

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/30/2025
NAME OF PROVIDER OR SUPPLIER  Benjamin Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  120 Fisher Avenue Boston, MA 02120	

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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. Resident #28 was admitted to the facility in August 2022 and has diagnoses that include but are not limited to Alzheimer's Disease, and urinary tract infection.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE], indicated Resident #28 scored a 0 out 15 on the Brief Interview for Mental Status indicating he/she as having severe cognitive impairment. The MDS also indicated Resident #28 was dependent on staff for most aspects of daily care.</p> <p>On 4/28/25 at 8:38 A.M., Resident #28 was observed near the nursing desk in a recliner chair, Resident #28 was observed to be frail and did not respond to the surveyor's greeting.</p> <p>Review of Resident #28's medical record indicated that Resident #28 had a legal guardian.</p> <p>Review of Resident #28's paper medical record under both the care plan tab and social service tab failed to indicate documentation related to interdisciplinary care plan meetings.</p> <p>Review of Resident #28's electronic medical record indicated a Social Worker note, dated 5/25/24, which indicated the following:</p> <p>-IDT (Interdisciplinary Team) review of care plan underway. Guard (sic) not available today for care plan review. Will schedule review at guardian's convenience (if desired).</p> <p>Further review of the record failed to indicate any further Social Work progress notes, or documentations that care planning meetings occurred.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said care plan meetings are scheduled by the social worker and the residents, their representatives and the interdisciplinary team are invited to attend. She said she believes they should be done quarterly but is unsure of the scheduling and/or requirements of the meeting. The Director of Nursing said if a care plan meeting occurred, there would be documentation of the meeting in the resident's medical record.</p> <p>During the survey the facility did not have a Social Worker, therefore there was no interview with a Social Worker.</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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on record reviews and interviews, the facility failed to ensure four Residents (#16, #28, #5, and #45) were allowed to participate in the development and implementation of his/her person centered care plan by failing to conduct an interdisciplinary care plan meeting quarterly, out of a total sample of 24 residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Resident Participation-Assessment/Care Plans, not dated, included but was not limited to the following:</p> <p>-The resident and his or her representative are encouraged to participate in the resident's assessment and in the development and implementation of the care plan. The resident/representative's right to participate in the development and implementation of his/her plan of care includes the right to: a. participate in the planning process, 7. A seven (7) day advance notice of the care planning conference is provided to the resident and his or her representative. The Social Service Director or designee is responsible for notifying the resident/representative and for maintaining records of such notices.</p> <p>Review of the facility policy titled, Care Planning-Interdisciplinary team, not dated, indicated the following:</p> <p>-Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized care plan for each resident. 2. The care plan is based on the resident's comprehensive and is developed by a Care Planning/Intradisciplinary Team which includes, but is not necessarily limited to the following personnel: a. The resident's attending physician, b. The Registered Nurse who has responsibility for the resident; c. The dietary Manager/dietician; d. The Social Services Worker responsible for the resident; e. The Activity Director/Coordinator; f. Therapists (speech, occupational, recreational, etc.) as applicable; g. Consultants (as appropriate); h. The Director of Nursing (as applicable); 1. The Charge Nurse responsible for the care; j. Nursing Assistants responsible for the resident's care; and k. Others as appropriate or necessary to meet the needs of the resident. 4. Every effort will be made to schedule care plan meetings at the best time of day for the resident and family.</p> <p>1. Resident #16 was admitted to the facility in September 2007 with diagnoses including hemiplegia and need for personal assistance.</p> <p>Review of Resident #16's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15, which indicated he/she is cognitively intact. The MDS also indicated Resident #16 requires substantial/maximal assistance for all functional tasks.</p> <p>During an interview on 4/28/25 at 8:32 A.M., Resident #16 was unable to say if he/she had participated in a care plan meeting recently.</p> <p>Review of Resident #16's medical record failed to indicate any evidence of a care plan meeting taking place within the past year.</p> <p>(continued on next page)</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said care plan meetings are scheduled by the social worker and the residents, their representatives and the interdisciplinary team are invited to attend. She said she believes they should be done quarterly but is unsure of the scheduling and/or requirements of the meeting. The Director of Nursing said if a care plan meeting occurred, there would be documentation of the meeting in the resident's medical record. The Director of Nursing said she was unaware of the last time Resident #16 had a care plan meeting.</p> <p>The facility is currently without a social worker to interview.</p> <p>3. Resident #5 was admitted to the facility in August 2010 with diagnoses that included hypertension, diverticulosis of the large intestine, anemia, unspecified convulsions, and major depressive disorder.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 3/15/25, indicated the Resident was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #95 is dependent for all self-care activities and requires supervision/touching assistance for self-feeding.</p> <p>Review of Resident #5's medical record on 4/30/25 at 1:57 P.M., indicated the last care plan meeting for the Resident took place on 6/22/24.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said care plan meetings are scheduled by the social worker and the residents, their representatives and the interdisciplinary team are invited to attend. She said she believes they should be done quarterly but is unsure of the scheduling and/or requirements of the meeting. The Director of Nursing said if a care plan meeting occurred, there would be documentation of the meeting in the resident's medical record.</p> <p>The facility is currently without a social worker to interview.</p> <p>4. Resident #45 was admitted to the facility in October 2023 with diagnoses that include hemiplegia and hemiparesis, anoxic brain injury and dysphagia</p> <p>Review of Resident #45's most recent Minimum Data Set (MDS) Assessment, dated 2/1/25 indicated that the Resident could not participate in the Brief Interview for Mental Status Exam and was assessed by staff as having severe cognitive impairment.</p> <p>Review of Resident #45's medical record failed to indicate any evidence of a care plan meeting taking place within the past year.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said care plan meetings are scheduled by the social worker and the residents, their representatives and the interdisciplinary team are invited to attend. She said she believes they should be done quarterly but is unsure of the scheduling and/or requirements of the meeting. The Director of Nursing said if a care plan meeting occurred, there would be documentation of the meeting in the resident's medical record.</p> <p>The facility is currently without a social worker to interview.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to provide a call light for one Resident (#11) out of a total sample of 24 residents.</p> <p>Findings include:</p> <p>Resident #11 was admitted to the facility in April 2020 with diagnoses including prostate cancer.</p> <p>Review of Resident #11's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 6 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #11 is dependent on staff for functional daily tasks.</p> <p>During an interview on 4/28/25 at 8:39 A.M., Resident #11 was observed lying in bed without a call light in place. Further observation indicated the Resident did not have a call light at all as the string was missing from the wall. Resident #11 said the call light string often breaks and he/she has not had a call light for some time. Resident #11 said he/she would like to have a call light as this is how he/she can call for help if needed.</p> <p>Throughout all days of survey, Resident #11 was observed without a call light available to him/her.</p> <p>Review of Resident #11's fall care plan last revised 3/19/25, indicated the following intervention:</p> <p>-Call light within resident's reach, answer call light promptly</p> <p>During an interview on 4/30/25 at 7:35 A.M., Nurse #1 said all residents should have a call light available in order to call for assistance if needed. Nurse #1 said the call light strings often break and she was unaware Resident #11's call light was broken.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said all residents should have a call light available for use.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>Based on record review and interview, the facility failed to ensure Advance Directives (written documents that instruct health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) were accurately documented for one Resident (#45) out of a total sample of 24 residents. Specifically, for Resident #45, the facility failed to ensure that Advanced Directives indicated on the MOLST form (Massachusetts Medical Order for Life-Sustaining Treatment form) were consistently documented in the medical record.</p> <p>Findings include:</p> <p>Review of Resident #45's most recent Minimum Data Set (MDS) Assessment, dated 2/1/25, indicated that the Resident could not participate in the Brief Interview for Mental Status Exam and was assessed by staff as having severe cognitive impairment. Further review of the MDS indicated the Resident's code status was a DNR (Do not resuscitate), DNI (Do not Intubate).</p> <p>Review of the medical record indicated a MOLST form signed and dated 9/21/22 that indicated Do Not Resuscitate (DNR), Intubate and Ventilate, use noninvasive ventilation, transfer to hospital, use dialysis, use artificial nutrition and use artificial hydration.</p> <p>Review of Resident #45's active physician orders indicated the following</p> <p>-Do Not Resuscitate (DNR) (DNI), dated 4/30/24.</p> <p>Review of Resident #45's active advanced directives care plan, dated 5/6/24, indicated, Legal Guardian in place. Follow MOLST---- Resident/family will express changes in code status wishes to appropriate persons, i.e. MD [doctor], social worker, nurse. [sic]</p> <p>During an interview on 4/30/25 at 7:37 A.M., Nurse #2 said that a MOLST form should be signed by the resident or health care proxy. She said the orders should match what is on the MOLST form and be consistently documented in the medical record.</p> <p>During an interview on 4/30/25 at 9:30 A.M., the Director of Nurses said that the physician's order should match the MOLST form and that all aspects of the medical record should have a resident's advanced directives consistently documented.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. Resident #72 was admitted to the facility in October 2024 and has diagnoses that include but are not limited to unspecified dementia with mood disturbance,</p> <p>Review of Resident #72's comprehensive MDS with an assessment reference date of 10/14/24, indicated Resident #72 scored a 5 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having severe cognitive impairment. The MDS also indicated Resident #72 was dependent on staff for daily care including eating, bathing and dressing.</p> <p>During an observation on 4/28/25 at 9:03 A.M., Resident #72 was observed with a wander guard on his/her right ankle. Resident #72 was pacing in and out of a different resident's room. Resident #72 made eye contact with the surveyor but did not respond to the surveyor's greeting.</p> <p>On 4/28/25 at 12:43 P.M., Resident #72 was observed walking/wandering and going in and out of a resident's room.</p> <p>During an interview on 4/29/25 at 9:39 A.M., Certified Nursing Assistant (CNA) #3 said Resident #72 is dependent on staff for care. CNA #3 said Resident #72 paces and walks in and out of other rooms and he/she has been like that since he/she was admitted . CNA #3 said Resident #72 does not wander as far as he/she used to but will go in and out of rooms near his/her room.</p> <p>During an interview on 4/30/25 at 10:18 A.M., Nurse #5 said Resident #72 is confused and paces back and forth on the unit. Nurse #5 said Resident #72 has paced and wandered since he/she was admitted and now does not wander as far.</p> <p>Review of Resident #72 medical record indicated the following:</p> <ul style="list-style-type: none"> <li>-A physician's order dated 10/9/24, May have wander guard, check placement every shift (right ankle) every shift.</li> <li>-A physician's order dated 10/8/24, Monitor behavior: pacing wandering, intrusive, every shift for behaviors.</li> <li>-A care plan focus, Resident has inappropriate behaviors: (pacing, wandering intrusive, and roaming) resident tears his/her clothes, dated 10/8/25.</li> <li>-Care plan focus, High Risk for injury r/t (related to) falls due to constantly pacing/wandering.</li> </ul> <p>Review of the Treatment Administration Record, dated October 2024 indicated Resident #72 was documented as having pacing, wandering, and intrusive behaviors 7 out of 7 days shifts, 6 out of 7 evening shifts and 4 out of 7-night shifts, preceding the seven days before the MDS Assessment reference date of 10/14/24.</p> <p>Review of the MDS assessment dated [DATE] failed to indicate the behaviors of intrusive wandering or pacing were coded as Resident #72's pattern of behavior.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/30/25 at 11:32 A.M., The Director of Nursing (DON) said the MDS nurse was not available for interview. The DON said she was familiar with Resident #72 and said his/her behaviors of pacing and intrusive wandering improved. The DON said the wandering/pacing should be coded on the MDS if it is occurring and documented during the look back period.</p> <p>3. Resident #82 was admitted to the facility in August 2021 and had diagnoses that included but not limited to cerebral infarction, dysarthria (difficulty articulating words), and major depressive disorder.</p> <p>Review of the Minimum Data Set assessment, dated 2/4/25, indicated Resident #82 was assessed by staff to have severely impaired cognition and requires supervision/touching to partial/moderate assistance for daily activities.</p> <p>Review of the Minimum Data Set assessment, dated 2/4/25, indicated Discharge-Return Not Anticipated was coded. Further review indicated the MDS was coded as a planned discharge and checked as a discharged to short term general hospital (acute hospital, IPPS).</p> <p>Review of Resident #82's medical record indicated in a Discharge Summary with an effective date 2/4/25 that Resident #82 was discharged home.