was not sent to the hospice agency until today, six weeks (42 days) after the request.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to provide education and/or offer the COVID-19 vaccination as required or appropriate per the Centers for Disease Control and Prevention (CDC) recommendations for one of one employee records reviewed for immunizations. Findings include:Review of the Centers for Disease Control (CDC) COVID-19 Vaccination for Long-term Care Residents, dated 6/11/25, indicated but was not limited to:-Vaccine recommendations: -CDC recommends an updated COVID-19 vaccine for most adults ages 18 years and older, including people who live and work in long-term care (LTC) settings, get 1 dose of an updated COVID-19 vaccine. -CDC recommends everyone ages 65 years and older, including people who live and work in LTC settings, get 2 doses of an updated COVID-19 vaccine 6 months apart. Review of the Facility Assessment, last updated 12/15/25, indicated but was not limited to:-We offer flu, Covid, and RSV vaccinations for all residents and staff including contracted staff if needed.-Staff are in-serviced and educated annually at a minimum on the prevention and spread of infection. Review of Dietary Aide #1's employee personnel file indicated a hire date of 9/26/25. The file failed to indicate documentation that he was offered and/or educated about the COVID-19 vaccine. During an interview on 1/21/26 at 12:19 P.M., the Director of Nursing reviewed Dietary Aide #1's personnel file. He said he could not find any evidence of Dietary Aide #1 being offered and educated about the COVID-19 vaccine. He said he thought only the influenza vaccine was required to be offered and education provided to staff. He said he was unaware facility staff must be educated and offered the COVID-19 vaccine and must have documentation of acceptance, declination, or education. He said there was no process to offer and/or educate facility staff about the COVID-19 vaccine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225608	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Haven Nursing Facility	137 Nichols Street Norwood, MA 02062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview, the facility failed to maintain records of certified nurse aide (CNA) training for continuing competency that included no less than 12 hours of mandatory training per year for each CNA employed by the facility for one CNA (#1), out of five employee training records reviewed. Findings include:Review of the Facility Assessment, last revised 12/15/25, indicated but was not limited to:-Staff training/education and competencies: -All employees complete training and competencies upon hire and annually thereafter. -Nurse Aides are provided 12 hours of annual training/education in house.-Nurse Aides: Annual in-service training for nurse aides is a minimum of 12-hours per year. During an interview on 1/21/26 at 12:19 P.M., the Director of Nursing said he and the Administrative Assistant were responsible for educating staff. He said there was not a system to track the number of hours of education provided or quantify the number of hours of education provided in a year for CNAs. He said CNAs had a yearly competency fair, dementia training, and if he noticed education was needed. Review of the Employee In-service Education Attendance Record (used to track yearly in-services attendance) indicated the following:-In-service Titles: -Abuse/Neglect/Mistreat, Resident Rights, Infection Control Prevention, Bloodborne Pathogens, Safety MSDS Manual Lock out tag out, Workplace Violence, Falls Prevention, Diversity and Sensitivity, Sexual Harassment, Fire Safety, Back Safety Ergonomics, HIPPA, Hepatitis B Vaccine/TB, Working with the Elderly, and 4 hours of Dementia Training. Review of the education records for CNA #1 failed to indicate 12 hours of CNA training education had been completed and documented since 2024. During an interview on 1/21/26 at 3:52 P.M., the Administrative Assistant said CNA #1 was provided with the education packet from the competency fair, but she had not completed the tests or returned the packet. She said she was unable to provide any additional education for CNA #1.