STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225637	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare at Provincetown	100 Alden Street Provincetown, MA 02657

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interviews, and document review, the facility failed to ensure that residents were fully aware of the grievance process. Specifically, for 13 of 13 residents attending the resident group meeting during the survey, the facility failed to ensure their grievance policy included notification that residents and their representatives have the right to file grievances anonymously, should they choose not to alert a staff member of their concern(s), and failed to include the contact information of the grievance official with whom a grievance can be filed, that is, business address (mailing and email) and business phone number, and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system.Findings include:Review of the facility's policy titled Grievances, last revised 10/2022, failed to indicate residents and/or their representatives had the right to file grievances anonymously, contact information (business address and phone number) of the grievance official and contact information of independent entities with whom grievances may be filed.On 3/31/26 at 9:00 A.M., the surveyor toured the facility's only unit and observed a poster mounted on the wall across from the nursing station titled Resident Rights. The section titled Grievances indicated:-You have the right to voice grievances to this facility or other agency concerning your care, treatment, behavior of staff and/or other residents as well as other concerns about your stay without fear of discrimination or reprisal.-You have the right to information on how to file a grievance or complaint.-You have the right to prompt resolution of grievances.The Resident Rights poster failed to indicate residents had the right to file grievances anonymously, failed to include contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number, and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system.On 4/1/26 at 10:57 A.M., the surveyor held a resident group meeting with 13 residents in attendance. Thirteen of 13 residents said that they were not aware of their right to file a grievance anonymously, who the grievance officer was and were not aware of any other entities with whom grievances could be filed. They said if they have an issue, they have to go to the Resident Council President or a staff member about it. The residents said if they were to fill out a grievance form, there was nowhere to file it to remain anonymous.During an interview with the Administrator and Regional Nurse Educator on 4/1/26 at 1:40 P.M., they reviewed the grievance policy and said it does not include the required notification that residents or their representatives have the right to file grievances anonymously and does not include contact information (business address and phone number) of the grievance official and contact information of independent entities with whom grievances may be filed as required.

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to provide a dignified existence for three Residents (#14, #16, #24) who were observed receiving care/treatment by health care professionals, out of a total sample of 13 residents. Specifically, the facility failed:1. For Residents #14 and #16, to provide privacy of his/her body during a blood draw; and2. For Resident #24, to provide privacy of his/her body while in bed during the application of a pain patch to his/her lower back. Findings include:Review of the facility's policy titled Dignity, last revised 1/2022, indicated but was not limited to:-Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.-Residents shall be treated with dignity and respect at all times.-Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures and use of telemedicine when applicable.1A. Resident #16 was admitted to the facility in March 2026 and had diagnoses including atrial fibrillation and hyperlipidemia.Review of the Minimum Data Set (MDS) assessment, dated 3/11/26, indicated Resident #6 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15 and was dependent of staff for activities of daily living.On 3/31/26 at 9:16 A.M., the surveyor observed Resident #16 sitting in a wheelchair in the unit's dayroom watching television with seven other residents in the room. A Laboratory Technician approached the Resident and said she was there to draw his/her blood. She retrieved a tourniquet and blood draw supplies from her cart and began to conduct the blood draw. At no time did the Laboratory Technician ask the Resident to go to his/her room or to a private location to perform the blood draw or ask if the Resident wanted his/her blood drawn in the room with seven other residents.B. Resident #14 was admitted to the facility in June 2025 and had diagnoses including dementia.Review of the MDS assessment, dated 3/30/26, indicated Resident #14 had severe cognitive impairment as evidenced by a BIMS score of 5 out of 15 and was dependent of staff for activities of daily living.On 3/31/26 at 9:35 A.M., the surveyor observed Resident #14 sitting in a wheelchair in his/her room at the bedside facing the doorway and clearly visible from the hallway. At this time, the Laboratory Technician entered the Resident's room and told him/her that she was going to draw his/her blood. She retrieved a tourniquet and blood draw supplies from her cart and began to conduct the blood draw. At no time did the Laboratory Technician ask the Resident if he/she wanted the door to remain open or move him/her to a location within the room that would provide the Resident privacy during the blood draw.During an interview on 4/1/26 at 11:55 A.M., Nurse #1 said either facility staff or the Laboratory Technician should have brought Resident #16 to his/her room or another private location to provide the Resident with privacy during the blood draw. She said the Laboratory Technician should have closed Resident #14's door so he/she was provided with privacy and not visible to passersby in the hallway.2. Resident #24 was admitted to the facility in November 2025 and had diagnoses including Alzheimer's disease and a history of falls.Review of the MDS assessment, dated 3/30/26, indicated Resident #24 had severe cognitive impairment as evidenced by a BIMS score of 5 out of 15 and required staff assistance for all activities of daily living.On 4/1/26 at 9:18 A.M., the surveyor observed Nurse #2 from the hallway applying a transdermal analgesic patch to Resident #24's lower back. The privacy curtain was not pulled, the door was wide open, and the care being provided to the Resident was easily observed by any passerby in the hallway. During an interview on 4/1/26 at 9:23 A.M., Nurse #2 said she did not realize the Resident's body was exposed and visible from the hallway. She said if a resident's body is exposed, either the privacy curtain should be pulled or the door closed.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview, the facility failed to implement written policies and procedures for an allegation of abuse for one Resident (#34), out of a total sample of 13 residents. Specifically, the facility failed to initiate their abuse policy after an allegation of abuse was documented and reported on 3/4/26.Findings include:Review of the facility's policy titled Abuse, revised 10/23/22, indicated but was not limited to:-The facility prohibits the mistreatment, neglect and abuse of residents/patients and misappropriation of resident patient property by anyone, including staff.-The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property.-Abuse: -The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. -Instances of abuse of all residents, irrespective of any mental or physical condition caused physical harm, pain or mental anguish. -It includes verbal abuse. -Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.-Verbal: -Use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability. -Examples of verbal abuse include, but are not limited to, threats of harm or saying things to frighten a resident. -Identification: -Instruct staff, resident/patient, family, or visitor to report immediately, without fear of reprisal any knowledge or suspicion of suspected abuse, neglect, mistreatment, and/or misappropriation of property. -Identify events such as suspicious bruising resident/patient occurrences, patterns, and trends that may indicate abuse, neglect and/or mistreatment and investigate.