</p> <p>During an interview on 4/30/25 at 11:29 A.M., the Director of Nursing said she would expect the discharge MDS to be coded correctly and confirmed Resident #82 was discharged home.</p> <p>The MDS Coordinator was not available to interview.</p> <p>Based on observation, record review and interview, the facility failed accurately complete the Minimum Data Set Assessments (MDS) for three Residents (#45, #82 and #72) out of a total of 24 sampled residents. Specifically,</p> <ol style="list-style-type: none"> <li>1. For Resident #45 the facility failed to accurately code the presence of a Stage 4 pressure ulcer.</li> <li>2. For Resident #72 the facility failed to accurately assess his/her behaviors patterns on the comprehensive MDS.</li> <li>3. For Resident #82 the facility failed to ensure an accurate discharge MDS assessment was completed.</li> </ol> <p>Findings include:</p> <p>Review of the Long-Term Care Facility Resident Assessment Instrument User's Manual (RAI Manual) 3.0, Version 1.19.1, dated October 2024 indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Clinical standards do not support reverse staging or back staging as a way to document healing, as it does not accurately characterize what is occurring physiologically as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse staging or back-staging would have permitted identification of such a pressure ulcer as a Stage 3, then a Stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed unless it becomes unstageable. Nursing homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e., depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool.</p> <p>1. Resident #45 was admitted to the facility in October 2023 with diagnoses that include hemiplegia and hemiparesis, anoxic brain injury and dysphagia.</p> <p>Review of Resident #45's most recent Minimum Data Set (MDS) Assessment, dated 2/1/25, indicated that the Resident could not participate in the Brief Interview for Mental Status Exam and was assessed by staff as having severe cognitive impairment. The MDS further indicated that the Resident had a stage 2 pressure injury.</p> <p>Review of the most recent wound consultant note, dated 4/23/25, indicated that Resident #45 has a stage 4 pressure wound (a wound that extends below the subcutaneous fat into your deep tissues, including muscle, tendons, and ligaments. In more severe cases, they can extend as far down as the cartilage or bone) to the sacrum, full thickness and that the duration of that wound is &gt; (greater than) 1569 days.</p> <p>Review of the medical record failed to indicate that Resident #45 has a stage 2 pressure ulcer (a wound that has opened into the first and some of the second layer of skin).</p> <p>Further Review of the MDS Assessment failed to indicate the presence of a stage 4 pressure ulcer.</p> <p>During an interview on 4/29/25 at 11:26 A.M. Nurse #1 said Resident #45 still has a small open area to his/her sacrum.</p> <p>During an interview on 4/30/25 at 7:36 A.M., Nurse #2 said the area to Resident #45's sacrum is smaller now but still present and getting treatment. Nurse #2 said it started as a stage 4 pressure ulcer.</p> <p>During an interview on 4/30/25 at 9:33 A.M., The Director of Nurses said that Resident #45's wound has improved and is no longer a stage 4 pressure ulcer, and it is now a stage 2 pressure ulcer and that is why it is coded that way on the MDS Assessment.</p> <p>The MDS coordinator was not available to interview.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. Resident # 16 was admitted to the facility in September 2007 with diagnoses including lack of coordination, hemiplegia, and need for personal assistance.</p> <p>Review of Resident #16's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 13 out of a possible 15, which indicated he/she was cognitively intact. The MDS also indicated Resident #16 required substantial/max assistance with bed mobility tasks.</p> <p>On 4/28/25 at 8:32 A.M., 10:00 A.M., and 12:11 P.M., Resident #16 was observed lying in bed with both heels lying directly on the mattress. Two protective heel booties observed on the Resident's wheelchair next to the bed.</p> <p>On 4/28/25 at 4:39 P.M., Resident #16 was observed lying in bed with both heels lying directly on the mattress. Resident #16 pointed to the protective booties on the wheelchair and said he/she typically wears the booties but no one helped to put them on today.</p> <p>On 4/29/25 at 6:50 A.M., Resident #16 was observed lying in bed with both heels lying directly on the mattress. Two protective heel booties observed on the Resident's wheelchair next to the bed.</p> <p>Review of Resident #16's risk for pressure injury care plan, last revised 4/28/25, indicated the following intervention:</p> <p>-Apply booties while in bed</p> <p>Review of Resident #16's physician orders indicated the following order as of 3/3/25:</p> <p>-May apply booties while resident is in bed.</p> <p>Review of Resident #16's last Norton assessment dated [DATE], indicated the Resident had a score of 7, indicating the Resident is at very high risk for pressure ulcer development.</p> <p>During an interview on 4/30/25 at 9:30 A.M., Nurse #2 said care plans and orders should be followed as written.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said she expects all care plans to be followed as written. The Director of Nursing said Resident #16 is a high risk for pressure ulcer development and should have his/her protective booties on at all times when in bed.</p> <p>Based on observations, record review and interviews, the facility failed to develop and implement a comprehensive person-centered care plan for two Residents (#31 and #16) out of a total sample of 24 Residents. Specifically,</p> <ol style="list-style-type: none"> <li>1. For Resident #1 the facility failed to develop an Activities of Daily Living (ADLs) care plan.</li> <li>2. For Resident #16, the facility failed to implement a care plan for risk of pressure injury.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Findings include:</p> <p>Review of facility policy titled, Care Plans, Comprehensive Person-Centered, not dated, indicated the following:</p> <p>-A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p> <p>-1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.</p> <p>1. Resident #31 was admitted to the facility in September 2024 with diagnoses that include diabetes, adult failure to thrive, pain and acute embolism and thrombosis of the deep veins in the left lower extremity.</p> <p>Review of Resident #31's most recent Minimum Data Set (MDS) Assessment, dated 3/22/25, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, indicating that the Resident is cognitively intact. The MDS further indicates that the Resident ranges from substantial/ maximal assist to dependent for various aspects of Activities of Daily Living (ADLs) and transfers.</p> <p>Review of Resident #31's care plan failed to indicate a plan of care around ADL care needs.</p> <p>Review of Resident #31's physician's orders failed to indicate any orders with instruction on how to transfer the resident or the level of assist required to assist the Resident with ADL care.</p> <p>During an interview on 4/30/25 at 7:32 A.M., Nurse #1 said that the Certified Nurse's Aides (CNAs) do not currently use a paper Kardex (a form explaining to staff the needs of each resident) or care card but they are able to pull it over from the Electronic Medical Record that triggers based on the resident's care plan.</p> <p>During a follow up interview on 4/30/25 at 8:12 A.M. Nurse #1 said that they used to use paper care cards, but they are out of date. She said the Kardex from the Electronic Medical Record (EMR) is the most up to date. She further said there should be an ADL care plan for all residents, so staff know the level of care that the resident requires.</p> <p>Review of Resident #31's current Kardex in the EMR failed to indicate the level of assistance needed for ADLS, transfers and eating.</p> <p>During an interview on 4/30/25 at 8:42 A.M., the Director of Nurses said that the CNA Kardex triggers from the care plan. She said it would primarily be the ADL care plan that would trigger onto the Kardex. The Director of Nurses reviewed Resident #31's care plan and said there is no plan of care in place for ADLs. She said she would expect that all residents will have a plan of care in place for ADL care to indicate the level of assistance that staff need to provide.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. Resident #184 was admitted to the facility in April 2025 with diagnoses including diabetes with polyneuropathy, edema and weakness.</p> <p>Review of Resident #184's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status score of 2 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated the Resident is dependent on staff for mobility tasks.</p> <p>Review of Resident #184's physician orders indicated the following order:</p> <p>-Apply compression stockings knee length (to) bilateral legs in the morning (for) edema, initiated on 4/9/25.</p> <p>On 4/28/25 at 12:19 P.M., and at 2:00 P.M., Resident #184 was observed out of bed sitting in his/her wheelchair. The Resident was not wearing bilateral compression stockings.</p> <p>On 4/28/25 at 4:38 P.M., Resident #184 was observed lying in bed and was not wearing compression stockings.</p> <p>On 4/29/25 at 1:07 P.M., Resident #184 was observed out of bed sitting in his/her wheelchair. The Resident was not wearing bilateral compression stockings.</p> <p>On 4/29/25 at 5:15 P.M., Resident #184 was observed lying in bed and was not wearing compression stockings.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said she expects all orders to be followed as written by the physician. The Director of Nursing said she was unaware Resident #184 had an order to wear compression stocking or that he/she had not been wearing them.</p> <p>Based on record review and interview, the facility failed to ensure that physician's orders were followed for two Residents (#45 and #184) out of a total sample of 24 residents. Specifically,</p> <ol style="list-style-type: none"> <li>1. For Resident #45 the facility failed to complete weekly skin checks as indicated in the physician's orders.</li> <li>2. For Resident #184, the facility failed to implement physician's orders to apply compression stockings.</li> </ol> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Resident #45 was admitted to the facility in October 2023 with diagnoses that include hemiplegia and hemiparesis and anoxic brain injury.</li> </ol> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #45's most recent Minimum Data Set (MDS) Assessment, dated 2/1/25, indicated that the Resident could not participate in the Brief Interview for Mental Status Exam and was assessed by staff as having severe cognitive impairment.</p> <p>Review of Resident #45's physician's orders indicated the following:</p> <p>-Weekly skin assessment on Mondays, dated 5/6/24.</p> <p>Review of Resident #45's most recent Norton Assessment (an assessment to determine risk for skin breakdown), dated 1/27/25, indicated a risk score of 7 which indicates a high risk for skin breakdown.</p> <p>Review of Resident #45's active skin care plan, updated 1/16/25, indicated:</p> <p>Potential for Further Skin Breakdown to Decreased Mobility &amp; Incontinence.</p> <p>pressure ulcer coccyx area point size 6/13/24 resolved</p> <p>new open area coccyx area 1/13/2025 [sic]</p> <p>Review of the Assessments tab in the Electronic Medical Record indicated that in the past three months, weekly skin checks were completed on 2/3/25, 3/3/25, 3/10/25, 3/31/25 and 4/28/25. Review of the medical record indicated that from 2/1/25 to 4/30/25 nine weekly skin checks were omitted.</p> <p>Review of the two most recent weekly skin checks completed on 3/31/25 and 4/28/35 indicated an intact dressing to the coccyx but failed to indicate any description of the wound.</p> <p>Review of the April Treatment Administration Record indicated that skin checks had been completed as ordered by the physician.</p> <p>During an interview on 4/29/25 at 11:26 A.M. Nurse #1 said that the facility does skin checks weekly, and they should be documented in the medical record.</p> <p>During an interview on 4/30/25 at 7:36 A.M., Nurse #2 said that Resident #45 has a pressure wound that is being treated.</p> <p>During an interview on 4/30/25 at 9:31 A.M., the Director of Nurses said that skin checks are completed weekly. She said the process is to open a skin check assessment in the documents tab and document the completed skin check. She said that she would expect that skin is fully assessed, including removing dressings and documenting the wound underneath. The Director of Nurses said that even if a resident is followed by the consulting wound physician weekly, the nursing staff should still be completing skin checks as ordered.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to provide assistance with meals for two Residents (#16 and #5) out of a total sample of 24 residents.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Preparing a Resident for a Meal, dated 2001, indicated the following:</p> <ul style="list-style-type: none"> <li>-Review the Resident's care plan and provide any special needs of the resident.</li> </ul> <p>Review of the facility policy titled, Assisting the Resident with In-Room Meals, dated 2001, indicated the following:</p> <ul style="list-style-type: none"> <li>-Review the Resident's care plan and provide any special needs of the resident.</li> <li>-Assist the resident as necessary. However, encourage the resident to feed himself or herself as much as possible.</li> </ul> <p>Review of the facility policy titled, Resident Nutrition Services, dated 2001, indicated the following:</p> <ul style="list-style-type: none"> <li>-Nursing personnel or feeding assistants will provide assistance with eating and ensure that assistive devices are available to residents as needed.</li> </ul> <p>1. Resident # 16 was admitted to the facility in September 2007 with diagnoses including dysphagia, feeding difficulties, lack of coordination, hemiplegia, and need for personal assistance.</p> <p>Review of Resident #16's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 13 out of a possible 15, which indicated he/she was cognitively intact. The MDS also indicated Resident #16 required substantial/max assistance with self-feeding tasks.</p> <p>On 4/28/25 at 10:09 A.M., Resident #16 was observed eating alone while lying in bed. The Resident was observed attempting to scoop pureed food out of a mug with a spoon and spilling some of the food as he/she brought it to his/her mouth.</p> <p>On 4/28/25 at 12:42 P.M., Resident #16 was observed eating alone while lying in bed. The privacy curtain was drawn, and the Resident was not visible from the hallway.</p> <p>On 4/30/25 at 8:39 A.M., Resident #16 was observed eating alone while lying in bed. The privacy curtain was drawn, and the Resident was not visible from the hallway.</p> <p>Review of Resident #16's activity of daily living care plan last revised 4/28/25, indicated the following intervention:</p> <ul style="list-style-type: none"> <li>-Fed at meal times to ensure sufficient amount of po intake, 2/12/21.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #16's nutritional plan last revised 4/28/25, indicated the following intervention:</p> <ul style="list-style-type: none"> <li>-Provide assistance at feeding, Provide built up silverware in place of liquid pureed diet, 1assist.</li> <li>-Monitor %PO intake and appetite/diet tolerance</li> </ul> <p>During an interview on 4/30/25 at 9:25 A.M., Certified Nursing Assistant (CNA) #1 said she was unaware of how to review a resident's care plan but she knows the level of assistance needed for each resident because the nursing staff verbally tell her. CNA #1 said Resident #16 is able to eat independently in his/her room.