STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225634	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Weymouth	64 Performance Drive Weymouth, MA 02189

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of four sampled residents (Resident #4), the Facility failed to ensure they maintained Resident #4's right to privacy and confidentiality related to his/her Protected Health Information (PHI), when one of Resident #4's provider progress notes, which contained (PHI) was included in another resident's discharge paperwork and the Facility only became aware after the discharged residents' family member called and notified the Facility.Findings include: Review of the Facility Policy titled Use and Discloser of Health Information, dated as last revised 09/12/2013, indicated that the Center respects the importance of its residents' personal privacy, and understands the sensitive nature of its residents' health information. The Policy further indicated that the Center also recognizes that Federal and State laws require that individually identifiable health information must be safeguarded against improper use or disclosure. During a telephone interview on 11/25/25 at 10:08 A.M., Family Member #1 said that on 09/14/25, Resident # 1 was discharged from the facility, she took him/her home and said when she read his/her Discharge Paperwork, she noticed that there was another resident's name in Resident #1's notes from the Facility. Family Member #1 said she called the Facility to inform them of a Health Insurance Portability and Accountability Act (HIPPA) Violation.Resident #1 was admitted to the Facility in 9/2025, diagnoses include respiratory failure, pneumonia, chronic obstructive pulmonary disease and is oxygen dependent.Review of Resident #1's discharge paperwork, dated 09/14/25, indicated that his/her Facility Provider had entered an admission Physician's Note for Resident #4 into Resident #1's Medical Record.The Note listed Resident #4 (by name) and included, but was not limited to, his/her medical diagnoses, hospital stay information, physical exam, code status, current clinical and medical status, vital signs, laboratory results, and medications.Resident #4 was admitted to the Facility in 9/2025, diagnoses include fall from a ladder with subsequent falls, rib fractures, a left clavicle fracture, and alcohol use disorder.During an interview on 11/26/25 at 12:14 P.M, Nurse #1 said that Family Member #1 had called the Facility shortly after she had taken Resident #1 home on [DATE]. Nurse #1 said that Family Member #1 told her that they had sent Resident #1 home with the wrong discharge paperwork and that it was a HIPPA violation. Nurse #1 was she was unaware that Resident #1's Provider had inadvertently written a progress note in the wrong medical record and said that she had not noticed it in his/her discharge paperwork.During an interview on 11/26/25 at 1:42 P.M., the Unit Manager said that she was aware that Resident #1's Family Member had called the Facility to report that another resident's (Resident #4) information was sent home with Resident #1. The Unit Manager said that she does not remember reporting it to anyone and said that she did not know she had to inform Resident #4 of the breach in privacy issues.During an interview on 11/26/25 at 2:18 P.M., the Assistant Director of Nurses (ADON) said that she was not aware (until after Resident #1 had been discharged) that Resident #1 had received some personal medical information that was for Resident #4 in his/her discharge paperwork. The ADON said that she does not recall informing Resident #4 of the error that had been discovered.During an interview on 11/26/25 at 3.32 P.M., the Director of Nurses (DON) said that she was unaware (until date of survey 11/26/25) that the Facility had some of Resident #4's private health information in Resident #1 paperwork upon discharge.The DON said that she should (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225634	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Weymouth	64 Performance Drive Weymouth, MA 02189

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been made aware of the issues when she had returned from vacation and the event should have been investigated when the complaint was given.The DON said that it is the Facility's expectation that Providers double-check that medical record entries are for the intended Resident being documented on prior to entering the information into a Resident's record and that the party involved with the privacy breach needs to be informed of the error in a timely manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225634	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Weymouth	64 Performance Drive Weymouth, MA 02189

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for two of three sampled residents (Resident #1 and #2), the Facility failed to ensure that upon admission, nursing developed and implemented baseline care plans with interventions, treatments, goals, and outcomes that addressed the residents' overall immediate care needs.Findings include:Review of the Facility Policy titled Baseline Care Plans, dated as last revised 3/2022, indicated that a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission.The Policy further indicated the baseline care plan includes instructions needed to provide effective, person-centered care of the residents that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the residents.1) Resident #1 was admitted to the Facility in 9/2025, diagnoses include respiratory failure, pneumonia, chronic obstructive pulmonary disease and is oxygen dependent.Review of Resident #1 Hospital Discharge summary, dated [DATE], indicated his/her immediate care needs were identified as followed;-Acute on chronic respiratory failure, dependent on four (4) liters (l) of oxygen;-Average Volume-Assured Pressure Support (AVAPS) use at night;-Pneumonia with antibiotic use;-Acute heart failure; and-Subcutaneous anticoagulation.Review of Resident #1's admission Resident Evaluation, dated 09/09/25, indicated he/she had an open area to his/her coccyx requiring a treatment.Review of Resident #1's Medical Record indicated that there was no documentation to support that Baseline Care Plans were developed and implemented to address these areas of concern within 48 hours of his/her admission.2) Resident #2 was admitted to the Facility in 11/2025, diagnoses include acute respiratory failure with hypoxia, dependent on supplemental oxygen related to chronic obstructive pulmonary disease, and congestive heart failure.Review of Resident #2 Hospital Discharge summary, dated [DATE], indicated his/her immediate care needs were identified as followed;- Chronic respiratory failure, dependent on two (2) l of oxygen;-Frequent falls; and-Constipation.Review of Resident #2's Medical Record indicated that there was no documentation to support that Baseline Care Plans were developed and implemented, or that the Comprehensive Care Plans addressed these areas of concern were in place within 48 hours of admission.During an interview on 11/26/25 at 1:42 P.M., the Unit Manager said that she was not aware that Resident #1 did not have a completed baseline care plan and said that it was her responsibility to complete the baseline care plans.The Unit Manager said that as a team the management staff is to review a new admission chart the next day at morning meeting to ensure that the baseline care plans are completed.During an interview on 11/26/25 at 2:18 P.M., the Assistant Director of Nurses (ADON) said that she was unaware that Resident #1 and Resident #2's baseline care plans had not been completed.The ADON said that each disciple should be initiating their individual baseline care plan and that the Unit Manager and Night Shift Supervisor should be checking for completion.During an interview on 12/26/25 at 3:32 P.M., the Director of Nurses (DON) said that she was not aware of Residents #1 and #2 were missing their baseline care plans upon admission.The DON said that it is the Facility's expectation that the admitting nurse is to initiate the resident's baseline care plan and said, along with the other disciplines complete the Baseline care plan within 48 hours of admission.