-Protection: -The facility will take all steps necessary to ensure that further potential abuse will not occur while the investigation is in process. -Any employee who is accused of resident abuse, neglect, exploitation or misappropriation of property will be suspended upon identification immediately. The accused employee will not be permitted to enter the facility unless at the discretion and under the direct supervision of the Administrator or Director of Nursing.-Investigate: -All alleged violations involving abuse, neglect, exploitation, or misappropriation of resident property will be thoroughly investigated by the facility under the direction of the Administrator and in accordance with state and federal law. -The facility will initiate the investigative process. The investigation should be thorough with witness statements from staff, residents, visitors and family members who may be interviewable and have information regarding the allegation. -The conclusion must include whether the allegation was substantiated or not and what information supported the decision. The conclusion/summary must take into account an objective overview of the facts and a reason or basis for the decision to substantiate or not substantiate the allegation. -Employee Suspension: -Anytime an allegation is made involving abuse and neglect or mistreatment of a resident/Patient which names a specific employee. The employee is suspended until the completion of the investigation. The employee must be relieved of his/her duty until the allegation is complete. If the allegation is substantiated, the facility will determine continuing employment status based on the facts and the outcome of the investigation.-Reporting: -Staff should notify the shift supervisor, charge nurse, or manager immediately if suspected abuse, neglect, mistreatment, or misappropriation of property occurs. -Once the allegation of abuse has been made, the supervisor who initially received the report must inform the Administrator or Director of Nursing immediately and initiate gathering requested information. An investigation MUST be directed by the Administrator or designee immediately. -Notify the local law enforcement and appropriate State Agency(s) immediately (no later than two hours after allegation or identification of the allegation) by Agency's designated process after identification of alleged/ suspected incident. The facility will report allegations to local police and initiate process according to the Elder Justice Act and State specific regulations. Report results of investigation to the proper authorities as required by State law.-Responding/Follow Through: -The (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility shall ensure that the appropriate corrective, remedial or disciplinary actions occur in accordance with local, state and federal law in response to the findings resulting from the investigation. The administrator or designee should inform the resident and his/her representative of the results of the investigation and corrective action taken. The facility will take all necessary corrective actions depending on the results of the investigation.Resident #34 was admitted to the facility in October 2023 with diagnoses including depression and anxiety.Review of the Minimum Data Set (MDS) assessment, dated 1/29/26, indicated Resident #34 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15.Review of the facility's Grievance Book, on 3/31/26, indicated but was not limited to:-Grievance/Concern and Comment Form -When did the incident happen and to whom: 3-11 shift -Date and time: 3/4/26 at 10:00 A.M. -Your Name and Relation to Resident: Family Representative #2 -Concern: - Family Representative #2 came into Social Work Office to report she was on the phone with Resident #34, who was left on the toilet too long, which resulted in Resident #34 calling Family Representative #2 to call the nurse's desk and request someone to come in to assist Resident #34. When said Certified Nursing Assistant (CNA) arrived, Resident felt CNA was rude and yelled at the Resident for his/her Family Representative needing to call the nurse's desk for assistance. - If you suspect any form of Abuse/Neglect/Mistreatment, please notify the nurse or a Manager immediately.-All concerns must be referred to the Department Head for review.-Department Head review and action taken, Department Head signature, and date were left blank.-Follow up must be made with the resident and/or individual who voiced/wrote the concern: Name of Individual contacted: Family Representative #2 Date: 3/5/26 -Comments: -CNA #5 was removed from the resident care assignment and was educated by staff. All staff were educated with Abuse/Neglect Policies, and a new CNA was assigned to Resident #34's care going forward. -Name of staff and date completed follow-up: Social Worker 3/6/26 -Signed by the Administrator on 3/5/26 -Response to Education, dated 3/10/26, indicated CNA #5 was re-educated on the facility policy titled Resident Rights and Privacy, Providing Care and Services, Abuse, Neglect, and Mistreatment, in response to satisfy Resident #34's grievance and to ensure continued resident safety and security from abuse, neglect, and mistreatment.During an interview on 3/31/26 at 4:27 P.M., with Resident #34 and Family Representative #2, Resident #34 said he/she preferred the surveyor to speak with his/her Family Representative. Family Representative #2 said on 3/4/26 they reported to the Social Worker about the incident that occurred the evening before (3/3/26) when Resident #34 called him/her from their cell phone and asked Family Representative #2 to call the nurses' station and ask for someone to come and help Resident #34 off of the toilet. Family Representative #2 said Resident #34 was on the toilet for a long time and was uncomfortable. Family Representative #2 said when CNA #5 came in to assist Resident #34 he/she yelled at CNA #5 first because he/she was uncomfortable. Then, CNA #5 yelled at Resident #34 to not talk to her like that and not to have his/her daughter call the nurses' station. Family Representative #2 said Resident #34 felt bad and apologized to CNA #5. Family Representative #2 said the follow-up was for CNA #5 to be counseled and all staff will be re-educated. During an interview on 4/1/26 at 11:11 A.M., the Director of Nursing (DON) said there were no incident/accident reports or investigations for Resident #34 for the past three months.During an interview on 4/2/26 at 2:51 P.M. and 4:45 P.M., the Social Worker said verbal abuse includes yelling at residents or making them feel bad or not respected. The Social Worker reviewed the Grievance/Concern and Comment Form, dated 3/4/26, and said Resident #34's Family Representative came in and reported the incident from the previous evening, 3/3/26, of Resident #34 being yelled at by CNA #5 to her and she completed a grievance form with them. She said CNA #5 no longer takes care of Resident #34 and was re-educated about abuse. She said Resident #34 being yelled at was considered abuse. She said she notified the Administrator and they treated it as a grievance and did not investigate it.During an interview on 4/2/26 at 3:17 P.M., the DON reviewed the Grievance/Concern and Comment Form, dated 3/4/26, and said he was unaware of the incident until the surveyor inquired about it. He said Resident #34's report of being yelled at was (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an allegation of abuse and should have been reported to the police right away and to the State Agency within two hours, then an investigation should have been conducted, but there was not one done.During an interview on 4/2/26 at 4:25 P.M., the Administrator said verbal abuse is yelling and shouting at a Resident. He said once abuse was reported the police must be notified, it must be reported to the State Agency, and an investigation started. He reviewed the Grievance/Concern and Comment Form, dated 3/4/26 and said on 3/4/26 the Social Worker called him into her office, and they met with Family Representative #2 where they reported that the previous evening that Resident #34 was yelled at by CNA #5. He said CNA #5 was sent home and did not return until 3/17/26, removed from Resident #34's assignment and re-educated about abuse. He said the facility did not follow their policy and the incident was not reported to the Police or State Agency and investigation had not been conducted.Refer to F609, F610

