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	01/13/2026

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the drug regimen for one Resident (#56), from a total sample of 28 residents, was free of unnecessary drugs. Specifically, the facility failed to ensure two oral antibiotic medications (Doxycycline and Amoxicillin/Clavulanate) were not given in excessive duration resulting in the Resident receiving five unnecessary doses of oral antibiotics while on intravenous (IV) antibiotics. Findings include:Review of the facility's policy titled Adverse Consequences and Medication Errors, last revised June 2025, indicated but was not limited to:-A medication error is defined as the preparation or administration of drugs or biological which is not accordance with provider's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services.-Examples of medication errors include: -unauthorized drug- a drug administered without a provider's order. Resident #56 was admitted to the facility in December 2025 with diagnoses including acute osteomyelitis (an infection in a bone) of the left ankle and foot, Methicillin Resistant Staphylococcus Aureus (MRSA, Staphylococcus aureus bacteria that are resistant to treatment with one of the semi-synthetic penicillin), and cutaneous abscess (painful, pus-filled pocket under the skin, usually caused by a bacterial infection) of the left foot. Review of the Minimum Data Set assessment, dated 12/23/25, indicated Resident #56 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15 and he/she was receiving IV antibiotics. During an interview on 1/12/26 at 9:02 A.M., Resident #56 said he/she went to an appointment on 1/9/26 and was told by the doctor to continue their IV antibiotics for two more weeks then switch to oral antibiotics. Review of Resident #56's Hospital Discharge summary, dated [DATE], indicated but was not limited to:-Antibiotics: -Daptomycin (antibiotic) 8 milligrams (mg) per kilogram (kg) every 24 hours and continue through 1/9/26 -Ceftriaxone (antibiotic) 2 grams (gm) every 24 hours and continue through 1/9/26 -14-day course of Doxycycline (antibiotic) 100 mg every 12 hours and Amoxicillin/Clavulanate (antibiotic) 875/125 mg every 12 hours from 1/10/26 to 1/23/26. Review of Resident #56's Physician's Orders indicated but was not limited to:-Ceftriaxone Sodium Injection Solution Reconstituted 2 grams (gm) intravenously in the morning for osteomyelitis until 01/23/26, dated 1/9/26-Daptomycin Intravenous Solution Reconstituted 575 milligrams (mg) intravenously in the evening for osteomyelitis until 1/23/26, dated 1/9/26-Doxycycline Capsule 100 mg, give 1 capsule by mouth two times a day for osteomyelitis for 14 days Start 1/24/26, dated 1/13/26-Amoxicillin/Clavulanate tablet 875-125 mg, give 1 tablet by mouth two times a day for osteomyelitis for 14 days Start 1/24/26, dated 1/12/26 Review of Resident #56's discontinued Physician's Orders indicated but was not limited to:-Doxycycline Capsule 100 mg, give 1 capsule by mouth two times a day for osteomyelitis for 14 days until 1/23/26, start date 1/10/26 discontinue date 1/12/26-Amoxicillin/Clavulanate tablet 875-125 mg, give 1 tablet by mouth two times a day for osteomyelitis for 14 days until 1/23/26, start date 1/10/26 discontinue date 1/12/26 Review of Resident #56's Physician's Consult, dated 1/9/26, indicated but was not limited to:-Continue Ceftriaxone and Daptomycin daily-Follow up in two weeks Review of Resident #56's January Medication Administration Record (MAR) indicated five doses of Doxycycline and Amoxicillin/ Clavulanate were administered to him/her on the following days and time:-1/10/26 at (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
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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9:00 A.M. and 9:00 P.M.-1/11/26 at 9:00 A.M. and 9:00 P.M.-1/12/26 at 9:00 A.M. During an interview on 1/13/26 at 10:57 A.M., Nurse Practitioner #1 said Resident #56 should not have received two different IV antibiotics and two different oral antibiotics. She said Resident #56 should have only received IV antibiotics to avoid duplicate/excessive therapy and potential adverse reaction. During an interview on 1/13/26 at 11:04 A.M., Nurse #5 said Resident #56 went out to a doctor's appointment on 1/9/26 and returned to the facility with new orders to continue their IV antibiotics for two more weeks. She said she did not know if Resident #56 was supposed to receive Doxycycline and Amoxicillin/Clavulanate, but she had administered them yesterday morning (1/12/26) as they appeared on the MAR. She said someone had been talking about clarifying Resident #56's antibiotic orders because four antibiotics is too many. During an interview on 1/13/26 at 11:28 A.M., Unit Manager #4 said