STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225651	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alliance Health at Rosewood	22 Johnson Street Peabody, MA 01961

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to distribute food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure that staff did not handle ready-to-eat food using bare, ungloved, hands on two of three units. Findings include: Review of the Massachusetts Food Code (105 CMR 590.001) indicated, but was not limited to, the following:-Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment.-Food Employee means an individual working with unpackaged food, food equipment or utensils, or food-contact surfaces. In health care facilities, this includes those who set up trays for patients to eat, feed or assist patients in eating, give oral medications or give mouth/denture care. On 1/21/26 at 8:34 A.M., the surveyor observed a staff member, who was providing feeding assistance to a resident in the second-floor dining room, touch her mask with her bare hand; the staff member then, using her bare hands, picked up the Residents toast, buttered it, and placed it back on the Residents' plate. At 8:37 A.M., the surveyor observed the same staff member using her bare hand to pick up the same ready-to-eat toast and handed it to the Resident to eat. On 1/21/26 at 12:55 P.M., the surveyor observed a staff member feeding a resident in the second-floor dining room. The staff member picked up a half of a sandwich with a fork and as she was bringing the sandwich to the Residents mouth the sandwich fell off of the fork and onto the Resident's lap. The staff member then picked up the sandwich using her bare hands and handed it to the Resident to eat. On 1/23/26 at 8:39 A.M., the surveyor observed a staff member providing meal tray set-up assistance for a Resident in the third-floor dining room. The staff member picked up both slices of the Resident's ready-to-eat toast with her bare hands and applied jelly to them; the staff member then placed the jellied toast back onto the Resident's plate. During an interview on 1/23/26 at 9:16 A.M., Nurse #2 said staff should not use their bare hands when handling ready-to-eat food. During an interview on 1/23/26 at 9:44 A.M., the Director of Nursing said staff should not use their bare hands when handling ready-to-eat food. During an interview on 1/23/26 at 9:57 A.M., the Administrator said staff should use gloves, a clean napkin or utensil to pick up ready-to-eat food when providing feeding assistance, not their bare hands.

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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Alliance Health at Rosewood	22 Johnson Street Peabody, MA 01961

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and interview, the facility failed to create a baseline plan of care within the required 48 hours of admission for one Resident (#124) out of a total sample of 26 residents.Findings include:Review of the facility policy titled ?Baseline Care Plan', dated 5/15/22, indicated the following but not limited to:A baseline care plan is developed within 48 hours of admission to the facility. The baseline care plan will include the instructions needed to provide effective and person-centered care of the residents that meet professional standards of quality care. Resident #124 was admitted to the facility in October 2025 with diagnoses including dementia and repeated falls. Review of the progress note dated 11/1/25 at 5:00 A.M., indicated the Resident had been found on the floor. Review of the medical record failed to indicate a baseline care plan. During an interview on 1/21/26 at 12:00 P.M., Unit Manager #2 said a baseline care plan should be completed within 48 hours of admission. She further said the baseline care plan would show what kind of assistance the Resident would require for care. During an interview on 1/21/26 at 1:05 P.M., the Director of Nursing (DON) said that a baseline care plan should have been completed within 48 hours of admission and that the nurses were responsible for initiating the baseline care plan.