</p> <p>During an interview on 4/30/25 at 9:30 A.M., Nurse #2 said Resident #16 can eat independently.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said she expects all care to be provided as needed and care planned. The Director of Nursing said Resident #16's level of assistance for feeding varies and staff should be checking on him/her throughout the meal to see if assistance is needed.</p> <p>2. Resident #5 admitted to the facility in August 2010 with diagnoses that included hypertension, diverticulosis of the large intestine, anemia, unspecified convulsions, and major depressive disorder.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 3/15/25, indicated the Resident was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #95 is dependent for all self-care activities and requires supervision/touching assistance for self-feeding.</p> <p>On 4/28/25 at 8:49 A.M., and 12:46 P.M., 4/29/25 at 8:47 A.M., 8:53 A.M., and 9:02 A.M., and 4/30/25 at 8:46 A.M., 8:52 A.M., and 9:04 A.M., Resident #5 was observed seated upright in his/her bed eating. There was no staff observed providing supervision or assistance, and the resident was not visible from the hallway.</p> <p>During a record review on 4/29/25 at 7:30 A.M., Resident #5's activities of daily living and nutrition care plans indicated the following:</p> <ul style="list-style-type: none"> <li>-Eating: Supervision-assist with meals. 1:8 SFG. Effective date 2/13/19.</li> <li>-Nutrition: Monitor/document/report PRN any s/sx of dysphagia: Pocketing, Choking, Coughing, Drooling, holding food in mouth, several attempts at swallowing, refusing to eat, Appears concerned during meals. Effective date 2/8/2022.</li> </ul> <p>During an interview on 4/30/25 at 9:15 A.M., Nurse #2 said we setup Resident #5's meal and he/she can feed him/herself and does not require assistance or supervision after setup.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/30/25 at 11:25 A.M., the Director of Nursing said she would expect Resident #5 would be provided the level of assistance and supervision indicated on his/her care plan for self-feeding.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record reviews and interviews, the facility failed to ensure standards of quality of care for two Residents (#22 and #35) out of a total sample of 24 residents. Specifically,</p> <ol style="list-style-type: none"> <li>1. For Resident #22 the facility failed to identify a change in his/her skin condition and failed to ensure the weekly skin checks documented the skin change.</li> <li>2. For Resident #35, the facility failed to a. accurately complete skin checks and b. complete skin checks weekly.</li> </ol> <p>Findings include:</p> <p>Review of the facility's policy, titled 'Skin Integrity Management Policy and Procedure', dated revised 12/1/2005 indicated the following:</p> <p>The implementation of an individual resident's skin integrity management occurs within the care delivery process. Staff continually observe and monitor residents for changes and implement revisions to the plan of care as needed. 3. Identify resident's skin integrity status and need for prevention intervention or treatment modalities through review of all appropriate assessment information. Perform skin inspection on admission, weekly, and readmission. Document weekly on Treatment Administration Record and on weekly body check sheet.</p> <p>1. Resident #22 was admitted to the facility in January 2024 and has diagnoses that include but not limited to depression, conversion disorder with seizures or convulsions, type 2 diabetes mellitus, and dementia.</p> <p>Review of Resident #22's Minimum Data Set assessment, dated 4/5/25, indicated Resident #22 scored an 8 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having moderately impaired cognition. Further review of the MDS indicated Resident #22 was dependent on staff for daily care including bathing and dressing.</p> <p>On 4/28/25 at 9:38 A.M., Resident #22 was observed lying in bed. Resident #22 right arm was exposed and observed to have a round nickel sized yellow faded area, consistent with a bruise on his/her right forearm. Resident #22 said he/she had breakfast and then said, 'good night'.</p> <p>On 4/28/25 at 12:36 P.M., Resident #22 was resting in bed. Resident #22's was observed with a round yellow faded discoloration area on his/her right forearm, consistent with a fading bruise.</p> <p>On 4/28/25 at 4:47 P.M., Resident #22 was observed resting in bed. A yellow faded discoloration area, consistent with a fading bruise, was observed on the upper part of his/her right forearm.</p> <p>During an interview on 4/29/25 at 9:51 A.M., Certified Nursing Assistant #3 said she washed and dressed Resident #22 this morning and Resident #22 did not have any skin changes.</p> <p>During an observation on 4/29/25 at 9:47 A.M., Resident #22 was resting in bed. Resident #22's right forearm had a round fading yellow discoloration consistent with a fading bruise.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 4/29/25 at 9:54 A.M., CNA staff transferred Resident #22 to a wheelchair.</p> <p>Review of Resident #22's medical record indicated the following:</p> <p>-A physician's order dated, 1/2/2024, Weekly skin assessment on every day shift every Tuesday for PROTOCOL COMPLETE SKIN ASSESSMENT WEEKLY ON PCC (sic) (electronic medical record).</p> <p>-A care plan with the focus, potential for skin breakdown due to decreased mobility, incontinence and variable PO (by mouth) intakes, dated 1/15/2024. A care plan intervention dated 1/15/24 indicated skin checks with am/pm (sic) care, note/report skin irritation for appropriate treatment.</p> <p>-A care plan focus, Resident has inappropriate behavior: accusatory, banging on furniture dated 1/15/2024.</p> <p>Further review of Resident #22's medical record indicated the following:</p> <p>-A weekly skin check dated, 4/8/25, indicating skin is warm and dry, and intact.</p> <p>-A weekly skin check dated, 4/15/25, indicating skin is warm and dry and intact.</p> <p>-A weekly skin check dated, 4/22/25, indicating skin is warm and dry and intact.</p> <p>-A weekly skin check dated, 4/29/25 at 10:42 A.M., indicating skin is warm and dry and intact. This skin check was conducted after several staff provided care to Resident #22 and the area was present on Resident #22's right forearm.</p> <p>During an interview and observation on 4/29/25 at 4:50 P.M., Nurse #7 said she works the 3-11 shift and is familiar with Resident #22. Nurse#7 said staff are to report any changes in a resident including skin issues. Nurse #7 said she was not aware of any skin issues related to Resident #22's right forearm. Nurse #7 and the surveyor went to Resident #22's room. Nurse #7 observed Resident #22 and said Resident #22 had a fading, healing bruise on his/her right arm. Nurse #7 said before a bruise fades it is usually black and blue. Nurse #7 said staff should have seen the area, reported it, and an incident report should be completed, and the family and doctor would be notified.</p> <p>During a subsequent interview on 4/29/25 at 5:07 P.M., Nurse #7 said Resident #22 had blood drawn on 4/9/25, and the bruised area could have been the result. Nurse #7 said if a bruise was present since the blood draw it should have been reported and documented on the weekly skin check.</p> <p>During an interview on 4/30/25 at 10:21 A.M., Nurse #5 said she observed the fading bruise on Resident #22 on 4/14/25. Nurse #5 said she knew she had recent blood work. Nurse #5 said she completed the skin check dated 4/29/25 and said she did not document the presence of the fading bruise on Resident #22's right forearm on the skin check but should have.</p> <p>During an interview on 4/30/25 at 10:45 A.M., the Director of Nursing (DON) said if staff observed a bruise on a resident, they should report it and do an incident report. The DON said she would expect any skin area to be on the weekly skin check.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #35 was admitted to the facility in June 2023 with diagnoses including Alzheimer's Disease.</p> <p>Review of Resident #35's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score 2 out of a possible 15, which indicated the Resident has severe cognitive impairment. The MDS also indicated Resident #35 is dependent on staff for functional daily tasks.</p> <p>a. On 4/28/25 at 8:36 A.M., Resident #35 was observed lying in bed with his/her right arm exposed. The Resident's right arm was covered in blood and a skin tear was observed.</p> <p>On 4/28/25 at approximately 11:45 A.M., Resident #35 was observed to have a dressing covering the skin tear on his/her arm.</p> <p>Review of the skin check completed on 4/28/25 indicated the nurse documented the following:</p> <p>-The skin is dry, warm to the touch, and fragile. Due to dermal dermatoporosis (sic), the resident is at a high risk for bruising or skin tears. Geri sleeves (protective arm coverings) and bed rail pads are in place.</p> <p>During an interview on 4/30/25 at 9:30 A.M., Nurse #2 said Resident #35 has very fragile skin. Nurse #2 said all skin impairments, including skin tears, should be documented on skin checks. Nurse #2 said she was not working on 4/28/25, but the skin tear could have been missed if Resident #35 was wearing geri sleeves as the skin check indicated.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said all skin impairments, including skin tears, should be documented on skin checks.</p> <p>b. Review of Resident #35's physician orders indicated the following order:</p> <p>-Weekly skin assessment on every day shift every Mon (Monday) for protocol complete skin assessment weekly on PCC (electronic medical record), initiated on 6/19/23.</p> <p>Review of Resident #35's medical record indicated weekly skin check were not completed twice in both April and March 2025.</p> <p>During an interview on 4/30/25 at 9:30 A.M., Nurse #2 said all residents have orders for weekly skin checks and these checks are expected to be completed by nurses as ordered.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said she expects all orders to be followed as ordered and skin checks should be completed weekly. The Director of Nursing was unaware Resident #35 had four missing skin checks.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to 1. follow the wound recommendations for one Resident (#184) and 2. implement wound treatment for a pressure ulcer for Resident (#60) out of a total sample of 24 residents.</p> <p>Findings include:</p> <p>Review of the facility policy 'Skin Integrity Management', undated, indicated:</p> <p>The implementation of an individual resident's skin integrity management occurs within the care delivery process. Staff continually observe and monitor residents for changes and implement revisions to the plan of care as needed.</p> <p>-10A. The Director of Nursing will review all wounds on a weekly basis with the Medical Director.</p> <p>-11. Document care daily in Nurse's Notes/ Treatment Administration Record (TAR) and weekly on Skin Integrity Report.</p> <p>-13. Evaluate resident and Center progress through routine, ongoing review and revision.</p> <p>-Review information at weekly wound meeting.</p> <p>1. Resident #184 was admitted to the facility in April 2025 with diagnoses including bilateral heel pressure ulcers, diabetes with polyneuropathy, edema and weakness.</p> <p>Review of Resident #184's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status score of 2 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated the Resident is dependent on staff for mobility tasks.</p> <p>On 4/28/25 at 8:33 A.M., Resident #184 was observed lying in bed. His/her right heel was directly on the mattress and his/her left heel was in a heel protecting bootie.</p> <p>On 4/28/25 at 4:38 P.M., Resident #184 was observed lying in bed. Resident #184 was wearing slipper socks and his/her heels were resting directly on the mattress. A protective bootie was on the bin across from his/her bed.</p> <p>On 4/29/25 at 6:50 A.M., Resident #184 was observed lying in bed. Resident #184 was wearing slipper socks and his/her heels were resting directly on the mattress. A protective bootie was on the bin across from his/her bed.</p> <p>On 4/29/25 at 10:10 A.M., Resident #184 was observed lying in bed. His/her right heel was directly on the mattress and his/her left heel was in a heel protecting bootie. At the time of this observation, Resident #184 said he/she had significant pain in his/her right heel.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Benjamin Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  120 Fisher Avenue Boston, MA 02120	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/29/25 at 5:15 P.M., Resident #184 was observed lying in bed. Resident #184 was wearing slipper socks and his/her heels were resting directly on the mattress. A protective bootie was on the bin across from his/her bed.</p> <p>Review of Resident #184's physician orders indicated the following order initiated on 4/8/25:</p> <p>-Apply floater booties to bilateral heels while in bed.</p> <p>Review of the Wound Physician note dated 4/9/25 indicated the following recommendation:</p> <p>-prevalon (a heel relieving bootie) boot.</p> <p>Review of the Wound Physician note dated 4/16/25 indicated the following recommendation:</p> <p>-off-load wounds</p> <p>Review of the Wound Physician note dated 4/23/25 indicated the following recommendation:</p> <p>-off-load wounds</p> <p>During an interview on 4/30/25 at 7:27 A.M., Nurse #1 said the wound physician visits the facility weekly and nurses are expected to follow all recommendations made.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of nursing said Resident #184 was admitted to the facility with bilateral heel pressure ulcers and has been seen by the wound physician weekly. The Director of Nursing said all recommendations from the wound physician should be followed to allow for proper wound management.</p> <p>2. Resident #60 was re-admitted to the facility in April 2025 with diagnoses including femur fracture and diabetes.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 2/1/25, indicated that Resident #60 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15.</p> <p>Review of Resident #60's discharge summary from the hospital prior to admission to the facility, dated 4/24/25, indicated Resident had lower back pressure wound, wound care was consulted and recommended 4x4 adhesive foam dressing, change every 3 days and as needed.</p> <p>Review of Resident #60's skin observation tool, dated 4/24/25, indicated Resident had mid back open wound change dressing every 3 days.</p> <p>Review of Resident #60's nursing progress note, dated 4/24/25, indicated Resident had an open area on his back.</p> <p>Review of Resident #60's physician orders, dated 4/29/25, failed to indicate a wound treatment order for open area to lower back.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #60's Treatment Administration Record (TAR), dated 4/29/25, failed to indicate a wound treatment order had been implemented.</p> <p>Review of Resident #60's plan of care failed to indicate any wound care interventions.</p> <p>During an interview on 4/29/25 at 12:18 P.M. Nurse #3 and surveyor observed wound on Resident #60's lower back together with assist of Rehabilitation staff #1 to hold resident forward in bed as Resident did not want to be positioned on his/her side. The wound on his/her lower back was covered with gauze dated 4/28. She did not change the dressing at this time, but pulled the gauze back to observe the wound.