Resident #56 returned from a doctor's appointment on 1/9/26 and an order to continue his/her IV antibiotics for two additional weeks. She said Nurse #5 had put an order in to continue the IV antibiotics for two additional weeks and an order to start Doxycycline and Amoxicillin/Clavulanate twice daily on 1/24/26 for 14 days, but she had not discontinued the previous order, dated to start on 1/10/26, for Doxycycline and Amoxicillin/Clavulanate twice daily. She said when she came in on 1/12/26 she had discovered Resident #56 had received their two IV antibiotics as ordered and oral Doxycycline and Amoxicillin/Clavulanate twice daily for five doses which was too many antibiotics. She said Resident #56 should not have received the oral Doxycycline and Amoxicillin/Clavulanate until 1/24/26. During an interview on 1/13/26 at 1:46 P.M., the Director of Nursing said she was notified of the medication error for Resident #56. She said Resident #56's Doxycycline and Amoxicillin/Clavulanate should not have been administered until 1/24/26 but the order for them to start on 1/10/26 had not been discontinued resulting in Resident #56 receiving duplicate antibiotic therapy.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to follow infection prevention and control practices. Specifically, the facility failed to:1. Ensure proper cleaning of resident shared equipment between resident use; and2. Ensure effective hand hygiene practices and appropriate personal protective equipment (PPE) were utilized when entering and exiting resident rooms, including residents on transmission-based precautions (implemented in addition to standard precautions in order to prevent or control infections.), to prevent the potential spread of infection. Findings include:1. Review of the facility's policy titled Cleaning and Disinfection of Resident-Care Items and Equipment, last revised September 2022, 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 or sterilized between residents.-Durable medical equipment is cleaned and disinfected before reuse by another resident. Review of CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 4/12/24, indicated but was not limited to:-Clean and reprocess (disinfect or sterilize) reusable medical equipment (e.g., blood pressure cuffs) prior to use on another patient or when soiled. On 1/8/26 between 8:22 A.M. and 9:05 A.M., the surveyor made the following observations:-Nurse #5 exited Resident #56's room with the vital signs machine and failed to clean and disinfect it.-Nurse #5 entered Residents #58 and #22's room with the vital signs machine. Nurse #5 obtained vital signs for Resident #22, and then for Resident #58. She failed to clean and disinfect the vital signs machine between residents. She then exited the room.-Nurse #5 entered Residents #40 and #23's room with the vital signs machine. Nurse #5 obtained vital signs for Resident #23 and then for Resident #40. Nurse #5 failed to clean and disinfect the vital signs machine between residents. She then exited the room.-Nurse #5 entered Resident #24's room with the vital signs machine. Nurse #5 obtained the vital signs for Resident #24 and brought the vital signs machine into the hallway. Nurse #5 failed to clean and disinfect the vital signs machine when she exited the room. On 1/8/26 at 12:07 P.M., the surveyor observed the following:-Nurse #5 entered a Resident's room with a glucometer (a portable medical device that measures the glucose level in a tiny drop of blood)-Nurse #5 exited the room and returned the glucometer to the medication cart.-Nurse #5 failed to clean and disinfect the glucometer machine prior to returning the glucometer to her medication cart. During an interview on 1/8/26 at 12:10 P.M., Nurse #5 said equipment that is shared between residents must be wiped cleaned and disinfected between residents or after use for a resident. Nurse #5 said she had not wiped down the vital signs machine between residents, but she should have. Nurse #5 said she used the glucometer to check a Resident's blood glucose level, and the glucometer was not a single resident glucometer but shared between multiple residents. She said she had not wiped down the glucometer after checking the blood glucose level, but she should have. During an interview on 1/13/26 at 1:46 P.M., the Director of Nursing (DON) and the Infection Preventionist (IP) said all shared equipment including the vital sign machine and glucometer need to be wiped down prior to use and between being used for each resident to prevent the spread of infection. 2. Review of the facility's policy titled Clostridioides (Clostridium) Difficile (C. Diff, a highly contagious bacterium that causes diarrhea and inflammation of the colon), last revised December 2024, indicated but was not limited to:-Steps toward prevention and early interventions include:-Frequent handwashing with soap and water by staff and residents; and-Wearing gloves and a gown when caring for residents with potential infectious diarrhea or when handling feces or articles contaminated with feces.