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews, the facility failed to report an allegation of abuse to the state agency for one Resident (#34), out of a total sample of 13 residents.Findings include: Review of the facility's policy titled Abuse, revised 10/23/22, indicated but was not limited to:-The facility prohibits the mistreatment, neglect and abuse of residents/patients and misappropriation of resident patient property by anyone, including staff.-The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property.-Abuse: -The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. -Instances of abuse of all residents, irrespective of any mental or physical condition caused physical harm, pain or mental anguish. -It includes verbal abuse. -Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.-Verbal: -Use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability. -Examples of verbal abuse include, but are not limited to, threats of harm or saying things to frighten a resident.-Reporting: -Staff should notify the shift supervisor, charge nurse, or manager immediately if suspected abuse, neglect, mistreatment, or misappropriation of property occurs. -Once the allegation of abuse has been made, the supervisor who initially received the report must inform the Administrator or Director of Nursing immediately and initiate gathering requested information. An investigation MUST be directed by the Administrator or designee immediately. -Notify the local law enforcement and appropriate State Agency(s) immediately (no later than two hours after allegation or identification of the allegation) by Agency's designated process after identification of alleged/ suspected incident. The facility will report allegations to local police and initiate process according to the Elder Justice Act and State specific regulations. Report results of investigation to the proper authorities as required by State law. Resident #34 was admitted to the facility in October 2023 with diagnoses including depression and anxiety.Review of the Minimum Data Set (MDS) assessment, dated 1/29/26, indicated Resident #34 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15.Review of the facility's Grievance Book, on 3/31/26, indicated but was not limited to:-Grievance/Concern and Comment Form -When did the incident happen and to whom: 3-11 shift -Date and time: 3/4/26 at 10:00 A.M. -Your Name and Relation to Resident: Family Representative #2 -Concern: - Family Representative #2 came into Social Work Office to report she was on the phone with Resident #34, who was left on the toilet too long, which resulted in Resident #34 calling Family Representative #2 to call the nurse's desk and request someone to come in to assist Resident #34. When said Certified Nursing Assistant (CNA) arrived, resident felt CNA was rude and yelled at the Resident for his/her Family Representative needing to call the nurses desk for assistance. - If you suspect any form of Abuse/Neglect/Mistreatment, please notify the nurse or a Manager immediately.-Signed by the Administrator on 3/5/26 Review of the Health Care Facility Reporting System (HCFRS-system used in Massachusetts by facilities to report suspected abuse/misappropriation) on 3/31/26, failed to indicate the facility submitted a report on 3/4/26 for an allegation of abuse. During an interview on 4/2/26 at 3:17 P.M., the Director of Nursing (DON) reviewed the Grievance/Concern and Comment Form, dated 3/4/26, and said he was unaware of the incident until the surveyor inquired about it. He said Resident #34's report of being yelled at was an allegation of abuse and should have been reported to the police right away and to the State Agency within two hours. During an interview on 4/2/26 at 4:25 P.M., the Administrator said verbal abuse includes yelling and shouting at a resident. He said once abuse was reported it must be reported to the State Agency within two hours. He reviewed the Grievance/Concern and Comment Form, dated 3/4/26, and said the allegation of abuse (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from Resident #34 and Family Representative #2 was not reported until 4/2/26, 29 days after being reported.Refer to F610

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interviews and record review, for one Resident (#34), of 13 sampled residents, the facility failed to ensure an allegation of verbal abuse was thoroughly investigated. Findings include:Review of the facility's policy titled Abuse, revised 10/23/22, indicated but was not limited to:-The facility prohibits the mistreatment, neglect and abuse of residents/patients and misappropriation of resident patient property by anyone, including staff.-The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property.-Abuse: -The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. -Instances of abuse of all residents, irrespective of any mental or physical condition caused physical harm, pain or mental anguish. -It includes verbal abuse. -Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.-Verbal: -Use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability. -Examples of verbal abuse include, but are not limited to, threats of harm or saying things to frighten a resident.-Protection: -The facility will take all steps necessary to ensure that further potential abuse will not occur while the investigation is in process. -Any employee who is accused of resident abuse, neglect, exploitation or misappropriation of property will be suspended upon identification immediately. The accused employee will not be permitted to enter the facility unless at the discretion and under the direct supervision of the Administrator or Director of Nursing.-Investigate: -All alleged violations involving abuse, neglect, exploitation, or misappropriation of resident property will be thoroughly investigated by the facility under the direction of the Administrator and in accordance with state and federal law. -The facility will initiate the investigative process. The investigation should be thorough with witness statements from staff, residents, visitors and family members who may be interviewable and have information regarding the allegation. -The conclusion must include whether the allegation was substantiated or not and what information supported the decision. The conclusion/summary must take into account an objective overview of the facts and a reason or basis for the decision to substantiate or not substantiate the allegation. -Reporting: -Once the allegation of abuse has been made, the supervisor who initially received the report must inform the Administrator or Director of Nursing immediately and initiate gathering requested information. An investigation MUST be directed by the Administrator or designee immediately.-Responding/Follow Through: -The facility shall ensure that the appropriate corrective, remedial or disciplinary actions occur in accordance with local, state and federal law in response to the findings resulting from the investigation. The administrator or designee should inform the resident and his/her representative of the results of the investigation and corrective action taken. The facility will take all necessary corrective actions depending on the results of the investigation.Resident #34 was admitted to the facility in October 2023 with diagnoses including depression and anxiety.Review of the Minimum Data Set (MDS) assessment, dated 1/29/26, indicated Resident #34 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15.Review of the facility's Grievance Book, on 3/31/26, indicated but was not limited to:-Grievance/Concern and Comment Form -When did the incident happen and to whom: 3-11 shift -Date and time: 3/4/26 at 10:00 A.M. -Your Name and Relation to Resident: Family Representative #2 -Concern: - Family Representative #2 came into Social Work Office to report she was on the phone with Resident #34, who was left on the toilet too long, which resulted in Resident #34 calling Family Representative #2 to call the nurses' desk and request someone to come in to assist Resident #34. When said Certified Nursing Assistant (CNA) arrived, Resident felt CNA was rude and yelled at the Resident for his/her Family Representative needing to call the nurses' desk for assistance. - If you suspect any form of Abuse/Neglect/Mistreatment, please notify the nurse or a Manager immediately.