</p> <p>During an interview on 4/29/25 at 12:25 P.M., Nurse #3 stated that she was working when Resident was readmitted on [DATE] and was aware of the open area, however, the order got missed and was not put in until today. Nurse #3 said she was aware that there was no order on TAR. She described the wound as superficial. Nurse #3 said the facility no longer uses a wound doctor to consult on wound care.</p> <p>During an interview on 4/30/25 at 11:27 A.M., Nurse #4 said if a new open area is discovered that the Director of Nursing was notified to look at this area. Nurse #4 said the open area wound should be measured, physician notified, and documented in nursing notes and on skin check.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said skin checks should be completed on new admissions, re-admissions, and weekly and anything on skin should be documented. She said any open areas should be measured and a description documented, physician notified, and a wound treatment implemented.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>Based on observations, record review and interviews, the facility failed to ensure that one Resident (#31) out of a total sample of 24 residents, received proper treatment and care in accordance with professional standards, to maintain good foot health and prevent complications from the resident's medical conditions.</p> <p>Findings include:</p> <p>Resident #31 was admitted to the facility in September 2024 with diagnoses that include diabetes, adult failure to thrive, pain and acute embolism and thrombosis of the deep veins in the left lower extremity and left foot pain.</p> <p>Review of Resident #31's most recent Minimum Data Set (MDS) Assessment, dated 3/22/25, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, indicating that the Resident is cognitively intact.</p> <p>-On 4/28/25 at 8:29 A.M., the surveyor observed Resident #31 awake in bed. Resident #31 was lying on his/her back with their heels directly on the mattress and blankets resting directly on his/her feet. Resident #31 said that he/she is waiting to see a podiatrist because of pain in his/her feet and problems with his/her toes. The surveyor observed Resident #31's feet and noted both to be edematous. On the left second toe the toenail was black and did not appear to be completely attached. Resident #31 said that his/her feet are their biggest concern.</p> <p>- On 4/29/25 at 8:19 A.M., the surveyor observed Resident #31 awake in bed with his/her heels directly on the mattress and blankets sitting directly on the Resident's feet. The Resident pointed to a device on the floor against the wall and said that it was delivered yesterday for him/her to use in bed to keep the blankets from resting on his/her toes. When asked why he/she was not utilizing it he/she said the staff did not offer it and said they did not know how to use it.</p> <p>-On 4/30/25 at 7:27 A.M., the surveyor observed Resident #31 awake in bed with the blankets resting directly on his/her feet. The Blanket lifter was on the floor against the wall. The Resident said that no one offered to put it on his/her bed last night. Resident #31 said that his/her toes were hurting this morning from the weight of the blanket on his/her toes.</p> <p>Review of a Nurse Practitioner progress note, dated 4/3/25, indicated the following:</p> <p>-Chief Complaint / Nature of Presenting Problem:</p> <p>Seen per nursing request reporting that pt (patient) is complaining of significant left foot pain especially send to great toe. [sic]</p> <p>- Has order to be evaluated by wound care for pain and fragile skin to bil feet [bilateral feet] [sic]</p> <p>- House podiatry for toe nail care.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- significant right foot pain, second to great toe is black without trauma, erythema or signs of infection. Referred to vascular MD/clinic for evaluation. PT does not wish for ER transfers at this time. ordered a bed cradle to keep bedding off the foot. Tramadol and apap [Tylenol] for pain. [sic]</p> <p>Review of Resident #31's active Physician's orders indicated the following:</p> <p>-Bed cradle when in bed (bedding not to touch toes), dated 4/3/25.</p> <p>-Referral to Vascular MD/Clinic dx [diagnoses] PVD [peripheral vascular disease]/ Diabetes Gangrene Left second toe, dated 4/3/25.</p> <p>Review of the medical record indicated one visit by the consulting podiatrist, dated 9/30/24.</p> <p>Review of a Nurse Practitioner progress note, dated 4/21/25 indicated the following:</p> <p>- Has order to be evaluated by wound care for pain and fragile skin to bil feet [bilateral feet]. [sic]</p> <p>- House podiatry for toenail care.</p> <p>- Pain in left foot, increased pain left foot. second to great toe is black without erythema, drainage or signs of infection. most probable PVD. referred to vascular clinic. PT has opted out of having foot evaluated at ER citing increased wait time for chronic condition. has been Followed by podiatry. Takes apap and tramadol for pain. requested for bed cradle to keep bedding off feet. [sic]</p> <p>Review of the April 2024 Treatment Administration Record (TAR) indicated that the bed cradle had been in use and applied every shift since 4/3/25.</p> <p>During an interview on 4/29/25 at 11:21 A.M., Nurse #1 said that she was not sure if or when Resident #31 saw the podiatrist while at the facility. Nurse #1 said that Resident #31 sometimes complains of pain in his/her feet. She further said that the bed cradle was just delivered yesterday because it needed to be ordered by the facility. She said that it should not have been signed off on the TAR if it was not in use.</p> <p>During an interview on 4/30/25 at 8:47 A.M., the Director of Nurses said that she would expect that once the bed cradle arrived it would be utilized as ordered for Resident #31. She further said that it should not have been signed off indicating use if it was not. The Director of Nurses further said that the Resident was seen by podiatry services in September 2024 but had not been seen again while in the facility.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record reviews and interviews, the facility failed to adequately maintain the nutrition and hydration status of three Residents (#71, #45 and #13) out of a total sample of 24 residents</p> <ol style="list-style-type: none"> <li>For Resident #71, the facility failed to ensure significant weight loss was assessed and continually monitored.</li> <li>For Resident #45, the facility failed to implement physician's orders for weekly weights, dietary recommendations for fortified foods and the dietitian failed to evaluate significant weight loss following hospitalization.</li> <li>For Resident #15 the facility failed to ensure quarterly nutrition assessments were completed on a resident with a feeding tube.</li> <li>For Resident #13, the facility failed to obtain weights as ordered.</li> </ol> <p>Findings include:</p> <p>Review of the facility policy titled, Resident Nutrition Services, dated 2001, indicated the following:</p> <p>-The multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits.</p> <ol style="list-style-type: none"> <li>Resident #71 was admitted to the facility in November 2024 with diagnoses including Alzheimer's Disease.</li> </ol> <p>Review of Resident #71's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) of 6 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #71 requires supervision for all functional daily tasks.</p> <p>Resident #71 was unable to be interviewed about his/her nutritional status secondary to cognitive impairment.</p> <p>Review of Resident #71's weights and physician orders indicated the following:</p> <p>-On admission, Resident #71 weighed 122 lbs. (pounds) and his/her diet orders was for house diet, regular texture, regular consistency, initiated on 11/13/24.</p> <p>-On 1/23/25, Resident #71 weighed 112 lbs., an 8.2% weight loss. On 1/29/25, a physician order was initiated for Ensure Plus, three times a day, give between meals. (This would be a daily supplement equaling 1,050 calories.)</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 3/6/25, Resident #71 weighed 108.9 lbs. On 3/19/25, Resident #71's physician order for Ensure Plus was discontinued and the Resident was prescribed Boost VHC. one time a day for weight monitoring. (This would be a daily supplement equaling 530 calories a day, 520 less calories than Ensure Plus.)</p> <p>-On 4/26/25, Resident #71 weighed 103.2 lbs., a continued 5.23% weight loss.</p> <p>Review of the dietary notes indicated the following:</p> <p>-1/28/25: Weight Watch. Resident with suboptimal PO (by mouth) intake at meals c/w (consistent with) a significant weight loss x1 month. Weight: 1/23/25 112 12/19/24 119 11/2/24 120. WT (weight) is down 7#(pounds)/5.9% x1 month and is down 8#/6.1% x3 months. Resident is consuming 26-50% at most meals intermittently 51-75%. 237ml (milliliters) Ensure + added 3x/day to help stabilize weight. Will follow.</p> <p>-3/18/25: Resident with a 3.1% WT loss x1mo and down 7.2% x3mos and down 10.7% x10mos. Tried Boost VHC, resident consumed 100%. Boost + and Boost breeze d/c'd and boost VHC 237ml added 1x/day. Will trial thrive ice cream.</p> <p>Review of Resident #71's medical record indicated the Dietitian had not completed a quarterly assessment due in February 2025.</p> <p>During an interview on 4/29/25 at 9:52 A.M., Nurse #1 said Resident #71 has had continual weight loss since admission to the facility. Nurse #1 said when a weight loss occurs, the Registered Dietitian, physician and health care proxy are notified. Nurse #1 said Resident #71 was a poor eater, however, has improved his/her intake over the last couple of months. Nurse #1 said Resident #71 used to be on a nutritional supplement three times a day and was changed to one time a day and she did not know why because the Resident would drink the supplement.</p> <p>During an interview on 4/29/25 at 1:47 P.M., the Registered Dietitian (RD) said she works at the facility twice a week. The RD said she was out of the facility in September for a medical issue and since coming back to work she has had a difficult time catching up and completing the resident assessments that need to be completed. The RD said significant weight loss is 5% in one month, 7.5% in three months and 10% in six months and that Resident #71 has had consistent and significant weight loss since admission to the facility. The RD said she started Resident #71's quarterly nutritional assessment in February 2025 but did not complete it, only entering the Resident's weight. The RD said she recommended a change to Resident #71's supplement after continued weight loss, however, could not answer why a change was recommended that would result in a total of less calories. The RD said she did not document her reasoning, and it could possibly be because the Resident refused to drink the supplement. The RD said she was unaware of Resident #71's weight on 4/26/25 and the newest significant weight loss. The RD said that the Resident is difficult to work with because of his/her cognition status and is a bane of my existence.</p> <p>Review of the Medication Administration Reports (MAR) for January 2025 to March 2025 failed to indicate the Resident refused the Ensure Plus supplement.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said she expects the Dietitian to complete assessments quarterly and was unaware Resident #71's supplement was decreased from three to one time a day and has had continued weight loss.</p> <p>2. Review of facility policy titled Assisting the Resident with In-Room meals, dated as revised December 2013, indicated the following:</p> <p>-1. Review the residents' care plan and provide for any special needs of the resident.</p> <p>-3. Check the tray before serving it to the resident to be sure that it is the correct diet ordered, and that the food consistency is appropriate to the resident's ability to chew and swallow.</p> <p>Resident #15 was admitted to the facility in March 2013 with diagnoses that included type 2 diabetes and need for assistance with personal care.</p> <p>Review of Resident #15's most recent Minimum Data Set (MDS) Assessment, dated 3/25/25, indicated a Brief Interview for Mental Status score of 6 out of a possible 15, indicating that the Resident has severe cognitive impairment.</p> <p>-On 4/28/25 at 8:54 A.M. Resident #15 was observed eating breakfast. Resident #15's meal ticket indicated double portions and fortified cereal, but his/her meal did not appear to be double portions.</p> <p>-On 4/29/25 at 8:45 A.M., the surveyor observed Resident #15 eating breakfast in the hallway. Resident #15's meal did not appear to be double portions. The surveyor observed two other residents on a puree diet who did not require double portions, and the portions were the same as Resident #15. The Resident also had oatmeal (which was not pureed) on his/her tray, the surveyor was unable to determine if it was fortified cereal.</p> <p>During an interview on 4/29/25 at 10:05 A.M., Dietary staff #1 said that he was the cook this morning and said that the oatmeal was fortified. He said he added some milk and honey to it to fortify it.</p> <p>-On 4/29/25 at 1:00 P.M., the surveyor observed Resident #15 eating lunch in the hallway. Resident #15's meal ticket called for double portions and fortified mashed potatoes, neither of which was observed on the Resident's tray. The Resident was also indicated to receive a fortified ice cream which was also not present.</p> <p>-On 4/29/25 at 1:08 P.M., the surveyor observed the lunch tray of another Resident (#28) who received a puree diet, and is not indicated to receive double portions, and the portion was the same as Resident #15.</p> <p>Review of Resident #15's most recent Mini Nutritional Assessment, dated 2/17/25, indicated a risk score of 8, which indicates at risk for Malnutrition.</p> <p>Review of Resident #15's active nutrition care plan indicated the following:</p> <p>-1/15/25, downward weight trend, add fortified mash potatoes at lunch and dinner meals and double portions at all meals, last revised 1/14/25.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-FF (fortified) mashed potatoes added at lunch and dinner and double portions added to all meals, created 2/16/25.</p> <p>- Monitor weight as ordered, created 2/12/21.</p> <p>-RD (Registered dietitian) to evaluate and make diet changes or recommendations PRN (as needed) RD available for diet education upon request, created 2/12/21.</p> <p>Review of progress notes indicated a note written on 1/14/25 by the Dietitian which indicated:</p> <p>-Resident with a downward weight trend without a significant weight loss noted at this time, weight is down 11.8 pounds or 7.9% over 6 months.</p> <p>-Interventions will provide double portions at all meals and fortified mashed potatoes at lunch and dinner meals.</p> <p>Review of Resident #15's meal tickets as of 4/29/25 indicated the following:</p> <p>-Breakfast: Diet Order: Puree, LCS (low calorie sweeteners), NAS (No added salt) , Regular liquids. Notes: Double portions, apple juice, fortified cereal</p> <p>-Lunch: Notes: Double portions, apple juice, send magic cup with meal, fortified mashed potatoes. Dislikes: potatoes</p> <p>-Dinner: Notes: Double portions, send magic cup with meal, fortified mashed potatoes. Dislikes: potatoes.</p> <p>Review of Resident #15's active physician orders indicated the following:</p> <p>-Weekly weight on THURSDAY 7-3, revised 4/1/25.</p> <p>-Nutrition consult for weight loss, dated 1/13/25.</p> <p>-NAS (No added salt) diet, Puree texture, Regular consistency. Double portions at all meals, dated 2/13/25.</p> <p>-Glucerna 1.5 four times a day for significant wt (weight) loss noted, dated 1/8/24.</p> <p>-Nutritional Consult, dated 4/1/25.