-When caring for residents with C. difficile, staff are to maintain vigilant hand hygiene. Handwashing with soap and water is superior to ABHR (alcohol-based hand rub) for mechanical removal of C. difficile spores from hands. Review of the facility's policy titled Isolation-Categories of Transmission-Based Precautions, last revised September 2022, indicated but was not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	limited to:-Transmission-based precautions are initiated when a resident develops signs and symptoms of transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents.-Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected.-Contact Precautions-Contact precautions are implemented for residents known or suspected of being infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental services or resident-care items in the resident's environment.-Contact precautions are also used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggests an increased potential for extensive environmental contamination or risk of transmission of pathogen, even before specific organism can be identified.-Staff wear gloves when entering the room.-Staff wear a gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after the gown is removed. Resident #190 was admitted to the facility in January 2026 with diagnoses including C. diff. Review of Resident #190's current Physician's Orders indicated but was not limited to:-Maintain Contact Plus Precautions related to C. diff infection every shift, dated 1/4/26 On 1/7/26 at 9:35 A.M., the surveyor observed Resident #190 in his/her room with a Contact Plus Precaution sign outside the door of their room which indicated but was not limited to:-STOP CONTACT PLUS-In addition to Standard Precautions Staff and Providers Must:-Must clean hands before entering a resident's room.-Gown.-Glove.-Wash Hands with soap and water before exiting a resident's room.-Hand sanitizer alone, is not sufficient when exiting a resident's room. On 1/7/26 at 9:39 A.M., the surveyor observed the following:-Certified Nursing Assistant (CNA) #2 walk into Resident #190's room and walk over to his/her bed. CNA #2 donned a gown but failed to don gloves. On 1/7/26, the surveyor observed the following:- At 12:06 P.M, CNA #3 entered Resident #190's, prior to entering his/her room she failed to perform hand hygiene and failed to don (put on) PPE.- At 12:14 P.M., CNA #3 exited Resident #190's room and failed to use soap and water to clean her hands. On 1/8/26 at 8:48 A.M., the surveyor observed the following:-Nurse #5 entered Resident #190's room carrying two cups of water.-Nurse #5 failed to perform hand hygiene and don PPE prior to entering Resident #190's room.-Nurse #5 gave one of the two cups of water to Resident #190.-Nurse #5 exited Resident #190's room and failed to wash her hands with warm soapy water.-Nurse #5 entered another Resident's room and gave him/her the second cup of water.-Nurse #5 failed to perform hand hygiene prior to entering the other Resident's room. During an interview on 1/13/26 at 10:43 A.M., CNA #2 said Resident #190 was on precautions for C. Diff. She said she should have donned a gown and gloves prior to entering his/her room. CNA #2 said she should have used warm soapy water prior to exiting Resident #190's room but she had not. During an interview on 1/13/26 at 11:09 A.M., Nurse #5 said Resident #190 was on Contact Precautions for C. Diff. She said staff must perform hand hygiene and don PPE prior to entering Resident #190's room and wash their hand with soap and water when exiting the room. Nurse #5 said she had not donned PPE or performed hand hygiene prior to entering and exiting Resident #190's room but should have. Nurse #5 said she should not have brought a cup of water for another resident into Resident #190's room to decrease the risk of infecting the other resident. During an interview on 1/13/26 at 11:33 A.M., Unit Manager #4 said Resident #190 was on contact precautions for C. Diff. She said all staff must perform hand hygiene and don PPE prior to entering Resident #190's room and wash their hands with warm soapy water after doffing PPE to help prevent the spread of infection. Unit Manager #4 said only drinks intended for Resident #190 should enter his/her room. During an interview on 1/13/26 at 1:46 P.M., the IP said all staff must follow signs for Contact Precaution for Resident #190 to help prevent the spread of C. diff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the Resident's Physician or Nurse Practitioner about a medication error to re-evaluate the potential need to alter the treatment plan for one Resident (#56), from a total sample of 28 residents. Specifically, the facility failed to notify the Physician or Nurse Practitioner of Resident #56 receiving five doses of two antibiotics.Findings include:Review of the facility's policy titled Adverse Consequences and Medication Errors, last revised June 2025, indicated but was not limited to:-A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with provider's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services.