-All concerns must (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be referred to the Department Head for review.-Department Head review and action taken, Department Head signature, and date were left blank.-Follow up must be made with the resident and/or individual who voiced/wrote the concern: Name of Individual contacted: Family Representative #2 Date: 3/5/26 -Comments: -CNA #5 was removed from the resident care assignment and was educated by staff. All staff were educated with Abuse/Neglect Policies, and a new CNA was assigned to Resident #34's care going forward. -Name of staff and date completed follow-up: Social Worker 3/6/26 -Signed by the Administrator on 3/5/26 -Response to Education, dated 3/10/26, indicated CNA #5 was re-educated on the facility policy titled Resident Rights and Privacy, Providing Care and Services, Abuse, Neglect, and Mistreatment, in response to satisfy Resident #34's grievance and to ensure continued resident safety and security from abuse, neglect, and mistreatment.During an interview on 3/31/26 at 4:27, with Resident #34 and Family Representative #2, Resident #34 said he/she preferred the surveyor to speak with his/her Family Representative. Family Representative #2 said on 3/4/26 they reported to the Social Worker about the incident that occurred the evening before (3/3/26) when Resident #34 called him/her from their cell phone and asked Family Representative #2 to call the nurse's station and ask for someone to come and help Resident #34 off of the toilet. Family Representative #2 said Resident #34 was on the toilet for a long time and was uncomfortable. Family Representative #2 said when CNA #5 came in to assist Resident #34 he/she yelled at CNA #5 first because he/she was uncomfortable, then CNA #5 yelled at Resident #34 not to talk to her like that and not to have his/her daughter call the nurse's station. Family Representative #2 said Resident #34 felt bad and apologized to CNA #5. Family Representative #2 said the follow-up was for CNA #5 to be counseled and all staff will be re-educated. During an interview on 4/1/26 at 11:11 A.M., the Director of Nursing (DON) said there were no incident/accident reports or investigations for Resident #34 for the past three months.During an interview on 4/2/26 at 3:17 P.M., the DON reviewed the Grievance/Concern and Comment Form, dated 3/4/26, and said he was unaware of the incident until the surveyor inquired about it. He said Resident #34's report of being yelled at was an allegation of abuse and an investigation should have been conducted, and a final report should have been submitted to the State Agency within five business days, but there was not one done.During an interview on 4/2/26 at 4:25 P.M., the Administrator said verbal abuse is yelling and shouting at a resident. He reviewed the Grievance/Concern and Comment Form, dated 3/4/26. He said on 3/4/26, he and the Social Worker met with Family Representative #2 who reported that Resident #34 was yelled at by CNA #5 the previous evening. He said CNA #5 was sent home and did not return until 3/17/26, removed from Resident #34's assignment, and re-educated about abuse. He said we made a mistake and did not conduct an investigation but should have.

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	225637	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare at Provincetown	100 Alden Street Provincetown, MA 02657

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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 document review and interview, the facility failed to ensure monthly medication regimen reviews (MRR) were communicated to the Physician/Nurse Practitioner and were reviewed and responded to in a timely manner for two Residents (#25 and #6), out of a total sample of 13 residents. Specifically, the facility failed:1. For Resident #25, to ensure:a. an October 2025 consultant pharmacist's recommendation to clarify a medication allergy for a medication currently being administered to the Resident was acted upon; andb. a February 2026 consultant pharmacist's recommendations for laboratory test due to an increased risk of the Resident taking the antipsychotic medication Risperdal was acted upon; and2. For Resident #6, to ensure the October 2025, December 2025, and February 2026 consultant pharmacist's recommendations to re-evaluate the continued use of as needed (PRN) psychotropic medication, Trazodone (antidepressant medication), note the medical justification for continued use in a progress note, and specify the number of days the order was to continue.Findings include: Review of the facility's policy titled Pharmacy Consultant Med Review, last revised 12/2025, indicated but was not limited to: -The facility shall employ/contract and maintain the services of a licensed pharmacist (pharmacy consultant), who shall review the medication regimen review (MRR) of each resident at least monthly and more frequently as needed. -The primary purpose of this review is to assist the facility in maintaining each resident's highest practicable level of functioning and quality of life, by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. -The pharmacy consultant will document his/her findings and recommendations on the monthly drug/regimen review report. -The Director of Nurses will give the unit manager/designee a copy of the monthly pharmacy consultant report. -The unit manager/designee will make sure: a. All recommendations are acted upon b. All of the recommendations are reported to the resident physicians c. There is documentation in the resident chart that notification and follow-up occurred d. Notify the resident's physician of the pharmacy consultant's recommendations and document in the resident's chart that it was done e. Remind the resident's physician to sign the resident's consultant report that is filed in the resident's chart/Electronic Health Record. -The unit manager/designee will return the copy of the consultant's report to the Director of Nursing when notifications, follow-ups and documentation have been completed. -The Director of Nursing will notify the facility's medical director if the resident physician does not (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow through on the consultant's recommendations. 1. Resident #25 was admitted to the facility in April 2025 and had diagnoses including dementia with behaviors, Parkinson's disease, and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 1/29/26, indicated resident #25 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status Score (BIMS) of 8 out of 15 and received antipsychotic and antianxiety medication daily. Review of Resident #25's medical record indicated he/she was allergic to Midazolam (sedative). Review of Physician's orders indicated but was not limited to: - Lorazepam (Ativan) 0.5 milligrams (mg). Give 1 tablet by mouth four times a day (last renewed 3/24/26) - Risperdal 0.5 mg. Give 1 tablet by mouth three times a day (last renewed 1/2/26) a. Review of Resident #25's MRR recommendation, dated 10/13/25, indicated the following: -This resident has an allergy to Midazolam but currently receives Ativan. Please clarify and if there is no issue, suggest having medical staff override allergy. The response section of the MRR recommendation was blank and unsigned by the Physician/Nurse Practitioner. b. Review of Resident #25's MRR recommendation, dated 2/8/26, indicated the following: -Resident is receiving the following antipsychotic medication: Risperdal. Please consider monitoring lipids & A1c due to potential for metabolic syndrome (a cluster of conditions that together increase the risk of heart disease, stroke, and type 2 diabetes). The response section of the MRR recommendation was blank and unsigned by either the Physician or Nurse Practitioner (NP). Review of Physician and NP documentation from October 2025 through April 2026 failed to indicate either the Physician or Physician Extender had reviewed and addressed the consultant pharmacist's recommendations dated 10/13/25 and 2/8/26. Further review of the medical record failed to indicate facility staff notified the Resident's Physician or NP of the pharmacy consultant's recommendations and document in the resident's chart that it was done. During an interview on 4/1/26 at 1:34 P.M., the Director of Nursing (DON) said he reviewed Resident #25's medical record and said he could not find any evidence that the Physician or NP reviewed or addressed the pharmacy recommendations. He said he did not document anything about the pharmacy recommendations in the medical record either. During an interview on 4/2/26 at 11:35 A.M., the NP said when the Consultant Pharmacist makes a (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recommendation, the forms are placed on his desk in his office. He said when he comes into the facility, he addresses them, signs/makes notations on the forms, documents in the medical record and places it in a folder at the nurse's station for them to enter the orders. He reviewed Resident #25's medical record and said neither he nor the Physician ever received the 10/13/25 and 2/8/26 MRR recommendations and therefore were not addressed. 