</p> <p>-Thrive ice cream twice daily, two times a day, dated 4/7/25.</p> <p>Review of Resident #15's weights for April 2025 indicated the following:</p> <p>4/3/25: 123.8 lbs. (pounds)</p> <p>4/25/25: 134.8 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the medical record failed to indicate that weights were obtained on 4/10/25 and 4/17/25 as indicated in physician's orders for weekly weights.</p> <p>Review of the medical record indicated that the Resident was hospitalized from [DATE] through 3/18/25.</p> <p>Review of Resident #15's weights indicated that prior to hospitalization the Resident weighed 146 lbs. on 2/27/25, and the next documented weight on 3/28/25 (10 days after returning from the hospital) indicated a weight of 122.6 lbs.</p> <p>Review of the Nurse Practitioner progress note, dated 3/25/25 indicated, This patient is well developed and in no acute distress, PT (patient) is frail post hospital stay with visible weight loss.</p> <p>Review of a nursing progress note, dated 4/1/25, indicated, The resident is noted with weight loss. [He/She] returned from the hospital weighing 127.6 lbs. This past week [his/her] weight was 122.8 and was double checked. The NP (Nurse Practitioner) was notified and she gave new orders for weekly weight, to obtain a nutritional consult. The dietician was made aware. [His/Her] HCP (health care proxy) was called with no answer, no voicemail. [sic]</p> <p>The medical record indicated that following return from the hospital, Resident #15 continued to lose weight, specifically, 5 lbs. between readmission from the hospital on 3/18/25 and reweight on 3/28/25.</p> <p>Review of the medical record on 4/30/25 failed to indicate that the Dietitian had evaluated Resident #15 following readmission from the hospital or since the order was obtained for a nutritional consult on 4/1/25.</p> <p>During an interview on 4/29/25 at 9:01 A.M., Nurse #5 said that fortified cereal can be cream of wheat or oatmeal and the cook adds butter, cream, sugar and other ingredients to add more calories for residents who are losing weight.</p> <p>During an interview on 4/29/25 at 1:38 P.M., the Food Service Director (FSD) said that if a resident on puree diet had double portions, there would be two scoops of everything on the plate, or very large scoops of everything that was served. He said that no fortified mashed potatoes have been made in the facility, he was not sure if any residents required this intervention. He said that fortified cereals for pureed diet orders are made with cream of wheat. He said that they add cream or half- and- half, sugar, cinnamon and nutmeg to the cereal. He said that this is what he expects his staff to use. He said adding milk and honey, as indicated by dietary staff #1 in the morning, would not be considered fortified cereal.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/29/25 at 2:24 P.M., the Dietitian said when residents experience weight loss, she may add fortified cereal to their menu, she further said that adding milk and honey to cereal would not be considered fortified cereal. When asked if fortified potatoes are an option as well, she said it's an option, but she generally does not recommend it. She did not recall recommending it for Resident #15. She said she was not sure if it was being implemented. She further said that if other residents receiving a puree diet without double portions recommended looked like they had the same amount of food on their plate, then the double portions were probably not being implemented. The Dietitian said she was aware of Resident #15's weight loss upon readmission from the hospital but was not aware of the physician's order for a nutritional consult. When the surveyor asked if one had been done if it would be documented in the medical record, she said it should be. The Dietitian said she was not sure if there was an exact recipe for fortified cereal or potatoes but that she would look into it. The Dietitian further said that the order for thrive ice cream that was started on 4/7/25 was a change from a magic cup supplement because the facility switched products but was not necessarily a new intervention. The Dietitian also said that if a resident has an order for weekly weights, she expects them to be completed.</p> <p>During an interview on 4/30/25 at 9:00 A.M., the Director of Nurses said that fortified cereal, fortified mashed potatoes and double portions of meals should be provided as recommended for residents. She said nurses should also be obtaining weights as ordered. The Director of Nurses said she would have expected the dietitian to evaluate the resident following readmission, especially since there was a weight loss noted on admission and would have expected the nutritional consult to have been completed after it was ordered by the physician on 4/1/25.</p> <p>-On 4/29/25 the Dietitian left a copy of the expected recipe for fortified cereal for the surveyor which included:</p> <ul style="list-style-type: none"> <li>-1 packet instant oatmeal (plain)</li> <li>-1/4 cup half- and- half</li> <li>-1/2 cup evaporated milk</li> <li>-1/2 cup water</li> <li>-1 tablespoon margarine</li> <li>-1 tablespoon brown sugar</li> </ul> <p>3. Resident #45 was admitted to the facility in October 2023 with diagnoses that include hemiplegia and hemiparesis, anoxic brain injury and dysphagia.</p> <p>Review of Resident #45's most recent Minimum Data Set (MDS) Assessment, dated 2/1/25, indicated that the Resident could not participate in the Brief Interview for Mental Status Exam and was assessed by staff as having severe cognitive impairment. The MDS further indicates the use of a feeding tube.</p> <p>Review of Resident #45's physician orders indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Jevity (a high-calorie, fiber-fortified therapeutic nutritional supplement often used for tube feedings) 1.2 @ 80 ml/hr [milliliters per hour] up at 7:30 pm and down at 6:30 am-up at 7:30 pm down 6:30a for supplement Jevity 1.2 @ 80 ml/hr up at 7:30 pm and down at 6:30 am, dated 8/14/24. [sic]</p> <p>Review of the medical record indicated that the most recent progress note written by the dietitian was completed on 7/16/24, nine and a half months ago.</p> <p>Review of the medical record indicated that the most recent Quarterly Nutrition Assessment was completed 8/14/24, eight and a half months ago and indicated the following:</p> <p>-A Mini Nutritional Assessment score of 10 indicating the resident is at risk for malnutrition.</p> <p>-Trial of reducing tube feeding to 11 hours per day and providing three meals per day. Will follow.</p> <p>Review of the medical record failed to indicate any further assessments or follow ups regarding Resident #45's nutrition</p> <p>During an interview on 4/29/25 at 1:47 P.M., the Dietitian said that she is the only dietitian for the facility. She said she works usually two days per week. The Dietitian said she assesses everyone on admission and that quarterly assessments should be completed after that, but the quarterly assessments have not always been done. She said that if a resident is at high risk, such as experiencing weight loss, or utilizing a feeding tube she will make sure they are completed. She said Resident #45 does not have an up-to-date quarterly assessment completed.</p> <p>During an interview on 4/30/25 at 9:34 A.M., the Director of Nurses said that she would expect Nutrition Assessments to be completed quarterly and would expect that the Dietitian will complete them. She said the facility only has one dietitian.</p> <p>4. Resident #13 was admitted to the facility in February 2020 with diagnoses including parkinsonism, dementia, schizophrenia, and depression.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 2/8/25, indicated that Resident #13 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 2 out of 15.</p> <p>Review of Resident #13's physician's order, dated 1/29/24, indicated weigh every 3 weeks in the afternoon on Thursday.</p> <p>Review of Resident #13's Weight and Vitals Summary indicated the following weights:</p> <p>-4/29/2025, 164.4 pounds (Lbs.) (35 days since last weight 3/25).</p> <p>-3/25/2025, 161.6 Lbs. (74 days since last weight 1/10).</p> <p>-1/10/2025, 163.6 Lbs. 38 days since last weight on 12/4).</p> <p>-12/3/2024, 162.0 Lbs. (82 days since last weight on 9/12 - 6lbs).</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-9/12/2024, 168.2 Lbs (31 days since last weight on 8/12).</p> <p>-8/12/2024, 169.8 Lbs.</p> <p>-8/10/2024, 169.8 Lbs. (45 days since last weight on 6/27).</p> <p>-6/27/2024, 170.0 Lbs. (54 days since last weight on 5/4 -3lbs.).</p> <p>-5/4/2024, 173.8 Lbs. (25 days since last weight 4/9).</p> <p>Review of Resident #13's Medication Administration Record (MAR) indicated that weights were signed off as complete on 10/10/24, 10/31/24, 11/21/24,12/12/24, 1/2/25,1/22/25, 2/13/25, 3/6/25, 3/27/25, 4/17/25, but review of entire medical record failed to find any documentation of weights recorded on these dates.</p> <p>During an interview on 4/30/25 at 11:27 A.M., Nurse #4 said she does not know why Resident has an order for weights every 3 weeks, but monthly weights are done during the first week of every month. She was not aware of Resident refusing to be weighed.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said that physician's order for weights should be followed and physician should be notified if weight not obtained according to order.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review and interview the facility failed to ensure that services were provided in accordance with professional standards for one Resident (#65) with a gastrostomy tube (g-tube: a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition) out of 2 applicable residents, out of a total sample of 24 residents. Specifically, Resident #65 was not seen by the Registered Dietician, when Resident #65 was no longer provided meal trays and became NPO (nothing by mouth) and had weight loss.</p> <p>Resident #65 was admitted to the facility in January 2025 with diagnoses that include type 2 diabetes mellitus, dementia and failure to thrive.</p> <p>Review of the Minimum Data Set (MDS) Assessment, dated 1/30/25, indicated Resident #65 was unable to complete the Brief Interview for Mental Status (BIMS) and staff has assessed him/her to have severe cognitive impairment. The MDS also indicated the Resident is dependent on staff for daily care activities including bathing, dressing and eating. Further review of the MDS indicated Resident #65 as 66 (5 feet 5 inches) inches in height and weighing 114 pounds and has the nutritional approach of a feeding tube with the percentage of intake by artificial route as 51% or more.</p> <p>During an observation and interview on 4/28/25 at 8:41 A.M., Resident #65 was in his/her bed and observed to be frail in stature. A pole with an enteral feeding pump was next to Resident #65's bed and running through a tube into Resident #65. Resident #65 responded to the surveyor's greeting and said he/she had pain in his/her legs.</p> <p>Review of Resident #65's medical record indicated the following:</p> <ul style="list-style-type: none"> <li>-A physician's order Tube feeding Jevity 1.2 cal at 55ml/hr. (milliliters/hour) continuously every shift, dated 1/27/25</li> <li>-A physician's order, dated 3/13/25, NPO every shift.</li> <li>-A nursing progress note, dated 3/13/25, indicated SLP (speech language pathologist) dc (discharge) and new order for NPO as resident not eating but a spoonful.</li> <li>-A diabetic snack at bedtime, initiated 1/24/25, discontinued 4/29/25.</li> <li>-A Mini Nutrition Assessment, dated 1/26/25 and locked 2/11/25, with a score of 1.0. (0-7 indicates malnourished).</li> <li>-A care plan focus: Potential for complications r/t (related to) feeding tube. Dependence on staff for nourishment and hydration. Date Initiated: 1/27/25.</li> <li>-A Speech Therapy Discharge summary, dated and signed 3/13/25, indicated the following: Functional outcomes Swallowing Abilities Severe Diet recs (recommendations) Solids NPO Diet recs-liquids NPO, intake protocol/positions NPO.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MDS, dated [DATE], Section V indicated Resident #65 triggered for nutrition. The Section V note indicated: BMI (body mass index)=18.3 mild malnutrition. Is on a prescribed weight gain diet. Diet order includes M/A textured diet: r/t dysphagia (swallowing disorder) Diet includes a therapeutic diet: LCS (low concentrated sweets) NAS (no added salt as c/w (came with) dx (diagnoses) of DM (diabetes mellitus) and HTN (hypertension). Resident with a stage 111 pressure ulcer receiving vitamins to promote healing via TFings (tube feeding) regimen.</p> <p>Review of discontinued (dc) physician's diet orders indicated the following:</p> <ul style="list-style-type: none"> <li>-NAS puree reg (regular) consistency DC 3/13/25</li> <li>-LCS diet puree texture reg 1/24/25 dc 3/13/25</li> <li>-house diet ground texture 1/24/25 dc 3/13/25</li> </ul> <p>During an interview on 4/29/25 at 9:39 A.M., Certified Nursing Assistant (CNA) #3 said Resident #65 used to receive meal trays but he/she no longer eats or takes anything by mouth for a while now.</p> <p>During an interview on 4/29/25 at 4:24 P.M., Nurse #7 said when Resident #65 was admitted he/she had an order for puree food and enteral feeding. Nurse #7 said Resident #65 began to refuse to eat and did not eat much of anything, so the Nurse Practitioner gave an order for Resident #65 to be NPO (nothing by mouth).</p> <p>Review of the Nurse Practitioner note dated 3/11/25 indicated evaluated by SLP, made NPO. Further, the note indicated: Has (Resident) muscle wasting and visible weight loss since admission. followed (sic) by dietician.</p> <p>Review of the Weights/Vitals in the medical record indicated on 1/30/25 Resident #65 weighed 114 pounds. On 3/13/25 he/she weighed 109.6 pounds, and on 4/24/25 Resident #65 weighed 108.6 pounds, which is 4.74 % total loss of body weight, which is not defined as significant.</p> <p>Review of Resident #65's medical record failed to indicate the Registered Dietician saw the Resident since the initial admission assessment, dated 1/26/25, and failed to evaluate the Resident after he/she became NPO and sustained weight loss.</p> <p>During an interview on 4/29/25 at 1:48 P.M., The Registered Dietician (RD) said she is in the facility on Tuesdays and Saturdays and will review residents for nutritional needs. The RD said she reviews the MDS schedule, reviews residents' weights entered in the medical record and determines who may need a reweight. The RD said she will also get referrals from the nursing staff if they know of any concerns. The RD said she is expected to be available to evaluate residents with tube feedings.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further interview on 4/29/25 at 2:14 P.M., the RD said she does an initial assessment on all admissions. The RD said residents on g-tube feedings would be evaluated to ensure that they are tolerating feedings, and do not have GI (gastrointestinal) pain or issues. The RD said Resident #65 came in with wounds, and she would want to know his/her weight and if there are any trends including loss. The RD said Resident #65 receives all his/her calories and hydration from the g-tube. The RD said she was not aware Resident #65 was made NPO and no longer receiving meal trays. The RD said she was not aware of Resident #65's weight loss and said regardless of his/her no longer eating by mouth she would want to be made aware of the weight loss. The RD said the weight loss is not significant. The RD said it would have been nice for her to be made aware that Resident #65 was made NPO and she could have assessed for any necessary changes in the g-tube feedings.