-Examples of medication errors include:-unauthorized drug- a drug administered without a provider's order.-Promptly notify the provider of any significant error or adverse consequences. Resident #56 was admitted to the facility in December 2025 with diagnoses including acute osteomyelitis (an infection in a bone) of the left ankle and foot, Methicillin Resistant Staphylococcus Aureus (MRSA, Staphylococcus aureus bacteria that are resistant to treatment with one of the semi-synthetic penicillin), and cutaneous abscess (painful, pus-filled pocket under the skin, usually caused by a bacterial infection) of the left foot.Review of the Minimum Data Set assessment, dated 12/23/25, indicated Resident #56 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15 and he/she was receiving intravenous (IV) antibiotics.During an interview on 1/12/26 at 9:02 A.M., Resident #56 said he/she went to an appointment on 1/9/26 and was told by the doctor to continue their IV antibiotics for two more weeks then switch to oral antibiotics.Review of Resident #56's Physician's Orders indicated but was not limited to:-Ceftriaxone Sodium (antibiotic) Injection Solution Reconstituted 2 grams (gm) intravenously in the morning for osteomyelitis until 01/23/26, dated 1/9/26-Daptomycin (antibiotic) Intravenous Solution Reconstituted 575 milligrams (mg) intravenously in the evening for osteomyelitis until 1/23/26, dated 1/9/2026-Doxycycline (antibiotic) Capsule 100 mg, give 1 capsule by mouth two times a day for osteomyelitis for 14 days. Start 1/24/26, dated 1/13/26-Amoxicillin-Pot Clavulanate (antibiotic) tablet 875-125 mg, give 1 tablet by mouth two times a day for osteomyelitis for 14 days. Start 1/24/26, dated 1/12/26 Review of Resident #56's discontinued Physician's Orders indicated but was not limited to:-Doxycycline Capsule 100 mg, give 1 capsule by mouth two times a day for osteomyelitis for 14 days until 1/23/26. Start date 1/10/26 discontinue date 1/12/26-Amoxicillin-Pot Clavulanate tablet 875-125 mg, give 1 tablet by mouth two times a day for osteomyelitis for 14 days until 1/23/26. Start date 1/10/2026 discontinue date 1/12/26 Review of Resident #56's Physician's Consult, dated 1/9/26, indicated but was not limited to:-Continue Ceftriaxone and Daptomycin until next visit-Follow up in two weeks Review of Resident #56's January Medication Administration Record indicated five doses of oral Doxycycline and Amoxicillin-Pot Clavulanate were administered to him/her on the following days and time:-1/10/26 at 9:00 A.M. and 9:00 P.M.,-1/11/26 at 9:00 A.M. and 9:00 P.M., and-1/12/26 at 9:00 A.M. During an interview on 1/13/26 at 10:57 A.M., Nurse Practitioner (NP) #1 said she was not aware Resident #56 had received five doses of Doxycycline and Amoxicillin-Pot Clavulanate orally. She said Resident #56 was only supposed to be on IV antibiotics and either she, the Physician, or the other two NPs should have been notified of the error. During an interview on 1/13/26 at 11:28 A.M., Unit Manager #4 said she discovered the medication error on 1/12/26 and she called the Consulting Physician's office to clarify the antibiotic order. She said Resident #56 was supposed to continue IV antibiotics and was not supposed to receive Doxycycline and Amoxicillin-Pot Clavulanate. She said she discontinued the Doxycycline and Amoxicillin-Pot Clavulanate but did not call or notify Resident #56's Physician or NP, but she should have notified them. During an interview on 1/13/26 at 1:46 P.M., the Director of Nursing said she was not aware of the medication error until today (1/13/26). She said when a medication error is identified the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician or NP should be notified because consulting physicians can make recommendations but cannot give orders for medication changes.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, the facility failed to provide care and maintenance of a Peripherally Inserted Central Catheter (PICC-a flexible tube inserted through a vein in one's arm and passed through to larger veins near the heart, used to deliver medications intravenously (IV)), consistent with professional standards of practice for one Resident (#56), out of a total of 28 residents. Specifically, the facility failed to change the PICC dressing per professional standards. Findings include:Review of the facility's policy titled Central Venous Catheter Care and Dressing Changes, last revised June 2025, indicated but was not limited to the following:- The purpose of the procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or well dressings.