2. Resident #6 was admitted to the facility in November 2024 with diagnoses including anxiety, dementia, and depression. Review of the MDS assessment, dated 1/1/26, indicated Resident #6 had a severe cognitive deficit as evidenced by a staff interview. Further review of Resident #6's MDS indicated he/she received an antidepressant medication. Review of Resident #6's current Physician's Orders indicated but was not limited to: -Trazodone 25 mg tab by mouth every 24-hours as needed in the evening for agitation/anxiety, dated 10/9/25 Review of the medical record indicated but was not limited to: -10/12/25 Pharmacy Note- Medications reviewed. Please see the Consultant Pharmacist's report for the recommendations. -12/8/25 Pharmacy Note- Medications reviewed. Please see the Consultant Pharmacist's report for the recommendations. -2/8/26 Pharmacy Note- Medications reviewed. Please see the Consultant Pharmacist's report for the recommendations. Review of the MRR, dated 10/12/25, 12/8/25, and 2/8/26, indicated but was not limited to: -Note to Attending Physician/Prescriber: -Resident is receiving the following PRN psychotropic medication. These medications are required to be re-evaluated after 14 days. If therapy is to continue beyond 14 days, please note medical justification for continued use in progress note and specify number of days the PRN order is to continue. -Trazodone -Signed by the prescriber on 10/14/25, 12/9/25, and 2/10/26. Further review of the medical record failed to indicate Resident #6's Trazodone was re-evaluated, medical justification for continued use was documented in a progress note, and an order for a specific number of days to continue the PRN Trazodone. During an interview on 4/2/26 at 12:28 P.M., the NP reviewed the MRRs and Resident #6's medical record. He said the MRR are left for him or the physician to review, after he documents if he agrees or disagrees with the recommendation and writes a note, he returns the MRR to the nurse. He said he (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	signed off the MRR recommendation, dated 10/14/25, 12/9/25, and 2/10/26, but the medical justification for continued use was not documented and an order for a specific number of days to continue the PRN Trazodone was missed. During an interview on 4/2/26 at 2:21 P.M., Nurse #1 said if she received the signed MRR from the Physician or NP, she would put in an order for the number of days to continue the Trazodone, but the Physician or NP was responsible for writing a progress note for medical justification to continue the PRN Trazodone. During an interview on 4/2/26 at 12:18 P.M., the DON said he receives the Consultant Pharmacist's recommendations and leaves them for the Physician/NP to review. Once they are reviewed and addressed, they get filed away in the resident's chart. He said the MRR recommendations were missed but should have been addressed to include a duration of use for the Trazodone and a progress note should have been written to address the medical justification of use.

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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 two nurses observed during a medication pass made three errors out of 25 opportunities, resulting in a medication error rate of 12%. Those errors impacted three Residents (#1, #19 and #6), out of seven 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 but was not limited to the following:Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers.Review of the facility's policy titled Medication Administration, last revised November 2025, indicated but was not limited to:- Medications must be administered in accordance with the orders, including any required time frame.1. For Resident #1, Nurse #3 administered:-Tamsulosin (used to treat symptoms of an enlarged prostate such as difficulty urinating, weak stream, and urgency) at the incorrect time.On 4/1/25 at 9:07 A.M., the surveyor observed Nurse #3 prepare and administer medications to Resident #1 including:-Tamsulosin 0.4 milligrams (mg) 1 capsuleReview of the medication card indicated but was not limited to:- Tamsulosin 0.4 mg capsule daily at bedtimeReview of Resident #1's current Physician's Orders indicated but was not limited to:-Tamsulosin 0.4 mg capsule at bedtime, dated 2/10/26During an interview on 4/1/26 at 1:47 P.M., Nurse #3 said she administered Tamsulosin to Resident #1 during morning medication administration. She reviewed Resident #1's physician's orders and said she thought the Tamsulosin was scheduled for the morning and not at bedtime. She said she did not look at the instructions on the medication card when she was preparing Resident #1's medications. She said she should have reviewed Resident #1's physician's orders and reviewed the instructions on the Tamsulosin medication card, but she did not.2. For Resident #19, Nurse #2 administered:-the incorrect dose of Calcium Carbonate (a supplement to support bone density and muscle function).On 4/1/26 at 9:22 A.M., the surveyor observed Nurse #2 prepare and administer medications to Resident #19 including:-Calcium Carbonate 750 mg tabletReview of Resident #19's Physician's Orders indicated but was not limited to:-Calcium Carbonate 500 mg tablet daily in the morning, dated 3/25/26During an interview on 4/1/26 at 1:45 P.M., Nurse #2 showed the surveyor a bottle of Calcium Carbonate 750 mg and said she administered it to Resident #19 during the morning medication pass. She reviewed Resident #19's physician's orders and said she should have administered Calcium Carbonate 500 mg as ordered by the Physician.3. For Resident #6, Nurse #2 administered:-the incorrect formula of Synthroid (a prescription medicine used to treat hypothyroidism (underactive thyroid)).On 4/1/26 at 9:42 A.M., the surveyor observed Nurse #2 prepare and administer medications to Resident #6 including:-Levothyroxine 75 Micrograms (mcg) tabletReview of the medication card indicated but was not limited to:-Levothyroxine 75 mcg, Generic for: Synthroid-Give 1 tab daily in the morning, Brand Name only, No Substitutions-Dispensed on 3/18/26Review of Resident #6's Physician's Orders indicated but was not limited to:-Synthroid 75 mcg (Levothyroxine), 1 tab daily, BRAND NAME ONLY, NO SUBSTITUTIONS, dated 1/10/25During an interview on 4/2/26 at 11:06 A.M., the Nurse Practitioner said Resident #6's Resident Representative requested Resident #6 be administered Synthroid brand name only because the generic Levothyroxine is not as effective for him/her as the brand name form.During a telephonic interview on 4/2/26 at 11:23 A.M., the Pharmacist reviewed Resident #6's physician's orders and allergies and said Resident #6 does not have an allergy to Levothyroxine. She said some people's bodies do not metabolize Levothyroxine as well as Synthroid, making Levothyroxine not as effective as it should be.During an interview on 4/2/26 at 11:37 A.M., Resident Representative #3 said Resident #6 can only take the brand name Synthroid, because the generic form of Levothyroxine is not as effective for him/her. Resident Representative #3 said when Resident #6 would take Levothyroxine his/her hair will thin and fall out and his/her laboratory levels can be off.During an interview on 4/2/26 at 12:18 P.M., the Director of Nursing said medication must (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be administered per physician's orders and should be given as ordered. He said they must be administered in the correct time, dose, and the correct formula.