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review and interviews, the facility failed to ensure one Resident (#137) who required respiratory care (continuous oxygen) received care consistent with professional standards of practice out of a total sample of 28 Residents.Specifically, for Resident #137, nursing administered continuous oxygen without a physician's order. Findings include:Review of the undated facility policy titled, Nasal Canula indicated, but was not limited to, the following:Verify physicians' orders. Resident #137 was admitted to the facility in January 2026 with diagnoses of chronic obstructive pulmonary disease (COPD) with (acute) exacerbation and dependence on supplemental oxygen. Review of Resident #137's current active physician's and telephone orders failed to include an order to administer continuous oxygen. Review of the Resident's discontinued physician's orders failed to indicate the Resident had an order for continuous oxygen this admission. On 1/20/26 at 9:02 A.M., the surveyor observed Resident #137 in his/her room. The Resident was receiving oxygen via nasal cannula at three liters per minute. Resident #137 said he/she has recently been utilizing supplemental oxygen. On 1/20/26 at 2:37 P.M., the surveyor observed Resident #137 in his/her room receiving oxygen via nasal cannula. On 1/21/26 at 7:29 A.M., the surveyor observed Resident #137 in his/her room receiving oxygen via nasal cannula. On 1/21/26 at 9:43 A.M. the surveyor observed Resident #137 in his/her room receiving oxygen via nasal cannula at three liters per minute. Review of Resident #137's nurse progress notes, including notes dated 1/14/26, 1/15/26, 1/16/26, 1/17/26, 1/19/26 and 1/20/26, indicated Resident #137 was receiving supplemental oxygen. Review of Resident #137's SNF (skilled nursing facility) Initial NP (nurse practitioner) visit progress note, dated 1/16/26, indicated the Resident had a history of COPD and was receiving O2 (oxygen) nightly and as needed during the day. Further review of the progress note indicated the Resident was wearing oxygen as prior to admission. Review of the physical exam portion of the progress note indicated that the oxygen was on. During an interview on 1/21/26 at 9:55 A.M., Certified Nurse Assistant (CNA) #1 said Resident #137 received supplemental oxygen all the time and that the staff frequently checked on the Resident to ensure his/her nasal cannula was on; CNA #1 said the Resident utilized a portable oxygen tank for when he/she left his/her room. During an interview on 1/21/26 at 9:51 A.M., Nurse #2 said Resident #137 was receiving supplemental oxygen and that the Resident had COPD. Nurse #2 said the risk of a Resident who had COPD receiving oxygen at too high of a rate would be that the Resident could retain C02 (carbon dioxide). Nurse #2 said she would expect a physician order to be obtained before the administration of oxygen. Nurse #2 said Resident #137 should have had an active physician's order for the oxygen he/she was receiving but did not. During an interview on 1/21/26 at 9:53 A.M. Unit Manager #2 said Resident #137 had received continuous supplemental oxygen since admission and that the Resident had COPD. Unit Manager #2 said it would not be safe to administer oxygen at too high of a rate for a Resident who had COPD. Unit Manager #2 said she would expect a physician order to be in place prior to administering supplemental oxygen. After reviewing the Residents current, discontinued and telephone orders in the electronic medical record and physical chart Unit Manager #2 said Resident #137 had not had an active order for supplemental oxygen throughout his/her entire admission but should have. During an interview on 1/21/26 at 10:16 A.M., NP #1 said Resident #137 had been receiving supplemental oxygen and should have had an order for the oxygen since admission. NP #1 added that if the order had been missed, an order should have been written on 1/16/26 when she had evaluated the Resident. NP #1 said that oxygen can be administered without an order in emergency situations and that an order would be placed within a business day after the emergency, however, this was not the case for Resident #137 and Resident #137 should have had an order for supplemental oxygen in place, specifying a rate of three liters per minute, prior to administering oxygen. During an interview on 1/21/26 at 10:38 A.M. the Director of Nursing (DON) said she would expect a physician order to be in place for supplemental oxygen prior to administering the oxygen, even if it was on an as-needed basis. The DON said that oxygen could be (continued on next page)