- Maintain sterile dressing (transparent semi-permeable membrane (TSM) dressing or sterile gauze) dressing for all central vascular access devices.- Change the dressing if it becomes damp, loosened or visibly soiled and: - at least every 7 days for TSM dressing; - at least every 2 days for sterile gauze dressing (including gauze under a TSM unless the site is not obscured). Review of the Centers for Disease Control and Prevention (CDC) Guidelines for the Prevention of Intravascular Catheter-Related Infections, last revised October 2017, indicated but was not limited to:- Catheter Site Dressing Regimens: - Replace dressings used on short-term CVC (central vascular catheter) sites every 2 days for gauze dressings. - Replace dressings used on short-term CVC sites at least every 7 days for transparent dressings.(https://www.cdc.gov/infection-control/media/pdfs/Guideline-BSI-H.pdf) Review of the National Library of Medicine (NLM), dated 5/15/23, indicated but was not limited to:- Gauze (a fabric dressing that does not stick to the skin) dressings to be changed every 48 hours, and transparent semi permeable dressings every seven days.(https://pmc.ncbi.nlm.nih.gov/articles/PMC8765739/) Resident #56 was admitted to the facility in December 2025 with diagnoses including acute osteomyelitis (an infection in a bone) of the left ankle and foot, Methicillin Resistant Staphylococcus Aureus (MRSA, Staphylococcus aureus bacteria that are resistant to treatment with one of the semi-synthetic penicillin), and cutaneous abscess (painful, pus-filled pocket under the skin, usually caused by a bacterial infection) of the left foot. Review of the Minimum Data Set assessment, dated 12/23/25, indicated Resident #56 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15 and he/she had a central line and was receiving intravenous (IV) antibiotics. Review of Resident #56's current Physician's Orders indicated but was not limited to:- Dressing: PICC 24 hours after insertion, then weekly and as needed. One time a day every 7 days and as needed, dated 12/18/25. During an interview with observation on 1/12/26 at 9:02 A.M., the surveyor observed Resident #56 sitting in his/her wheelchair with a PICC line in his/her right upper arm. There was a 2-centimeter (cm) x 2 cm split gauze over the insertion point of the PICC line covered with a transparent dressing, undated. Resident #56 said he/she had received IV antibiotics through his/her PICC line twice daily and the dressing to the PICC line was last changed last week. Review of Resident #56's January Treatment Administration Record (TAR) indicated the PICC line dressing was last changed on 1/9/26. Further review of medical record failed to indicate no as needed dressing changes had been documented. On 1/12/26 at 2:43 P.M. and 1/13/26 at 8:42 A.M., the surveyor observed a transparent dressing over Resident #56's PICC line dressing with a 2 cm x 2 cm gauze covering the insertion point of the PICC line. During an interview on 1/13/26 at 11:04 A.M., Nurse #5 said Resident #56 had an order to change their PICC line dressing every seven days and as needed. She said she had last changed Resident #56's PICC line dressing on 1/9/26 as indicated on his/her treatment sheet and covered the insertion site with gauze. She said she was not sure if there was a difference in the frequency a PICC line dressing would need to be changed depending on if it was covered with gauze or not. During an interview on 1/13/26 at 1:46 P.M., the Director of Nursing said if a resident had a PICC line dressing it would need to be changed weekly or more often if soiled. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said if the insertion site of the PICC line was covered with gauze it would need to be changed every 48 hours because you cannot assess the insertion site if it is covered.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on interviews and record review, the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for one Resident (#18), in a total sample of 28 residents. Specifically, the facility failed to assist Resident #18 in their request for discharge planning. Findings include:Review of the facility's policy titled Discharge Summary and Plan, revised in March 2025, indicated the following:-every resident has an individualized discharge plan, which begins at admission and is part of the comprehensive care plan-the discharge plan is based on the resident assessment, the goals for care, the desire for discharge and the resident's capacity for discharge-residents are periodically assessed for their interest in returning to the community-if the resident indicates an interest in returning to the community, the facility determines if appropriate and adequate support is in place-the facility makes referrals to local agencies, the local ombudsman, and support services that can assist in accommodating the resident's post-discharge preferences, as appropriate. Referrals made for this purpose, and the response to these referrals are documented in the medical record.