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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 store all drugs and biologicals in accordance with currently accepted professional principles for one of one unit. Specifically, the facility failed to secure drugs and biologicals during a medication pass when medications were left unattended and were improperly disposed of in an unsafe manner.Findings include:Review of the facility's policy titled Medication Storage, revised December 2025, indicated but was not limited to:-The center will have medications stored in a manner that maintains the integrity of the product, ensures safety of the residents, and is in accordance with the Department of Health guidelines.-All medications including emergency drug kits will be stored in a locked cabinet, cart, or medication room that is accessible only to authorized personnel.Review of the facility's policy titled Medication Administration, Revised November 2025, indicated but was not limited to:-During administration of medications no medications are kept on top of the cart.a. On 4/1/26 at 9:13 A.M., the surveyor observed Nurse #3 prepare the following medications for Resident #1 and bring them into his/her room:-Tamsulosin 0.4 milligrams (mg) (used to treat symptoms of an enlarged prostate such as difficulty urinating, weak stream, and urgency) capsule-Multivitamin with Minerals tablet (mineral supplements)-Vitamin C 500 mg tablet (boosts the immune system, acts as a powerful antioxidant to protect cells from damage)-Oxycodone 5 mg tablet (an opioid pain reliever)-Guaifenesin 400 mg tablet (thins mucus in the chest)-Ferrous Sulfate 325 mg tablet (iron supplement)-Docusate Sodium 100 mg capsule (stool softener)Nurse #3 left Resident #1 holding the medication cup with four pills in it and went out into the hall. Nurse #3 stepped out into the hallway with her back to Resident #1 and the medication cup with four medications in it.During an interview on 4/1/26 at 1:47 P.M., Nurse #3 said she should not have left Resident #1 holding the medication cup unattended. She said medication must be in view of the nurse.b. On 4/1/26 at 9:30 A.M., the surveyor observed Nurse #2 prepare and administer medications to Resident #32 including but not limited to:-Escitalopram 10 mg tablet (antidepressant medication)The Escitalopram tablet fell on the floor. Nurse #2 picked up the tablet and disposed of it into an opened, uncovered, and unsecured trash receptacle on the medication cart.On 4/1/26 at 11:20 A.M., the surveyor observed the opened, uncovered, and unsecured trash receptacle on Nurse #2's medication cart containing the trash bag containing the Escitalopram tablet.During an interview on 4/1/26 at 2:29 P.M., Nurse #2 said she disposed of the Escitalopram tablet into the uncovered and unsecured trash receptacle. She said medications should be disposed of in a secure manner without allowing residents access to unsecured medications.c. On 4/1/26 at 1:23 P.M., the surveyor observed the following:-Nurse #3 prepare and administer medications to Resident #14.-Nurse #3 left a medication card containing eight Amiodarone (a potent antiarrhythmic medication used to treat life-threatening heart rhythm) 400 mg tablets on top of the medication cart in the hallway unattended and unsecure with her back to the medication cart.On 4/1/26 at 1:47 P.M , Nurse #3 said she should not have left the medication card of Amiodarone unattended and unsecured in the hallway allowing anyone who walks by access to it.During an interview on 4/1/26 at 2:22 P.M., the Director of Nursing said medication should not be left unattended and unsecure in a resident's room or in the hallway. He said medication should not be disposed of in an unsecured and uncovered trash receptacle. He said medication must be disposed of in a safe and secure manner and medications must remain in view of the nurse.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain accurate documentation of the consent or declination of the pneumococcal vaccine, including education regarding the benefits and potential risks associated with the vaccine for three Residents (#20, #24 and #26), out of a sample of five residents. Findings include: Review of facility's policy titled Pneumococcal Vaccination, dated 7/2019 and last revised 9/10/25, indicated but was not limited to the following:- All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections- Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated.- Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination.- Administration of the pneumococcal vaccine will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. 1. Review of the medical record for Resident #20, admitted [DATE], failed to include any documentation to indicate the Resident had an opportunity to either consent or decline the Pneumococcal vaccine and did not include an Immunization Consent form. Further review of the medical record failed to indicate the Pneumococcal vaccination status for Resident #20. 2. Review of the medical record for Resident #24, admitted [DATE], failed to include any documentation to indicate the Resident had an opportunity to either consent or decline the Pneumococcal vaccine and did not include an Immunization Consent form. Further review of the medical record failed to indicate the Pneumococcal vaccination status for Resident #24. 3. Review of the medical record for Resident #26, admitted [DATE], failed to include any documentation to indicate the Resident had an opportunity to either consent or decline the Pneumococcal vaccine and did not include an Immunization Consent form. Further review of the medical record failed to indicate the Pneumococcal vaccination status for Resident #26. During an interview on 4/1/26 at 9:30 A.M., Nurse #1 said consents for vaccinations were scanned into the electronic medical record. Nurse #1 and the surveyor reviewed the medical record and did not locate a Pneumococcal consent form for Resident #20, Resident #24 or Resident #26. Nurse #1 said consent forms should have been completed with the residents/representatives and placed in the medical record.Nurse #1 and the surveyor further reviewed the medical record for Resident #20, Resident #24 and Resident #26 for Pneumococcal vaccination status. Nurse #1 said the vaccines are documented in the electronic medical record under the immunization tab. Nurse #1 said the Pneumococcal vaccine for Resident #20, Resident #24 and Resident #26 were not documented. During an interview on 4/2/26 at 11:00 A.M., the Infection Control Preventionist (ICP) said she was overseeing the vaccination program for both residents and staff. The ICP said she was behind on obtaining consents for the Pneumococcal vaccine. The ICP said the Pneumococcal consent form had not been reviewed with Resident #20, Resident #24 and Resident #26. During an interview on 4/2/26 at 12:42 P.M., the Director of Nurses (DON) said there had not been a focus on Pneumococcal vaccinations by the last administration. The DON reviewed the most recent CDC guidance for Pneumococcal vaccination for people over [AGE] years old and did not observe documentation in any of the sampled Resident records to demonstrate the guidelines had been met.