</p> <p>During an interview on 4/30/25 at 10:31 A.M., the Director of Nursing said Resident #65 came to the facility with wounds and had nutrition through tube feedings and had an order for puree meals. The DON said Resident #65 was provided with meal trays, but he/she did not eat much, and the meal trays were discontinued, and the Resident was made NPO after being evaluated by the Speech Pathologist. The DON said the RD should have been made aware of the change in the Residents status of being NPO and evaluated him/her. The surveyor requested Resident 65's documented meal intake percentage and was not provided with the documentation.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, record review and interviews, the facility failed to ensure professional standards of practice for two Residents (#59 and #79) requiring respiratory care and treatment, out of a total sample of 24 residents. Specifically, For Residents #59 and #79, the facility failed to clean the oxygen concentrator filter and failed to provide the oxygen as ordered.</p> <p>Findings include:</p> <p>1. Resident #59 was admitted to the facility in July 2023 with diagnoses including rheumatoid arthritis and dependence on oxygen.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 1/8/25, indicated that Resident #59 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 2 out of 15. The MDS also indicated that Resident used oxygen.</p> <p>On 4/28/25 at 8:01 A.M., 4/29/25 at 8:02 A.M., and 4/30/25 at 8:23 A.M., the surveyor observed oxygen concentrator filter covered with a layer of gray dust. During all observations, the Resident's oxygen was set at 4 Liters.</p> <p>Review of Resident #59's physician orders indicated the following order initiated 4/8/25:</p> <p>-oxygen at 2 litres as needed via nasal cannula for dyspnea to keep O2 saturation (sats) above 92% every 8 hours as needed for shortness of breath related to dependence on supplemental oxygen.</p> <p>During an interview on 4/30/25 at 11:27 A.M., Nurse #4 said that oxygen should be set according to the physician's orders and the oxygen concentrator filter should be cleaned weekly when the oxygen tubing is changed.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing (DON) said that oxygen should be provided according to physician's orders and the oxygen concentrator cleaning should be included with the nursing weekly tubing changing.</p> <p>2. Resident #79 was admitted to the facility in December 2024 with diagnoses that including acute respiratory failure with hypoxia and chronic diastolic heart failure.</p> <p>Review of Resident #79's most recent Minimum Data Set (MDS) Assessment, dated 3/8/25, indicated a Brief Interview for Mental Status (BIMS) score of 8 out of a possible 15, indicating that the Resident had moderate cognitive impairment. The MDS further indicated that the Resident used oxygen.</p> <p>On 4/28/25 at 8:29 A.M., 4/29/25 at 8:06 A.M., and 4/30/25 at 8:18 A.M., the surveyor observed Resident #79's oxygen concentrator filter covered with a thick layer of gray dust.</p> <p>On 4/28/25 at 8:29 A.M., 4/29/25 at 8:06 A.M., and 4/30/25 at 8:18 A.M., the surveyor observed Resident #79 wearing oxygen set at 3 liters.</p> <p>Review of Resident #79's physician orders indicated the following order initiated 12/7/24:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-oxygen at 2 liters via nasal cannula as needed for O2 less than 90% on room air as needed every 6 hours as needed for shortness of breath.</p> <p>During an interview on 4/30/25 at 11:27 A.M., Nurse #4 said that oxygen should be set according to the physician's orders and the oxygen concentrator filter should be cleaned weekly when the oxygen tubing is changed.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing (DON) said that oxygen should be provided according to physician's orders and the oxygen concentrator cleaning should be included with the nursing weekly tubing changing.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>Based on record review, policy review and interviews, the facility failed to ensure a comprehensive care plan was developed for Trauma Informed Care for one Resident (#78) who had a history of trauma out of a total sample of 24 residents. Specifically, for Resident #78, the facility failed to develop a comprehensive trauma care plan, with individualized triggers.</p> <p>Findings Include:</p> <p>Resident #78 was admitted to the facility in April January 2025 with diagnoses that included Post-Traumatic Stress Disorder (PTSD), major depressive disorder, conversion disorder, and anxiety.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 3/17/25, indicated that Resident #78 had a Brief Interview for Mental Status (BIMS) exam score of 14 out of 15 indicating he/she is cognitively intact. The MDS further indicated Resident #78 has an active diagnosis of PTSD.</p> <p>Review of Resident #78's medical record failed to indicate a plan of care was developed for PTSD with identified triggers or that a trauma assessment was completed.</p> <p>During an interview on 4/30/25 at 8:07 A.M., Nurse #1 said the social worker completes the trauma assessments and develops the PTSD care plans, but the facility has been without a social worker. Nurse #1 said she would expect a PTSD care plan to be developed and triggers to be identified.</p> <p>During an interview on 4/30/25 at 11:27 A.M., the Director of Nurses said she would expect a PTSD assessment to be completed, and a care plan developed with identified triggers. The Director of Nursing said the social worker is responsible for developing the PTSD care plan, but the facility has been without a social worker for the past few weeks.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review and interview, the facility failed to ensure that side rails were implemented in accordance to the Resident assessment for one Resident (#45) out of a total sample of 24 Residents.</p> <p>Findings Include:</p> <p>Review of facility policy titled Informed Consent for Use of Bed Rail(s), undated, indicated the following:</p> <p>-The [facility] will use bed rail(s) only after evaluation and care planning has indicated it is appropriate to treat the resident's medical symptoms and will assist the resident to attain or maintain his/her highest practicable physical and psychosocial well-being, and other considered alternatives are inadequate- The center will endeavor to use the least restrictive device.</p> <p>Resident #45 was admitted to the facility in October 2023 with diagnoses that include hemiplegia and hemiparesis, and anoxic brain injury.</p> <p>Review of Resident #45's most recent Minimum Data Set (MDS) Assessment, dated 2/1/25, indicated that the Resident could not participate in the Brief Interview for Mental Status Exam and was assessed by staff as having severe cognitive impairment.</p> <p>On 4/28/25 at 8:40 A.M. and 9:06 A.M., the surveyor observed Resident #45 lying in bed awake. Four side rails were up on the bed, two half rails bilaterally at the head of the bed and two half rails bilaterally at the foot of the bed.</p> <p>On 4/28/25 at 9:06 A.M., the surveyor observed Resident #45 lying in bed awake. Four side rails were up on the bed, two half rails bilaterally at the head of the bed and two half rails bilaterally at the foot of the bed.</p> <p>On 4/29/25 at 7:06 A.M., and 8:06 A.M., the surveyor observed Resident #45 sleeping in bed. Four side rails were up on the bed, two half rails bilaterally at the head of the bed and two half [NAME] bilaterally at the foot of the bed.</p> <p>On 4/29/25 at 11:31 A.M., the surveyor observed the resident lying awake in bed. Resident #31 was dressed and had a total lift pad under him/her. Four side rails were up on the bed, two half rails bilaterally at the head of the bed and two half rails bilaterally at the foot of the bed.</p> <p>On 4/30/25 at 6:44 A.M., the surveyor observed Resident #31 sleeping in bed. Three side rails were up on the bed, two half rails bilaterally to the head of the bed and one side rail on the left side of the foot of the bed.</p> <p>Review of Resident #31's side rail assessments, dated 1/27/25, 11/6/24 and 7/30/24, indicated to utilize half side rails to both sides of the bed (upper).</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #31's active care plan and physician orders failed to indicate the use of side rails or bed rails.</p> <p>During an interview on 4/30/25 at 7:34 A.M., Nurse #2 said that she is not sure why Resident #31 utilizes four side rails. She said that the Resident does not exhibit behaviors and does not think that he/she tries to get out of bed as they utilize a total lift for transfers.</p> <p>During an interview on 4/30/25 at 8:08 A.M., Certified Nurse's Aide (CNA) #2 said that Resident #45's family purchased the bed that he/she uses which is why there are four side rails utilized on the bed. CNA #2 said that Resident #45 doesn't try to get up out of bed but will occasionally put his/her leg over one of the side rails. She said she is not sure how many side rails should be used.</p> <p>During an interview on 4/30/25 at 11:16 A.M., the Director of Nurses said that Resident #45 should only have two side rails up on his/her bed. She said if the Resident is assessed to use two upper side rails on the side rail assessment, then that is what should be used. She further said that there should be a physician's order and care plan in place for the use of side rails.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on records reviewed and interview, the facility 1) failed to ensure one Resident (#71) was free from unnecessary medications by not reassessing a PRN (as needed) psychotropic medication and 2) failed to ensure an Abnormal Involuntary Movement Scale (AIMS) assessment (a test used monitor for adverse consequences of antipsychotic medication) was completed for one Resident (#47) who was receiving antipsychotic medications out of a total sample of 24 Residents.</p> <p>Findings include:</p> <p>The surveyors asked for polilcies for the as needed psychotropic medication and AIMS assessments and they were not provided to them.</p> <p>1. Resident #71 was admitted to the facility in November 2024 with diagnoses including depression and Alzheimer's Disease.</p> <p>Review of Resident #71's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) of 6 out of a possible15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #71 requires supervision for all functional daily tasks.</p> <p>Review of Resident #71's physician orders indicated the following order initiated on 11/16/25:</p> <p>-Trazodone Oral Tablet. Give 12.5 mg (milligrams) orally every 8 hours as needed for restlessness and agitation related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety.</p> <p>Review of the medical record and physician orders, since admission, failed to indicate the physician reassessed the order for PRN trazodone after the initial 14 days of the order, or at anytime subsequently after. The medical record also failed to indicate Resident #71 was seen by behavioral health services for medication management.</p> <p>Review of the Medication Administration Record (MAR) for November 2024 to April 2025 indicated the following:</p> <p>-In November 2024, the Resident used the PRN trazodone 11/24/24 and 11/29/24.</p> <p>-In February 2025, the Resident used the PRN trazodone on 2/11/25, twice on 2/24/25, 2/26/25 and 2/28/25.</p> <p>-In March 2025, the Resident used the PRN trazodone on 3/22/25, 3/3/25, twice on 3/8/35, 3/14/25, 3/16/25, 3/16/25 and 3/28/25.</p> <p>-In April 2025, the Resident used the PRN trazodone on 4/1/25 and 4!425.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/29/25 and 9:52 A.M., Nurse #1 said PRN psychotropic medications need to have an end date or a date of reassessment on the order so that the physician can reassess the appropriateness of their usage. Nurse #1 was unaware the physician had never reassessed the medication.</p> <p>During an interview on 4/29/25 at 11:39 A.M., the Director of Nursing said psychotropic medications used as a PRN should only be ordered for 14 days and then re-evaluated for continued use. The Director of Nursing said the physician would oversee this re-evaluation if the resident is not being seen by behavioral health services and said she was unaware Resident #71 has been utilizing a psychotropic medication as PRN for the past six months without it being re-evaluated.</p> <p>2. For Resident #47 there was no documentation to support an Abnormal Involuntary Movement Scale (AIMS) assessment was completed.</p> <p>Resident #47 was admitted to the facility March 2025 with diagnoses including suicidal ideations, depression, aphasia, and chorea (a neurological disorder that causes involuntary, random, and continuous muscle movements while awake).</p> <p>Review of the Minimum Data Set Assessment, dated 3/23/25, indicated Resident #32 received an antipsychotic medication.</p> <p>Review of the Physician's order, dated 3/17/25, indicated for nursing to administer:</p> <p>-Risperdal Oral Table 2 milligrams (mg) (Risperidone). Give 1 tablet by mouth at bedtime for behaviors.</p> <p>Review of Resident #47's Medication Administration Record (MAR) indicated that he/she has received Risperdal every day since admission.</p> <p>Review of the Electronic Medical Record and the Chart on 4/29/25, indicated there was no documentation to support that staff completed an Abnormal Involuntary Movement Scale (AIMS) assessment as required.</p> <p>During an interview on 4/30/25 at 11:27 A.M., Nurse #4 said that behavioral services completes the AIMS assessment, she has never done an AIMS before and was not aware of when they should be completed.</p> <p>During an interview on 4/30/25 at 1:58 A.M., the Director of Nursing said that the AIMS should be completed on admission, quarterly and when a new antipsychotic medication is started.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, record review and interview, the facility failed to ensure meals were provided in accordance with standards of nutritional standards to ensure the nutritional needs of residents were met. Specifically, the facility failed to ensure the menu, including the therapeutic breakdown for specialized diets, was provided to the staff serving the daily meals.</p> <p>Findings include:</p> <p>Review of the 268 CMR: BOARD OF REGISTRATION OF DIETITIANS/NUTRITIONISTS 268 CMR 5.00: PROFESSIONAL STANDARDS AND ETHICAL CODES, included but was not limited to the following:</p> <p>(4) Foodservice Systems: In the areas of menu planning, foodservice purchasing, production, distribution and service, safety and sanitation, facility layout, and management, examples of appropriate activities include, but are not limited to, the following:</p> <p>(a) Planning, developing, controlling and evaluating food service systems;</p> <p>(b) Establishing and maintaining standards of food production, service, sanitation, safety, and security;</p> <p>(c) Developing menu patterns and evaluating such for nutritional adequacy;</p> <p>(d) Planning layout designs and determining equipment requirements for food service facilities;</p> <p>(e) Developing specifications for the procurement of food and food service equipment and supplies.</p> <p>Review of a document provided to the surveyor on 4/30/25 by the Food Service Director, titled, Resident Summary Report indicated the following breakdown of residents with Special Diets: Multiple residents are listed as having one or more of the following Special Diets:</p> <p>-Fifty residents require NAS (No Added Salt, which is a regular diet with no additional salt with meals)</p> <p>-Thirty-nine residents require LCS (Low Concentrated Sugar, a diet which means avoiding foods with a lot of sugar or high calorie sweeteners and is prescribed to manage blood sugar levels).