-if it is determined that returning to the community is not feasible, it is documented why this is the case and who made the determination Review of the facility's policy titled Social Services, revised in March 2022, indicated the following:-the facility provides medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being-the social worker/social service staff are responsible for: making referrals and obtaining needed services from outside entities, helping residents with transitions of care services (for example, community placement options, home care services, transfer arrangements, etc.) Resident #18 was admitted to the facility in November 2023 with a diagnosis of end stage renal disease. Review of the Minimum Data Set (MDS) assessment, dated 12/22/25, indicated Resident #18 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. Review of Section S indicated Resident #18 had a health care proxy on file, which was not invoked indicating the Resident was responsible for their own decision making. Review of Section Q indicated there was no active discharge plan for Resident #18 to return to the community and the Resident's clinical record indicated to only ask the Resident about returning to the community on a comprehensive assessment (yearly or with significant change). During an interview on 1/7/26 at 4:10 P.M., Resident #18 said he/she had a problem with the Social Service department. The Resident said he/she wished to return to the community and to live with their significant other and had been asking the facility Social Work staff about the process for four months. The Resident said he/she had attempted to leave a voicemail for the Social Service Department, and the voicemail indicated it was not checked regularly. He/she said they had provided information to someone whom they believed was a Social Work intern, had written down the information, but had never followed up. He/she said another Social Worker had come to speak with him/her about this and the Social Worker had indicated they would make a referral to the Elder Service agency, but the Resident was not sure this had been done. Resident #18 said he/she had a scheduled care plan meeting for the following day (1/8/26) and was looking forward to asking the Social Work staff about how the referrals to outside services were going. Review of all Social Service notes failed to indicate any discussion with Resident #18 regarding wanting to return to the community, where the Resident would like to discharge to, who the supports/care givers in the community would be or if any referrals to local agencies had been initiated to inquire the feasibility of discharge. Review of the consultant psycho-therapy progress notes indicated the following:9/30/25: spoke about relocating (out of state), though unsure about leaving family11/18/25: plans to leave the facility after mid-December when significant other arrives from out of state; discussed wanting to marry significant other and relocate out of state and feels it's their own life and believes he/she deserves happiness. Resident is collaborating with the facility's (continued on next page)

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	01/13/2026

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

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Worker on detailed discharge plans12/2/25: Resident hopeful about being discharged with significant other soon12/16/25: significant other visiting from out of state, Resident contemplating leaving with the significant other with mixed emotions about leaving family but expressing a desire for love and happiness During an interview on 1/13/26 at 9:15 A.M., Social Worker #3 said she had worked part-time for the facility for the previous four years. She said she had been doing remote work (not coming into the facility) for two years. She said she helps in completing quarterly social service progress notes, MDSs and care plans. She said she had completed the most recent MDS for Resident #18. She said she completed Section Q based on information in the medical record and had not spoken directly with Resident #18. She said she had no information on Resident #18 wishing to return to