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review and interviews, the facility failed to implement and revise individual care plans for one Resident (#17) out of a total sample of 13 residents. Specifically, the facility failed to revise the plan of care to ensure care approaches were effective, individualized, and appropriate for Resident #17 who was at risk for falls. Findings include: Review of the facility's policy, titled Fall Prevention and Management (revised 1/2023), indicated but was not limited to the following:- The interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence- The staff will implement goals and interventions with resident/patient/family for inclusion in the interdisciplinary care plan based on the resident's individual needs- If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions-Residents who continue to fall with interventions in place will be assessed for changes in or additions to interventions Resident #17 was admitted to the facility in September 2025 with diagnoses that included dementia and anxiety. Review of the Minimum Data Set (MDS) Assessment, dated 1/1/26, indicated Resident #17 scored 9 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had moderate cognitive impairment. Further review of the MDS indicated Resident #17 had two or more falls. Review of the care plan, initiated 10/16/25, indicated Resident #17 was at risk for falls. The goal identified was that Resident #17 will not sustain a fall related injury by utilizing fall precautions through the next review. Interventions included but were not limited to the following:-10/16/25 Resident educated on safety needs while in room: call bell in reach and call for assist with transfers-10/16/25 Invite, encourage, remind, escort to activity program consistent with resident's interests to enhance physical strengthening needs-10/16/25 Provide environmental adaptations:-Low/platform bed-Call light within reach-Adequate glare free lighting-Area free of clutter-10/16/25 Report falls to physician and responsible party-12/22/25 Resident will wear appropriately sized pants that are cuffed at the bottom-12/15/25 Sign reminder Remember to use your Walker on the walker and white board-10/16/25 Use of fall screen to identify risk factors Review of the care plan, initiated 10/1/25, indicated Resident #17 requires assist with Activities of Daily Living (ADL) related to cognitive loss. The goal identified was that Resident #17 will perform ADL self-performance activities as possible. Interventions included but were not limited to the following:-10/6/25 Dycem to wheelchair to assist with slipping-10/16/25 Resident will spend majority of time in common area due to history of falls in room-10/1/25 Toilet hygiene moderate assist Review of the incident accident reports for falls, included the following reports with interventions:10/5/25- slip from wheelchair; Dycem added to wheelchair cushion10/11/25- educated safety needs12/12/25-toilet assist after meals12/12/25-appropriately sized pants that are cuffed at the bottom Further review of the fall care plan, (revised 10/23/25), did not provide documented evidence to toilet assist after meals. During an observation and interview on 3/31/26 at 10:30 A.M., the surveyor observed Resident #17 standing up from his/her bed and self-transfer to a straight back chair at his/her bedside. The Resident said he/she does not use a wheelchair. The surveyor did not see a wheelchair in the resident's room and the whiteboard on the wall across from resident's bed was blank. During an observation and interview on 3/31/26 at 1:05 P.M., the surveyor observed Resident #17 stand from the bed and ambulate to the bathroom without his/her walker. Resident #17 said he/she goes to the bathroom on his/her own. During an observation and interview on 4/1/26 at 9:49 A.M., the surveyor observed Resident #17 sitting in a straight back chair at his/her bedside. Resident #17 said he/she does not like to leave his/her room. Resident #17 said he/she did not like to go to activities or the day room. During an interview on 4/1/26 at 11:58 A.M., Certified Nursing Assistant (CNA) #2 said she was aware Resident #17 was a fall risk. She said Resident #17 did not (continued on next page)

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	225637	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare at Provincetown	100 Alden Street Provincetown, MA 02657

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use a wheelchair. CNA #2 said Resident #17 does not like to come out of his/her room. CNA #2 said Resident #17 does not need assistance to use the bathroom. During an interview on 4/1/26 at 2:06 P.M., Nurse #2 said nurses do not update Resident's care plans. Nurse #2 said she believed that the MDS nurse updated care plans. Nurse #2 said Resident #17 very seldom comes out of his/her room. Nurse #2 said Resident #17 is independent in his/her room and requires no supervision. During an interview on 4/2/26 at 2:21 P.M., the Regional Nurse Consultant (RNC) said the expectation was the nurse who was documenting the falls incident report would put the intervention into the care plan. The RNC said all falls are reviewed in the morning meeting and updated/revised as needed. Staff would be educated to new interventions. During an interview on 4/2/26 at 3:14 P.M., the Director of Nurses (DON) reviewed Resident #17's current falls care plan. The DON said he was not aware Resident #17 was no longer using a wheelchair or Resident preferred to stay in his/her room. The DON said Resident #17 did have a fall on 12/12/25 and interventions were not revised to prevent further falls. The DON said the current care plan needed to be revised. Although the plan of care, revised 10/23/25, for the risk of falls included approaches to prevent falls, there was no documented evidence that the interdisciplinary team reviewed the effectiveness of the interventions being put in place to prevent the falls.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview, the facility failed to ensure staff provided care and services consistent with accepted standards of clinical practice for one Resident (#1), out of a total sample of 13 residents. Specifically, the facility failed to ensure a physician's order for Lidocaine 5% patch (topical anesthetic) was complete and included the duration/time of removal.Findings include:Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following:- Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber 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 error.Resident #1 was admitted to the facility in January 2026 and had diagnoses including arthritis and one stage 2 pressure ulcer (partial-thickness skin loss involving the epidermis and dermis).Review of the Minimum Data Set (MDS) assessment, dated 2/12/26, indicated Resident #1 cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15, and received pain medication daily.Review of the medical record indicated the following Physician's Order:-Lidoderm Patch 5% (Lidocaine), Apply to low back topically in the morning for low back pain (2/10/26)During an interview on 4/1/26 at 11:39 A.M., Nurse #3 reviewed Resident #1's medical record and said the order for the Lidocaine pain patch indicates it is to be applied in the morning but does not include a duration or a time when it is to be removed. She said Lidocaine 5% patches can be applied for up to 12 hours but can be ordered for different durations. She said the physician's order should be complete and include a duration/time of removal and it does not.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, interviews, and records reviewed, the facility failed to ensure one Resident (#1), out of a total sample of 13 residents, received care and treatment to prevent and to promote healing of a pressure injury consistent with professional standards of practice. Specifically, the facility failed to ensure an air mattress was set according to the physician's order.Findings include:Review of the facility's policy titled Support Surfaces-Air Mattresses, last revised 10/2022, indicated but was not limited to:Low air loss mattress use is indicated as follows:-To assist in the treatment and/or prevention of pressure ulcers as part of a holistic program of pressure ulcer management.