

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225653	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Copley at Stoughton Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 380 Sumner Street Stoughton, MA 02072	
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)		
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose family initiated a transfer to the Hospital Emergency Department (ED) for an evaluation after concerns he/she may have fallen, the Facility failed to ensure Resident #1 was able to return to the Facility following his/her evaluation and considered Resident #1 discharged at the time of transfer. Findings include: Review of the Facility Policy titled Bed-Holds and Returns, dated as last revised 10/2022, indicated all residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies either well in advanced of any transfer or at the time of transfer (or, if the transfer was an emergency, within 24 hours). The Policy further indicated the requirement that residents be permitted to return to the facility following a hospitalization or therapeutic leave applies to all residents regardless of payor source. Review of the Report submitted by the Facility via Health Care Facility Reporting System (HCFRS), dated 01/02/26, indicated that Resident #1's Family Member had voluntarily discharged him/her from the Facility because Family Member #1 had called the local Police Department (PD) and Emergency Medical Services (EMS). During a telephone interview on 01/13/26 at 2:13 P.M., Family Member #1 said that on 12/18/25, while visiting, after an incident occurred in Resident #1's bathroom with his/her nurse, (during which they heard a loud bang and he/she was found on the floor), they called the local Police Department (PD) and Emergency Medical Services (EMS) to transfer him/her to the Hospital Emergency Department (ED) for evaluation. Family Member #1 said Resident #1 recently had a fall and had just returned to the facility from the hospital, two days earlier (on 12/16/25) where it had been identified that he/she had chronic vertebral fractures, and they thought it would be best to have Resident #1 seen at the ED for an evaluation, after seeing him/her on the floor. Review of Resident #1's Facility Incident Report, dated 12/18/25, indicated that he/she had been involved in an incident with Nurse #1 in his/her bathroom and although Family Member #1 had not witnessed the incident, a loud bang was heard from the bathroom and Family Member #1 thought that Resident #1 had fallen to the floor. The Report indicated, despite Nurse #1 informing Family Member #1, the noise that Family Member #1 heard was his/her wheelchair hitting the wall, Family Member #1 called the local PD, EMS arrived and asked the Nurse for a Face Sheet and list of medications for transfer. The Report indicated the nurse informed the Police Officer that the Facility was not transferring Resident #1 to the ED, and he/she had no Physician's Order to do so. Resident #1 was admitted to the Facility in April 2024 diagnoses include dementia, history of urinary tract infections, anxiety, repeated falls, and anemia. Review of Resident #1's MassHealth Eligibility Form, dated 08/29/24, indicated that his/her Medicaid benefit was his/her primary payor source on the day of his/her transfer (12/18/25) and therefore a bed hold should have been in place. Review of Resident #1's Physician's Order dated, 10/22/24, indicated his/her Health Care Proxy (HCP) had been invoked. Review of Resident #1's Care Plan titled Long Term Care Placement, dated as last reviewed on 12/17/25, indicated that he/she will remain long term care</p> <p>(continued on next page)</p>		

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
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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>secondary to his/her medical diagnoses, care needs and that Resident #1 will be comfortably assured in a long-term care setting. Review of Resident #1's EMS Patient Care Report, dated 12/18/25, indicated, Family Member #1 had called EMS secondary to Resident #1 having a fall and requested to have him/her evaluated at the Hospital ED. The Report indicated that the Facility was requesting that Resident #1 not be sent back to the Facility and that the Facility said they will not be accepting his/her back. During a telephone interview on 01/21/26 at 9:56 A.M., Nurse #1 said on 12/18/25 while attempting to get Resident #1 off the toilet, his/her legs buckled and she had lowered Resident #1 to the floor. Nurse #1 said that Family Member #1 opened the bathroom door and observed Resident #1 on the floor and assumed he/she had fallen unassisted to the floor. Nurse #1 said that she had lowered him/her and he/she had not struck the floor with any force. Nurse #1 said by the time she had gotten Resident #1 back into bed, the Police and EMS had arrived. Nurse #1 said that EMS asked for transfer paperwork to send Resident #1 to the ED and that she told EMS that Resident #1 did not have a physician's order to be transferred. Nurse #1 said that she did not which Hospital EMS was transferring him/her to. Nurse #1 said that she had been told by Administration not to let Resident #1 back into the Facility and that he/she had been discharged. During a telephone interview on 01/23/26 at 10:54 A.M., the Nurse Practitioner (NP) said that she would have given a verbal order to transfer Resident #1 to the ED for evaluation, however the Supervisor had told her that he/she was a discharge from the Facility. Review of Resident #1's Police Report, dated 12/19/25, indicated that upon return to the Facility (on 12/18/25, only four hours after being transferred to the ED for an evaluation), that Facility Staff (later identified as the Nursing Supervisor) stated that because Resident #1 had been transferred to the ED Against Medical Advice (AMA), that he/she had discharged Resident #1 from the Facility. During a telephone interview on 01/14/26 at 4:01 P.M., the Nursing Supervisor said that on 12/18/25 Resident #1's Family had called Police and EMS, EMS asked the nurse for paperwork for transfer and when staff asked where they were transferring Resident #1, they responded with they would let us know. The Supervisor said she had called Resident #1's Nurse Practitioner but did not ask for any order to transfer and or discharge Resident #1 to the ED because Resident #1 had already left the building and was considered a discharge. The Supervisor said she informed the Administrator and Director of Nurses (DON), and they said Resident #1 had left against medical advice and that she was told that Resident #1 was considered discharged from the Facility and was not allowed to return. During an interview on 01/14/26 at 12:32 P.M., the DON said that Resident #1's Family discharged him/her when they called the Police, EMS, and initiated transfer to the ED for evaluation after an incident. The DON said that to the best of her knowledge, no discharge paperwork was provided to Resident #1 upon transfer and that nursing had not obtained a physician's order for him/her to be transferred to the ED. The DON said that the Administrator made the final decision regarding the discharge status of Resident #1. During a telephone interview on 01/20/26 at 1:10 P.M., the Administrator said that Family Member #1 had discharged Resident #1 from the Facility and Family Member #1 had not informed the Facility what the plan was. The Administrator said that there was no discharge/transfer order and that Resident #1 did not need to go to the ED. The Administrator said that because the Family initiated the discharge, the Facility did not have to readmit Resident #1 back to the Facility despite his/her payor source.</p>		