the community. She said in reviewing the Social Service information it looked as though in April 2024 Resident #18 had indicated they would need to stay at the facility and had given up their apartment. She said the note indicated contacting Elder Services if Resident #18 would like assistance at any time transitioning back to the community. She said there was no documentation to indicate the Resident had been referred for services as of this time. During an interview on 1/13/26 at 10:00 A.M., the Director of Social Services said he had worked at the facility for a month and was unfamiliar with the Resident and had not met him/her. During an interview on 1/13/26 at 10:05 A.M., Social Worker #2 said he had started at the facility about two weeks prior and he was unfamiliar with Resident #18 but was the assigned Social Worker. When the surveyor inquired if the Social Worker attended the care plan meeting for Resident #18 which was scheduled for 1/8/26, he said the care plan meetings were scheduled (and showed the surveyor the schedule with Resident #18 scheduled for 1:00 P.M.) but had not been held because he was new to the facility. He said he had not reached out to any of the residents or families with scheduled meetings on 1/8/26 and had not spoken with Resident #18 about rescheduling as of five days later. During an interview on 1/13/26 at 10:11 A.M., Unit Manager #3 said the care plan meetings scheduled for 1/8/26 did not occur because the Social Worker was new and she did not know what the plan was. During an interview 1/13/26 at 10:18 A.M., the Activity Director said the care plan meetings scheduled for 1/8/26 did not occur and she was not sure why. During an interview on 1/13/26 at 10:29 A.M., the former Social Worker (#4) indicated she had worked at the facility until mid-December 2025. She said she was familiar with Resident #18 and had talked in length with the Resident about the Resident's desire to return to the community and live with their significant other out of state. She said she had not referred the Resident to any community agencies for assistance with the feasibility in returning to the community. The Social Worker said she thought that maybe she had been waiting for the significant other to come visit but does not know what happened with this. She said she was not sure why there was no documentation to indicate her discussions with the Resident and their desire to return to the community. During an interview on 1/13/26 at 2:51 P.M., the Administrator said Social Worker #4 should have documented the discussions with Resident #18 regarding wanting to return to the community and the MDS and goals of care should have reflected this. He said he had not directly spoken with Resident #18 about wanting to return to the community but had heard that the Resident wanted to move out of state with their significant other. He said he was aware the significant other had come to visit in December but had not heard of any staff meeting with the significant other to discuss discharge planning or feasibility of discharge. He said as far as he was aware Resident #18 had not been referred to any community agencies for assistance or to determine eligibility to access programs for assistance. He said the care plan meeting scheduled for 1/8/26 should have occurred with Resident #18 and had since been rescheduled.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interviews, and records reviewed, the facility failed to ensure residents were free from significant medication errors when one of two nurses observed during the medication pass failed to follow physician orders for an antiseizure medication. Specifically, for Resident #66, with a history of epilepsy (a brain disease that causes repeated seizures due to abnormal electrical signals in the brain), Nurse #1 failed to administer the correct dose of his/her anticonvulsant medication (drugs that control or prevent seizures by calming excessive electrical activity in the brain). Findings include:Review of the facility's policy titled Administering Medications, dated as revised April 2019, indicated but was not limited to:-Medications are administered in accordance with prescriber orders Review of Up To Date (an evidence-based clinical resource), Antiseizure medication maintenance therapy and drug monitoring, dated as revised 12/29/2025, indicated but was not limited to:-Studies have shown that those taking therapeutic doses of Levetiracetam have levels in the order of 12 to 46 milligrams/liter (mg/L).