-As part of a pain management program when indicated for resident comfortSettings:-The patient weight indication is a close proximation of the correct setting.Resident #1 was admitted to the facility in January 2026 and had diagnoses including one stage 2 pressure ulcer (partial-thickness skin loss involving the epidermis and dermis) to his/her left buttock and one unstageable deep tissue injury to his/her right heel.Review of the Minimum Data Set (MDS) assessment, dated 2/12/26, indicated Resident #1 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15, had one stage 2 pressure ulcer and one unstageable deep tissue injury and had a pressure reducing device for his/her bed.On 3/31/26 at 10:05 A.M., the surveyor observed Resident #1 lying in bed resting. An air mattress was in place, and the compressor was on and set to 280 pounds (lbs.). Review of the medical record indicated the following Physician's Order:- Air mattress to bed for pressure relief. Set per Resident's weight. Check functionality every shift for pressure relief (3/23/26)Review of the medical record indicated Resident #1's weight was last measured on 2/18/26 and was 193.0 lbs.On 4/1/26 at 9:17 A.M., the surveyor observed Resident #1 sitting upright in bed awake. An air mattress was in place, and the compressor was on and set to 280 lbs. Review of comprehensive care plans indicated, but was not limited to:-Focus: Impaired skin integrity related to pressure, decreased mobility, incontinence as evidenced by a stage 2 pressure injury to left buttock (3/13/26)-Interventions: Utilize air mattress set per Resident's weight (3/13/26)-Goal: Resident's stage 2 pressure injury to left buttock will show signs of healing within review period; Resident will remain free from additional pressure injuries during review period (target date: 6/10/26)During an interview with observation on 4/1/26 at 11:39 A.M., Nurse #3 and the surveyor went to Resident #1's room to inspect the air mattress in place on the Resident's bed. She said the air mattress was set to 280 lbs. and should be set to his/her weight as indicated in the physician's orders. She reviewed the Resident's medical record and said the Resident's last weight was taken on 2/18/26 and it was 193.0 lbs. She said the air mattress was set too high and should be set close to 193 lbs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to properly date, label, and store food and drink items in one of two kitchenettes.Findings include:Review of the facility's policy titled Unit Food Storage, last revised January 2023, indicated but was not limited to:-Food items stored for nourishment or brought in by residents shall be stored in designated areas only. The unit area designated for food storage will remain clean and safe for food handling.-Food items will be identified with name of the owner and date placed in designated refrigerator.-All resident food items will be dated with use by date.-Dietary and nursing staff will be responsible to ensure food items stored in pantry, refrigerators, and freezers are not expired or past perish dates.Review of the facility's policy titled Food from Outside-Safety, last revised January 2023, indicated but was not limited to:-It is the policy of this facility to provide safe and sanitary storage, handling, and consumption of all food including food and fluids brought to residents by family and other visitors.-Education on safe food handling will be provided to all staff, family, residents, resident council, visitors.-Education will include at a minimum: -Proper labeling and dating of each item. -Leftover foods be used within 3 days or discard. -Foods requiring refrigeration will be received by the facility designee (activity department, food and nutrition department, and charge nurse) for proper and immediate storage including labeling and dating.-Staff will examine food for quality (smell, packaging, appearance) to identify potential concerns. If concerns are identified, staff will notify the resident or resident representative of findings and necessary actions per proper food and beverage safe handling.On 3/31/26 at 12:26 P.M., in the Living Room refrigerator, the surveyor made the following observations:- A sign on refrigerator indicated but not limited to: -Attention Everyone, All food put into the refrigerator must be labeled with name and date. Any Item that is not dated will be thrown out.-One paper bag with a plastic container inside with fried chicken pieces, labeled as packed on 3/24/26, sell by 3/25/26. Both the bag and plastic container failed to indicate a Resident's name and date brought in.-Plastic container with a clear cover, covered with condensation and food inside, labeled with a Resident's name and dated 3/24/26- A gray insulated cup with soup inside, labeled with Resident's initials and undated- One opened container of sliced cheese with a black, fuzzy looking substance on a few of the cheese slices, labeled with a Resident's name and use by date of 5/8/26, but failed to indicate the date opened- One jar of tomato sauce, manufacturer's recommendations to use within 3 days after opening, failed to indicate a resident's name and date opened- One plastic container of ricotta cheese, manufacturer's recommendations to use within 3 to 5 days after opening, failed to indicate a resident's name or date opened- Half of an egg salad sandwich, dated 3/26/26- One open jar of olives, failed to indicate resident's name or date openedOn 3/31/26 at 4:17 P.M., in the Living Room refrigerator, the surveyor made the following observations:- One plastic container of ricotta cheese, manufacturer's recommendations to use within 3 to 5 days after opening, failed to indicate a resident's name or date opened- One jar of tomato sauce, manufacturer's recommendations to use within 3 days after opening, failed to indicate a resident's name and date opened- One opened container of sliced cheese with a black, fuzzy looking substance on a few of the cheese slices, labeled with a Resident's name and use by date of 5/8/26, failed to indicate date opened- One open jar of olives, failed to indicate resident's name or date opened- A gray insulated cup with soup inside, labeled with Resident's initials and undatedDuring an interview with observation on 3/31/26 at 4:46 P.M., Nurse #5 said the kitchen staff was responsible for cleaning the refrigerator, but sometimes she cleaned it on the overnight shift. She said foods brought in for a resident must be labeled with the resident's name and dated, then discarded after 72 hours. She said if food is unlabeled with a resident's name and undated then it should be thrown out. She opened the gray insulated cup and said, Oh, that soup doesn't look good and she was unsure (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when it was brought in. She said the sliced cheese looked moldy. She said the ricotta, tomato sauce, and olives should not be in the refrigerator and needed to be discarded.During an interview on 4/1/26 at 11:14 A.M., Dietary Aide #1 said the unit refrigerators were cleaned four times a day by the kitchen staff. He said resident items needed to be labeled with a resident's name and date brought in. He said foods that are not labeled with a with a resident's name and/or dated must be discarded. He said the nursing staff know that nothing should go in the refrigerator without being labeled and dated. During an interview on 4/1/26 at 12:04 P.M, the Food Service Manager said nursing was responsible for discarding food items which were not labeled and dated appropriately. He said the dietary department only cleans up spills. He said the dietary department was told not to discard any food in the refrigerator as not to upset residents or their families.During an interview on 4/2/26 at 3:25 P.M., the Director of Nursing said residents' food items needed to be labeled with a resident's name and date brought in and then discarded after 72 hours. He said if food is not labeled and dated then it should be discarded. He said the dietary department was responsible for cleaning the refrigerator and discarding foods not labeled and dated appropriately.