</p> <p>-Twenty-one residents require Low Fat (A diet plan that limits the amount of dietary fat consumed).</p> <p>-Twelve residents require Low K (Low Potassium, a diet which limits food with high potassium levels, like potato, and stewed tomatoes).</p> <p>-One Resident has a Low Lactose Diet (A diet which involves avoiding or limiting the consumption of lactose-containing foods and beverages, like milk, cheese, yogurt and ice cream).</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation of the main kitchen and interview on 4/28/25 at 7:25 A.M., [NAME] #1 said the we have problems here, When asked what [NAME] #1 meant by problems, he said we do not have enough food. [NAME] #1 said we do not follow the menus, and we cook what we have available. [NAME] #1 said today for breakfast they are having scrambled eggs and toast. [NAME] #1 pointed to a binder with menus and said these are the menus and he was not sure which week they were using. A review of the menu did not indicate a breakdown for the specialized diets, also known as therapeutic diets.</p> <p>(A therapeutic diet is a specialized eating plan designed to meet the nutritional needs of individuals based on their specific health conditions or illnesses. It may involve modifying nutrient levels, such as carbohydrates or fats, and can be ordered by healthcare professionals as part of treatment for various diseases or clinical conditions).</p> <p>During an interview on 4/28/25 at 12:07 P.M., the Food Service Director (FSD) said they are following the menu for week 4 today because they did not receive items for the week 2 menu which was what week they were on.</p> <p>Review of the menu week 4 for Monday lunch, used for today 4/28/25 indicated Spaghetti, meat sauce, garlic bread, with a lunch alternate of grilled cheese, roast potato and steamed vegetables. The menu indicated cookie for dessert. The menu did not indicate what the 50 residents who have a NAS diet could or could not have or how much they could have. The menu did not indicate what the thirty-nine residents requiring LCS could have or not have or how much of something they could have to meet the LCS diet. The menu did not indicate what the twenty-one residents on a low-fat diet could have or could not have or how much of something they could have to meet the low-fat diet. The menus did not indicate what the twelve residents on a low-potassium diet could or could not consume or how much of something they could have to meet the low-potassium diet. The menu did not indicate what the one resident on a lactose free diet could consume or not consume or how much of something they could eat to meet the low-lactose diet.</p> <p>Review of the four-week cycle of menus did not indicate the specialized diets and how the specialized diets were met.</p> <p>During an interview on 4/28/25 at 4:54 P.M., [NAME] #2 said the freezer was broken but the meal for tonight was planned and was cooked ham (a meat higher in sodium), rice and vegetables. This meal was not on the week 2 menu and did not have a breakdown for the specialized diets.</p> <p>During an interview on 4/29/25 at 11:56 A.M. [NAME] #2 said he follows the menu provided and that the Resident's diet ticket has the diet order and any special needs like special cups or plates. [NAME] #2 said he is provided with a menu and does not have any therapeutic breakdown to indicate what should be served or not served and how much to serve for the diets including NAS, LCS, Low-fat, and Low- Potassium diets.</p> <p>During an interview on 4/29/25 at 8:34 A.M., The Registered Dietician (RD) said the kitchen is working off the week 2 menu. The RD said the facility takes care of residents with diagnoses that include hypertension, congestive heart failure and diabetes that require specialized nutritional needs to maintain their health. The RD said they have specific therapeutic diets such as NAS, low cholesterol, LCS. The RD said residents do well with liberalized diets, but diet orders are to be provided and followed. The RD said the menus provided to the cooks do not have the breakdown for the therapeutic diets and should be detailed with the breakdown for the individual needs for the therapeutic diets.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/29/25 at 10:05 A.M., the FSD said Residents require many types of diets including different diet textures like puree, ground and different diet portions and therapeutic diets. The FSD said since he began working at the facility last August or September 2024, therapeutic diets were non-existent and this was a concern. The FSD said the cooks use the resident's tray ticket which has the diet order, and aside from the order, the cooks do not know the therapeutic breakdown or know which foods are restricted due to a specialized diet. The FSD said the breakdown needs to be worked on with the RD.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, record reviews and interviews, the facility failed to ensure food is stored, prepared and distributed in accordance with professional standards in food safety and sanitation to prevent the spread of pathogens, which could result in foodborne illness for the residents. Specifically:</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure frozen foods were maintained frozen.</li> <li>2. The facility failed to ensure available food was not expired, and that food was dated and securely stored.</li> <li>3. The facility failed to ensure the dietary staff practiced proper hand hygiene and handled food in a way to minimize possible cross-contamination.</li> <li>4. The facility failed to ensure the dish machine met proper sanitation requirements when staff used expired test strips and the wrong test strips.</li> <li>5. The facility failed to ensure staff tested the sanitation buckets used to clean and sanitize the kitchen and surfaces.</li> </ol> <p>Findings include:</p> <p>Review of the facility's policy titled (4) Freezers, Policy: It is the policy of the facility that the freezer be maintained in a clean and sanitary condition.</p> <p>Review of the facility's policy titled: Chapter 3 Food, not dated, indicated the following:</p> <p>(E) A food that is labeled frozen and shipped by a food processing plant shall be received frozen.</p> <p>Gloves, Use limitation. (A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or with raw animal food, use for no other purpose, and discarded when damaged or soiled, or when interruptions occur in operation.</p> <p>Review of the facility's policy titled Personal Hygiene, dated 2010, indicated, Hands are the major source of food contaminants. Frequent hand washing with special attention under fingernails can greatly reduce instances of foodborne illness.</p> <p>Clean Hands:</p> <p>Before handling or service food</p> <p>After returning to kitchen from another work area</p> <p>After handling soiled equipment, dishes, or utensils.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Use a dedicated hand-washing sink supplied with soap dispenser and disposable paper towels. 8. Leave the water running while drying hands. Dry hands with a clean, disposable towel being careful to avoid touching the faucet handles or towel holder with clean hands. Discard the towel.</p> <p>1. On 4/28/25 at 7:25 A.M., the following was observed in the main kitchen:</p> <p>The walk-in freezer outside built-in thermometer read 30 degrees Fahrenheit. Upon walking into the freezer, the surveyor immediately felt the temperature was not consistent with freezing. After stepping out and confirming with [NAME] #1 that it was the walk-in freezer the surveyor returned to the freezer. There was no internal thermometer in the freezer and the following was observed:</p> <ul style="list-style-type: none"> <li>-Multiple boxes of food were labeled keep frozen,</li> <li>-A bag of shrimp was soft, not solid to touch and was not frozen.</li> <li>-A plastic bag of French fries, not labeled or dated was soft and not solid to touch.</li> <li>-Ice fell from the corner of the unit as if it was melting.</li> <li>-A bag of imitation crabmeat was soft and not frozen solid to touch.</li> <li>-A plastic bag containing whipped cream was soft and not solid frozen to touch.</li> <li>-A sealed bag of beef and port meatballs was soft and not frozen solid to touch.</li> <li>-An open cardboard box with the internal plastic bag open and not secure had pasta with filling and was not frozen to touch.</li> </ul> <p>All the food observed and touched was consistent with being defrosted and not frozen.</p> <p>Review of the document labeled Dietary Temperature Sheet dated 4/26/25 indicated the freezer was documented as -2 (-2 degrees Fahrenheit) at breakfast, -3 (-3 degrees Fahrenheit) at lunch and -2 (-2 degrees Fahrenheit) at dinner.</p> <p>Review of the document labeled Dietary Temperature Sheet dated 4/27/25 indicated the freezer was documented as (0 degrees Fahrenheit), at breakfast, lunch and dinner. The Dietary Temperature Sheet indicated at the bottom and underlined: If any of the temperatures are out of range, please notify the Food Service Director Immediately.</p> <p>On 4/28/25 at 7:52 A.M., the Maintenance Director entered the kitchen and entered the freezer with the surveyor and used a thermometer and obtained the temperature of 40 degrees Fahrenheit. The Maintenance Director said he began working at the facility about 4 weeks ago and has been checking the freezer almost daily because of some mechanical issues which affected the temperature. The Maintenance Director was asked for work orders for work done on the freezer and he said he did he fixing with parts he had and did not have any invoices.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a return visit to the kitchen on 4/28/25 at 10:40 A.M., the walk-in freezer thermometer outside of the freezer was at 30 degrees Fahrenheit. The inside of the freezer did not feel consistent with freezing. The food inside the freezer was soft and not frozen to touch. [NAME] #1 said food remains in the freezer, that he did not know the plan for the food stored in the freezer that was no longer frozen. [NAME] #1 said he thought the Food Service Director was called about the freezer. Further, [NAME] #1, with [NAME] #2 present, said food in the freezer has been soft, this has been going on and that the temperatures in the Dietary Temperature Sheet do match-up with the temperatures he has seen.</p> <p>On 4/28/25 at 11:07 A.M., the Administrator and Food Service Director were not available for interview. The Surveyor asked the Director of Nursing (DON), who was identified as being the leadership for the facility, if she was aware that the walk-in freezer which was storing food was not keeping the food frozen. The DON said she was not aware. The DON and Assistant Director of Nursing (ADON) went to the kitchen and entered the walk-in freezer and said the food they touched was soft, defrosted and not frozen. The DON said a plan would need to be put in place.</p> <p>During an interview on 4/28/25 at 12:07 P.M., the Food Service Director (FSD) said he was not notified by staff that the walk-in freezer was not maintaining the frozen food frozen. The FSD said he was just told now when he got to the facility. The FSD said they are currently tossing out the food saying, 'when in doubt toss it (food) out'. The FSD said there have been issues with the freezer and he believed they were resolved. The FSD said the Maintenance Director has been monitoring the freezer daily. The FSD said no one had directly told him that the food was soft and not solid, and staff should have made him aware of any concerns. The FSD said he would expect frozen food to be solid to touch.</p> <p>During an observation and interview on 4/28/25 at 12:35 P.M., the FSD and surveyor observed the walk-in freezer, including a large entr&amp;eacute;e pan which was soft to touch. The FSD said large food items like the entr&amp;eacute;e would not be that soft in a short time and it would take one or two days of above freezing to defrost.</p> <p>2. Review of a poster in the kitchen, next to the walk-in refrigerator indicated the following:</p> <p>Proper Food Labeling. Food that has been removed from the original container or has been prepared must be labeled for easy identification. Clearly marked labels allow for easy use-by date identification.</p> <p>On 4/28/25 at 7:25 A.M., the following was observed in the main kitchen:</p> <p>The Dry Storage room:</p> <ul style="list-style-type: none"> <li>-A large plastic bag of split peas, not dated when opened and tied in a knot.</li> <li>-A box of taco shells, with the bag inside revealing taco shells open to air, not secured and not dated as to when the taco shells were opened.</li> <li>-A large open bag of jasmine rice not dated when opened and secured with a knotted bag.</li> <li>-A open bag of shell pasta with the plastic bag knotted and not dated.</li> </ul> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Benjamin Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  120 Fisher Avenue Boston, MA 02120	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-A plastic wrapped opened bag labeled cheese sauce mix, with a best by date of 'SEP 2024' (September)</p> <p>-A bottle of [NAME] Food coloring, covered with dust with a faded lable date of 3/15/17.</p> <p>-An unidentified food product in an open bag with no label or date.</p> <p>During an observation and interview on 4/29/25 at 9:13 A.M., the Registered Dietician (RD) and surveyor observed the Dry Storage room:</p> <p>-Two boxes of corn meal, one opened the other not opened with a best by date of SEP (September) 24.</p> <p>-Two bags of pasta, not in box with delivery date, that were open, tied in a knot and did not have an open date.</p> <p>During an interview at the time of this observation, the RD said all food items should be labeled with the date it was opened, that food should be stored securely, and food should not be expired.</p> <p>3. During an observation of the meal distribution line on 4/29/25 at 11:41 A.M., the surveyor observed the following:</p> <p>Cook #1 wearing gloves on both hands was touching ready to eat bread directly, then touched his clothing with his gloved hands. [NAME] #1 removed the gloves, did not wash his hands, went and picked up a spatula, then placed gloves on both hands and touched the knob of the oven and touched the oven's surface. [NAME] #1 used his potentially contaminated gloves and touched grilled cheese sandwiches directly and placed them in wax bags. [NAME] #1 then touched the fry pan handle where the grilled cheese was being cooked and then touched three more grilled cheese sandwiches. [NAME] #1 reached into a box of wax bags, removed a few bags and touched the grilled cheese sandwiches directly and placed them in the bag. [NAME] #1 then touched the door to the food steamer appliance, walked the length of the serving table then picked up several serving utensils.</p> <p>At 11:50 A.M., two Diet Aids took turns to wash their hands in the hand washing sink. Both were observed to use their washed hands to turn off the water and in doing so potentially contaminating their hands, before pulling paper towels to dry their hands.</p> <p>During an interview on 4/29/25 at 3:22 P.M., the FSD said he saw [NAME] #1 handling food and did not know he did not wash his hands prior to placing the gloves on. The FSD said hand washing is required prior to putting on and taking off gloves. The FSD said if gloves are used to touch food directly, they should not be in contact with other surfaces, other items and should be changed between tasks. The FSD said he expects the staff to provide proper hand washing.