-The clinician should impress upon the patient, family, and caregivers the critical need to follow the prescribed antiseizure medication regimen. -The RANSOM (Research on Antiepileptic Nonadherence and Serious Outcomes in Medicaid) study of more than 30,000 epilepsy patients found that nonadherence was associated with a more than threefold risk of mortality compared with adherence. Other consequences include a higher incidence of attendance to emergency departments, hospital admissions, fractures, head injuries, and increased health care costs. Another study in which nonadherence was identified by therapeutic drug monitoring with reference to the patient's own control value found that adherence was a factor in 39 percent of patients admitted to hospital with seizures. Resident #66 was admitted to the facility in September 2024 with diagnoses which included epilepsy. On 1/8/26 at 9:04 A.M., the surveyor observed Nurse #1 prepare and administer medication to Resident #66. Nurse #1 prepared Levetiracetam (an anticonvulsant medication primarily used to prevent and control various types of seizures in people with epilepsy) 500 milligrams (mg) one tablet. Nurse #1 referred to the electronic medication administration order and told the surveyor the order states 1,000 mg give one half tablet, which is equal to 500 mg so the Resident will get one tablet. Review of Resident #66's Physician's Orders indicated but was not limited to:-Levetiracetam 1000mg, give 1.5 tablet by mouth every 12 hours, dated 1/21/25 During an interview on 1/8/26 at 11:15 A.M., Nurse #1 said Resident #66 was administered Levetiracetam 500mg because the order said to give one half of a 1,000mg tablet. Nurse #1 and the surveyor reviewed Resident #66's physician's orders and Nurse #1 said she thought the order said 0.5 tablet and not 1.5 tablets and that Resident #66 received the wrong dose. Nurse #1 said Resident #66 needed two more tablets of Levetiracetam 500mg. During an interview on 1/8/26 at 11:26 A.M., the Director of Nurses (DON) said medications should be administered as ordered and physician's orders should be followed.

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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 record review and interviews, the facility failed to ensure staff maintained complete and accurate medical records for one Resident (#153), out of a total sample of 28 residents. Specifically, for Resident #153, the facility failed to ensure his/her medical record included his/her weight results.Review of the facility's policy titled Weight Assessment and Intervention, dated as revised March 2022, indicated but was not limited to:-Weights are recorded in each individual's medical record Resident #153 was admitted to the facility in December 2025 with diagnoses which included bacteremia (bacteria in the bloodstream) and sepsis (the body's reaction to extreme infection). Review of the Minimum Data Set (MDS) assessment, dated 12/23/25, indicated Resident #153 was 71 inches tall, weighed 155 pounds, and had no weight loss or gain. Review of Resident #153's Physician's Orders indicated but were not limited to:-weight every Monday for three weeks, start date 12/22/25 Review of Resident #153's December 2025 Treatment Administration Record (TAR) indicated but was not limited to:-12/22/25: weight signed off as obtained but result was not indicated-12/29/25: weight signed off as obtained but result was not indicated Review of Resident #153's January 2026 TAR indicated but was not limited to:-1/5/26: weight signed off as obtained but result was not indicated Review of Resident #153's December 2025 Documentation Survey Report indicated but was not limited to:-12/24/25: weight obtained but result was not indicated-12/31/25: weight obtained but result was not indicated Review of Resident #153's Weight and Vitals Summary indicated but was not limited to:-1/7/26: 145.6 pounds (lbs.)-1/13/26: 146.6 lbs. During an interview on 1/12/26 at 3:42 P.M., the Dietitian said residents should be weighed on admission and then weekly for 4 weeks. The Dietitian said weights should be recorded in the medical record.During an interview on 1/13/26 at 9:13 A.M., Certified Nursing Assistant (CNA) #1 said weights are completed on Mondays for all residents and documented in the electronic medical record. During an interview on 1/13/26 at 11:27 A.M., Nurse #3 said weights are obtained on Mondays and as needed. Nurse #3 said weights should be recorded in the electronic medical record. During an interview on 1/13/26 at 11:29 A.M., Unit Manager #2 said the dietitian provides a list of weights that need to be obtained. Unit Manager #2 said weights should be recorded in the electronic medical record. Unit Manager # 2 reviewed the medical record and said the medical record indicated the resident was weighed on 12/22/25, 12/29/25 and 1/5/26 but the results were not documented. During an interview on 1/13/26 at 1:22 P.M., the Director of Nurses (DON) said weights should be documented in the medical record and weights should be complete and accurate.