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Alliance Health at Rosewood	22 Johnson Street Peabody, MA 01961

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered in an emergency and that a physician's order would be placed after the emergency, however, Resident #137's case was not an emergency.

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Alliance Health at Rosewood	22 Johnson Street Peabody, MA 01961

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record reviews for two Residents (#77 and #114) out of four residents observed, the facility failed to ensure it was free from a medication error rate of greater than 5%. Two out of four nurses observed made 3 errors out of 34 opportunities resulting in a medication error rate of 8.82%. Specifically, 1.) For Resident #77, the nurse administered incorrect doses of vitamin D and polyethylene glycol (a laxative medication).2.) For Resident #114, the nurse administered the incorrect type of eye drops. Findings include:Review of the facility policy titled 'Preparation and General Guidelines', revised December 2019, indicated:-FIVE RIGHTS: Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away.-a. Check #1: Select the Medication - label, container and contents are checked for integrity and compared against the medication administration record (MAR) by reviewing the 5 Rights.-b. Check #2: Prepare the dose - the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. -c. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights.-Administration: 2) Medications are administered in accordance with written orders of the prescriber. 1.) Resident #77 was admitted to the facility in December 2024 with diagnoses including vitamin D deficiency and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/11/25, indicated Resident #77 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 6 out of 15. Review of Resident #77's active physician's orders indicated:-Cholecalciferol (vitamin D3) tablet, 25 micrograms (mcg) (1,000 units), once a day, initiated 1/20/25-Polyethylene glycol 3350 powder, 17 gram/dose, once a day, initiated 3/25/25 On 1/21/26 at 8:11 A.M., the surveyor observed Nurse #4 prepare and administer the following medication to Resident #77:-Cholecalciferol (vitamin D3) tablet, 10 mcg (400 units)-Polyethylene glycol 3350 powder, filled approximately two-thirds to 17 gram (gm) indicator line in the bottle cap (which is used to measure the dose). Instructions on the polyethylene glycol bottle indicate instructions that 17g (cap filled to line). During a follow-up interview on 1/21/26 at 8:35 A.M., Nurse #4 said she administered an insufficient dose of vitamin d because she administered 400 units instead of the physician ordered 1000 units. Nurse #4 further showed the surveyor there was no bottle of vitamin d 1000 units within her medication cart and could not have given the full dose. Nurse #4 said she was unaware that the 17 gram line on the polyethylene glycol bottle cap was where it was. Nurse #4 showed the surveyor an area in the cap below the 17 gram indicator line, which appeared to be a cap thread used to close the bottle, and said that it was the line she filled the polyethylene glycol to. Nurse #4 inspected the bottle closely and said she now sees the 17 gram indicator line is higher and that she administered an insufficient dose of polyethylene glycol. During an interview on 1/21/26 at 10:01 A.M., the Director of Nursing said all medications, including vitamin D and polyethylene glycol, should be administered according to the physician's order. 2.) Resident #114 was admitted to the facility in September 2025 with diagnoses including Alzheimer's dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/11/25, indicated Resident #114 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 7 out of 15. Review of Resident #114's active physician's orders indicated:-Artificial Teams (PF) (dextran 70-hypromellose (pf)) dropperette, 0.1-0.3%, instill 1 drop into each eye twice a day, initiated 9/4/25. This physician's order pharmacy fill status note indicated that the pharmacy filled this order with a generic equivalent drug and that the dispensed drug was GenTeal Tears Moderate PF 0.1-0.3% solution. On 1/21/26 at 9:33 A.M., the surveyor observed Nurse #1 prepare and administer the following medication to Resident #114:-Systane eye drops (polyethylene glycol 400 0.4%, propylene glycol 0.3%), instilled 1 drop in each eye. During a follow-up interview on 1/21/26 at 9:53 A.M., Nurse (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 said she was unsure if the Systane eye drops were the correct eye drops because the active ingredients in Systane did not match the order. Nurse #1 reviewed the pharmacy fill status note for the physician's order for artificial tears and said she did not administer the GenTeal eye drops as the pharmacy indicated they dispensed for this order. During an interview on 1/21/26 at 10:01 A.M., the Director of Nursing (DON) said all medications, including eye drops, should be administered according to the physician's order. The DON said Nurse #1 should have clarified the physician order before administering the eye drops if the active ingredients did not match the physician's order.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to accurately document a peripheral inserted central catheter (PICC) line site assessment for one Resident (#9) out of a total sample of 26 residents. Findings include: Review of the facility policy titled Central Venous Access Device (CVAD) Catheter Dressing Change, dated 1/2022, indicated the following:Dressing changes will occur according to the IV (intravenous) order and when dressing is compromised (drainage/moisture observed, loose, soiled).VAD (venous Access Device) assessments should occur:At least every 2 hours during a continuous infusion.Before and after medication administration.At a minimum of once each shift, when not in use.With each assessment of the VAD, presence of the following, at a minimum, should include drainage. Resident #9 was admitted to the facility in November 2025 with diagnoses including Acute on chronic diastolic congestive heart failure, chronic kidney disease and artificial opening of urinary tract status. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident scored a 13 out of a total possible 15 on the Brief Interview for Mental status (BIMS) assessment, which indicated he/she was cognitively intact. During an observation on 1/21/26 at 8:14 A.M., Resident #9 was lying in bed, the surveyor observed his/her PICC line to the right arm. A dressing dated 1/19/26 was in place the insertion site had a bruise and bright red blood that had saturated into the dressing. Review of Resident #9's physician orders indicated the following:PICC: Assess IV site every shift and as needed. Document site condition and patency of the line every shift.PICC: Change dressing as needed if listing, wet, loose or soiled or has gauze or you are unable to inspect insertion site. Review of Resident #9's active care plan date initiated 1/18/26, indicated the Resident was at risk for excessive bleeding and /or bruising due to anticoagulant administration related to atrial fibrillation. Review of Resident #9's January 2026 Medication Administration Record (MAR) indicated Nurse #5 documented the following for PICC line site, (CDI) clean dry intact in response to physician's order to assess the site every shift on 1/21/26 shift one. During an interview and observation on 1/21/26 at 12:00 P.M., the surveyor along with Unit Manager #2 observed Resident #9's PICC line. Unit Manager #2 said the dressing needs to be changed as there was a large amount of bright red blood at the insertion site and on the dressing and would notify the Nurse Practitioner as the Resident was on a blood thinning medication. She further said the nurse should not have documented the PICC site as clean dry and intact. During an interview on 1/21/26 at 3:27 P.M., Nurse #5 said she was a new nurse in training and that she saw the bleeding on the PICC line site and did not think it was a big deal. She said she shouldn't have documented the site as clean dry and intact. During an interview on 1/21/26 at 3:08 P.M., the Director of Nursing (DON) said the PICC site was monitored for swelling, migration of line, and bleeding. If a nurse sees bright red blood at the PICC site, the dressing should be changed and physician notified if the Resident was on an anticoagulant (a blood thinning medication). She further said nurses should also document accurately when they assessed a resident.