</p> <p>4. During an observation and interview on 4/29/25 at 2:27 P.M., of the dish machine (a dish machine is designed to handle a high volume of dishes. A low temperature dish machine model uses chemicals to sanitize and to kill bacteria or harmful microorganisms). The FSD ran the dish machine with a rack. Diet Aid #1 said they test the dish machine three times a day. Diet Aide showed the surveyor the test strips he used, and both bottles of test strips were expired. One expired February 2024 and the other February 2025. Diet Aid #1 said these test strip bottles are what he has been using every day.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the document not dated of the manufacturer's Installation Instructions provided by the FSD for the dish machine indicated:</p> <p>-The black or gray cam controls sanitizer. The sanitizer cam is adjustable. Set sanitizer concentrations to 50 parts per million (notice do not exceed 100 PPM'S (parts per million)). Monitor chlorine levels by using chlorine test strips.</p> <p>On 4/29/25 at 2:42 P.M., the FSD said staff monitor the dish machine by using test strips to ensure the sanitizer is at 50 PPM. The FSD he was not aware the staff was using expired test strips and that because the test strips are expired, they may not have the same effect to measure the sanitation process.</p> <p>5. During an observation on 4/29/25 at 11:41 A.M., a Diet Aid was observed to remove a rag from a red bucket of liquid and use it to wipe down a cart used for transporting kitchen items and then returned the rag to the red bucket.</p> <p>During an observation and interview on 4/29/25 at 2:47 P.M., the FSD said they clean and sanitize the kitchen with a solution which is a calibrated mix, which is at the three-bay sink. The FSD said they do not fill the sink and use the premix solution to fill the red buckets. The FSD said the staff are not monitoring the solution in the red buckets. The FSD said there is no control or nothing to demonstrate the sanitizer is at the correct level to ensure it is properly sanitizing the kitchen.</p> <p>During the survey the Administrator was not available for interview and the Director of Nursing was identified as being in charge.</p> <p>During an interview on 4/29/25 at 3:47 P.M. the Director of Nursing said proper hand washing and food handling should be followed by staff.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. Resident #65 was admitted to the facility in January 2025 with diagnoses that include type 2 diabetes mellitus, dementia and failure to thrive.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE], indicated Resident #65 was unable to complete the Brief Interview for Mental Status (BIMS) and the staff assessed his/her to have severe cognitive impairment. The MDS also indicated Resident #65 is dependent on staff for daily care activities including bathing, dressing and eating. Further review of the MDS indicated Resident #65 as being 66 inches in height and weighing 114 pounds and has the nutritional approach of a feeding tube with the percentage of intake by artificial route as 51% or more.</p> <p>During an interview on 4/29/25 at 9:39 A.M., Certified Nursing Assistant (CNA) #3 said Resident #65 used to receive meal trays but he/she no longer eats or takes anything by mouth.</p> <p>During an interview on 4/29/25 at 4:24 P.M., Nurse #7 said when Resident #65 was admitted he/she had an order for puree food and enteral feeding. Nurse #7 said Resident #65 began to refuse to eat and did not eat much of anything, so the Nurse Practitioner gave an order for Resident #65 to be NPO (nothing by mouth).</p> <p>Review of Resident #65's medical record indicated a physician's order, dated 3/13/25, NPO every shift.</p> <p>Review of the Medication Administration Record (MAR) dated March 3/13/25 through 3/31/25 indicated nursing staff documented by a check mark that the Diabetic Snack at Bedtime was administered.</p> <p>Review of the MAR dated 4/1/25 through 4/28/25 indicated nursing staff documented by a check mark that the Diabetic Snack at Bedtime was administered.</p> <p>During an interview on 4/29/25 at 4:28 P.M., Nurse #7 said Resident #65 is NPO and said the order for the diabetic snack at bedtime should have been discontinued when the Resident became NPO. Nurse #7 reviewed the MAR and said the nursing staff checked that the diabetic snack was provided.</p> <p>During an interview on 4/30/25 at 10:31 A.M., the Director of Nursing (DON) said the nurses should be aware of the orders they are signing off as administered and should not have signed that the diabetic snack was administered to Resident #65 who is NPO.</p> <p>Based on observations, record review and interviews, the facility failed to ensure medical records were maintained accurately for Residents (#184, #65, #5, #59 and #79) out of a total sample of 24 residents. Specifically,</p> <ol style="list-style-type: none"> <li>1. For Resident #134, the facility failed to accurately document the completion of physician orders;</li> <li>2. For Resident #65, who had a physician's order dated 3/13/25 to be NPO (nothing by mouth) the facility documented that Resident #65 was administered a diabetic snack at bedtime.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. For Resident #5, the facility documented the Resident received a dietary supplement with all meals when they did not.</p> <p>4. For Resident #59, the facility failed to follow physician's order for correct oxygen setting and for documenting use of oxygen.</p> <p>5. For Resident #79, the facility failed to follow physician's order for correct oxygen setting and for documenting use of oxygen.</p> <p>Findings include:</p> <p>1. Resident #184 was admitted to the facility in April 2025 with diagnoses including diabetes with polyneuropathy, edema and weakness.</p> <p>Review of Resident #184's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status score of 2 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated the Resident is dependent on staff for mobility tasks.</p> <p>On 4/29/25 at 1:07 P.M., Resident #184 was observed out of bed sitting in his/her wheelchair. The Resident was not wearing bilateral compression stockings.</p> <p>On 4/29/25 at 5:15 P.M., Resident #184 was observed lying in bed and was not wearing compression stockings.</p> <p>Review of Resident #184's physician orders indicated the following order:</p> <p>-Apply compression stockings knee length (to) bilateral legs in the morning (for) edema, initiated on 4/9/25.</p> <p>Review of Resident #184's Treatment Administration Record for April 2025 indicated nursing inaccurately marked this order as complete on 4/29/25.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said she expects all orders to be followed as written by the physician and nurses should not be marking orders as complete if not actually completed.</p> <p>3. Resident #5 admitted to the facility in August 2010 with diagnoses that included hypertension, diverticulosis of the large intestine, anemia, unspecified convulsions, and major depressive disorder.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 3/15/25, indicated the Resident was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #95 is dependent for all self-care activities and requires supervision/touching assistance for self-feeding.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/29/25 at 8:47 A.M., 8:53 A.M., 9:02 A.M. and 12:27 P.M., and 4/30/25 at 8:46 A.M., 8:52 A.M., and 9:04 A.M., Resident #5 was observed eating his/her meal. There were no nutritional supplements observed on his/her meal tray.</p> <p>Review of physician's order dated 12/12/24 indicated the following:</p> <p>-Ensure Plus, three times a day 237mlb/wmeals [sic].</p> <p>Review of Resident #5's Medication Administration Record (MAR) indicated that nursing on 4/29/25 for breakfast and lunch and on 4/30/25 at breakfast, the Resident received his/her Ensure Plus with their meal, contrary to direct observation.</p> <p>Review of Resident #5's medical record failed to indicate he/she refused Ensure Plus supplements with his/her meals.</p> <p>During an interview on 4/30/25 at 9:15 A.M., Nurse #2 said supplements do not come up from the kitchen on the Resident's meal tray, it is provided by the nurse. Nurse #2 and the surveyor reviewed the physician's order and Nurse #2 confirmed Resident #5 should be receiving an Ensure Plus supplement with all his/her meals per the physician's order.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing said she expects all orders to be followed as written by the physician and nurses should not be marking orders as complete if not actually completed.</p> <p>4. Resident #59 was admitted to the facility in July 2023 with diagnoses including rheumatoid arthritis and dependence on oxygen.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 1/8/25, indicated that Resident #59 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 2 out of 15. The MDS also indicated that Resident used oxygen.</p> <p>On 4/28/25 at 8:01 A.M., 4/29/25 at 8:02 A.M., and 4/30/25 at 8:23 A.M., the surveyor observed Resident #59 wearing oxygen set at 4 liters.</p> <p>Review of Resident #59's physician order, dated 4/8/25, indicated oxygen at 2 litres as needed via nasal cannula for dyspnea to keep O2 saturation (sats) above 92% every 8 hours as needed for shortness of breath related to dependence on supplemental oxygen.</p> <p>Review of Resident #59's physician progress note, dated 4/8/25, indicated Resident was oxygen dependent.</p> <p>Review of Resident #59's nursing progress notes, dated 4/1/25- 4/29/25, indicated that Resident is on oxygen 2 liters via nasal cannula.</p> <p>Review of Resident #59's Medication Administration Record (MAR) for April 2025, failed to indicate that Resident #59 used oxygen.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/30/25 at 11:27 A.M., Nurse #4 said that oxygen should be set according to the physician's orders and should be documented when used.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing (DON) said that oxygen should be provided accorded to physician's orders and should be documented on MAR and nurses notes when used.</p> <p>5. Resident #79 was admitted to the facility in December 2024 with diagnoses that including acute respiratory failure with hypoxia and chronic diastolic heart failure.</p> <p>Review of Resident #79's most recent Minimum Data Set (MDS) Assessment, dated 3/8/25, indicated a Brief Interview for Mental Status (BIMS) score of 8 out of a possible 15, indicating that the Resident had moderate cognitive impairment. The MDS further indicated that the Resident used oxygen.</p> <p>On 4/28/25 at 8:29 A.M., 4/29/25 at 8:06 A.M., and 4/30/25 at 8:18 A.M., the surveyor observed Resident #79 wearing oxygen set at 3 liters.</p> <p>Review of Resident #79's physician order, dated 12/7/24, indicated oxygen at 2 liters via nasal cannula as needed for O2 less than 90% on room air as needed every 6 hours as needed for shortness of breath.</p> <p>Review of Resident #79's physician progress note, dated 4/25/25, indicated Resident remains oxygen dependent.</p> <p>Review of Resident #79's nurses progress notes, dated from 4/1/25-4/29/25, indicated Resident continued on 2 liters of oxygen.</p> <p>Review of Resident #79's MAR for April 2025 failed to indicate that Resident used oxygen.</p> <p>During an interview on 4/30/25 at 11:27 A.M., Nurse #4 said that oxygen should be set according to the physician's orders and should be documented when used.</p> <p>During an interview on 4/30/25 at 10:58 A.M., the Director of Nursing (DON) said that oxygen should be provided accorded to physician's orders and should be documented on MAR and nursing notes when used.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations and interview the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . Specifically,</p> <ol style="list-style-type: none"> <li>1. The facility failed to maintain Enhanced Barrier Precautions (EBP) while performing wound care on a resident.</li> <li>2. For Resident #60, the facility failed to implement EBP for a resident with an open wound.</li> <li>3. The facility failed to provide documentation of measures to prevent the growth of Legionella (can grow in building water systems, particularly in warm, stagnant water and can cause a severe form of pneumonia -Legionnaires' disease) and other opportunistic waterborne pathogens in building water systems.</li> </ol> <p>Findings include:</p> <p>Review of the Centers for Disease Control (CDC) website indicated the following, dated June 28, 2024:</p> <ul style="list-style-type: none"> <li>-Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).</li> </ul> <p>Review of the CDC recommends guidelines for water management in nursing homes, dated October 24, 2024:</p> <ul style="list-style-type: none"> <li>-Maintain water temperatures outside the ideal range for Legionella growth.</li> <li>-Prevent water stagnation.</li> <li>-Ensure adequate disinfection.</li> <li>-Monitor water quality.</li> <li>-Develop and implement comprehensive water management programs to reduce the risk of Legionella growth and transmission.</li> </ul> <p>1. On 4/29/25 at 11:38 A.M., the surveyor observed a nurse on the 2 [NAME] Unit entering a resident's room to perform a dressing change on a resident with a wound. On the doorway of the resident room was a sign that indicated Enhanced Barrier Precautions were necessary in the room. The nurse entered the room and put on gloves but failed to put on a gown. Outside of the room was a drawer with gowns and gloves stocked in it. She exited the room to retrieve scissors, and upon reentering the room, again failed to put on a gown.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/29/25 at 11:50 A.M., Nurse #6 said that residents who have foley catheters, an ostomy or a wound would require the use of Enhanced Barrier Precautions. Nurse #6 said that she just did a wound treatment on the resident and that she did not wear a gown, but that she should have.</p> <p>During an interview on 4/30/25 at 9:36 A.M., the Director of Nurses said that any resident with a wound would require the use of Enhanced Barrier Precautions and if changing a dressing, then a gown and gloves should be worn.</p> <p>2. Resident #60 was re-admitted to the facility in April 2025 with diagnoses including left femur fracture, lower back pressure wound, and diabetes.</p> <p>On 4/28/25, 4/29/25, and 4/30/25 the facility failed to implement any signage to inform staff of the need to use EBP when providing high-contact care activities to Resident #60.</p> <p>On 4/29/25 at 12:18 P.M., the surveyor observed Nurse #3 entering the room to perform a dressing change on a resident with a wound. There was not sign on the doorway to indicate EBP were necessary in the room. Nurse #3 entered to room and put on gloves, but failed to put on a gown.</p> <p>During an interview on 4/29/25 at 12:25 P.M., Nurse #3 said that residents who have a wound would require the use of Enhanced Barrier Precautions. Nurse #3 said that EBP should have been implemented for that room and she should have worn a gown when providing wound care, but did not.</p> <p>During an interview on 4/30/25 at 9:36 A.M., the Director of Nurses said that any resident with a wound would require the use of Enhanced Barrier Precautions and if changing a dressing, then a gown and gloves should be worn.</p> <p>3. During an interview on 4/30/25 at 1:30 P.M., the Maintenance Director was unable to provide a water management plan with measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems.</p> <p>During an interview on 4/30/25 at 12:05 P.M., the Infection Control Nurse was unable to provide a water management plan with measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems.</p>		