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	02/26/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on records reviewed and interviews for one of three sampled residents (Resident #2), who was newly admitted related to his/her need for skilled nursing services, the Facility failed to ensure it provided treatment and care in accordance with professional standards of quality care, when during two separate Physician's visits, his/her provider indicated there were new treatment and/or medication orders for Resident #1, however they were not transcribed and entered as a Physicians order in a timely manner.Findings include:Based on the Facility Policy titled Medication and Treatment Orders, dated as last revised 07/2016, indicated orders for medications and treatments will be consistent with principles of safe and effective order writing.The Policy further indicated the following;-Medications shall be administered only upon the written order of a person duty licensed and authorized to prescribe such medication in this State;-Drugs and biological orders must be recorded on the Physician's Order sheet in the resident's chart; and-All drugs and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order.Resident #2 was admitted to the Facility in 11/2025 diagnoses include a urinary tract infection, status post fall, diabetes mellitus, and asthma.Review of Resident #2's Physician Progress Note, dated 11/28/25, indicated he/she was admitted related to a subacute level of service, and his/her plan was to include a repeat urinalysis culture with sensitivity (UA/CS) and add back his/her glargine (Lantus, long-acting insulin) at a lower dose.Review of Resident #2's Medical Record, from 11/28/25 through 12/23/25, including but not limited to physician's orders, Medication Administration Records (MAR), and nurse progress notes, indicated there was no documentation to support he/she had physician's orders to obtain a repeat UA/CS or an order for Lantus at a lower dose. There was also no documentation to support nursing contacted the Physician to clarify the orders.Review of Resident #2's Physician Progress Noted, dated 12/23/25, indicated to administer low dose Lantus six (6) units (u) every A.M. (morning) subcutaneously. Review of Resident #2's MAR, dated 12/23/25 through 12/29/25, (date of transfer/discharge) indicated there was no documentation to support he/she had physician's orders to administer Lantus 6 unit every A.M. subcutaneously. There was also no documentation to support nursing contacted the Physician to clarify the order.During an interview on 02/25/26 at 5:39 P.M., Nursing Supervisor #2 said that Physician's Orders are put into Point Click Care PCC, electronic medical record) system by the physician's themselves and if the physician does not put the orders in themselves, they should be informing nursing to do so as a verbal order.During an interview on 02/26/26 at 8:51 A.M., Unit Manager #2 said that physicians put their orders for each resident into PCC and said if they are unable, they will give a verbal order to the nurse responsible for the resident at the time of the visit and the nurse will enter the order.During an interview on 02/26/26 at 9:30 A.M., Physician #2 said he was not aware that the intended orders (in his 11/28/25 and 12/23/25 progress notes) had not been entered for Resident #2 after being written in his progress note.Physician #2 said that he usually puts his orders right into the PCC system and said that he must have missed putting in the orders that he (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	02/26/2026

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Care One at Weymouth	64 Performance Drive Weymouth, MA 02189

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	intended for Resident #2. During an interview on 02/26/26 at 2:40 P.M., the Director of Nurses (DON) said that she was unaware of the intended physician's orders within the progress note [that were not acted upon] written by Resident #2's physician.The DON said the Facility's expectation is that all physicians either input their orders directly into the PCC system or communicate with nursing staff with a verbal or written order so the nurse can enter the order and be placed into PCC for each resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on records reviewed and interviews, for one of three sampled residents, (Resident #2), the Facility failed to ensure they maintained complete and accurate medical/treatment records when nursing documentation nursing on his/her Medication Administration Record (MAR) and/or Treatment Administration Record (TAR) were omitted, with some care areas left blank.Findings include:Review of the Facility Policy titled Charting and Documentation, dated as last revised July 2017, indicated that all services provided to the resident, progress towards the care plan goals, or any changes in the resident medical, physical, functional or psychosocial condition, shall be documented in the residents medical record, The Medical record should facilitate communication between the interdisciplinary team regarding the residents condition and response to care.The Facility indicated medication administration and treatments or services performed must be documented in the resident's medical record.Resident #2 was admitted to the Facility in 11/2025 diagnoses include a urinary tract infection, status post fall, diabetes mellitus, and depression.Review of Resident #2's Physician's Orders, dated 12/01/25 through 12/29/25, indicated he/she had orders for the following:-Vital Signs every evening shift;-Diabetic foot care daily every evening at bedtime;-Behavior tracking for depression every shift; and -Evaluate for pain every shift.Review of Resident #2's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 12/01/25 through 12/29/25, indicated that on Resident #2's MAR and/or TAR documentation for the following were omitted (left blank);-Vital Signs every evening shift; (omitted and/or left blank) on 12/06/25, 12/07/25, 12/08/25, 12/09/25, 12/10/25, 12/16/25, 12/18/25, 12/20/25, and 12/25/25.-Diabetic foot care daily every evening at bedtime; (omitted or left blank) on 12/06/25-12/10/25, 12/16/25, 12/18/25, 12/20/25, 12/21/25, 12/25/25, and 12/26/25.-Behavior tracking for depression every shift; (omitted and/or left blank on the evening shift) on 12/09/25, 12/10/25, 12/16/25, 12/18/25, 12/20/25, and 12/25/25.-Evaluate for pain every shift; (omitted and/or left blank on the evening shift) on 12/09/25, 12/10/25, 12/16/25, 12/18/25, 12/20/25, and 12/25/25.During an interview on 02/25/26 at 2:25 P.M., Supervisor #1 said that daily documentation is to be done every shift and said he was not sure why Resident #2's record had missing documentation. During an interview on 02/26/26 at 1:28 P.M., Unit Manager #1 said that nursing should be documenting daily on their residents and both the MAR and TAR should be completed daily as the care is provided.During an interview of 02/26/26 at 2:40 P.M., the Director of Nurses (DON) said that it is the Facility's expectation that all nurses complete their required documentation daily and in a timely manner. The DON said that documentation in MAR's and TAR's should be done by nursing upon completion of the administration of a medication or treatment.