STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225663	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Concord	57 Old Road to Nine Acre Corner W Concord, MA 01742

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 15203 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had severe cognitive impairment, the Facility failed to ensure staff implemented and followed their Abuse Policy when on 04/08/25, after Nurse #1 witnessed an incident of alleged physical abuse of the resident by staff member, Nurse #1 left Resident #1 and the accused staff member (Certified Nurse Aide (CNA) #1) alone together and did not immediately separate them. Findings include: Review of the Facility's Abuse Policy titled Recognizing Signs and Symptoms of Abuse, dated as revised April 2021, indicated all types of resident abuse are strictly prohibited and personnel are expected to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services immediately. Review of the Facility's Policy titled Protection of Residents During Abuse Investigations, dated as revised April 2021, indicated residents are protected from harm, retaliation, reprisal, discrimination or coercion during investigations of abuse, neglect, exploitation and misappropriation of resident property. The Policy indicated that if the alleged perpetrator is an employee or staff member, the individual is immediately reassigned to duties that do not involve resident contact or are suspended until the findings of the investigation are reviewed by the administrator. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 04/08/25, indicated that on 4/08/25 at approximately 11:15 A.M., the Nurse Manager reported to the Director of Nursing that Nurse #1 perceived that CNA #1 slapped the left side of Resident #1's face with an open hand. Review of the Facility's Internal Investigation Summary Report, undated, indicated that after witnessing CNA #1 slap Resident #1, Nurse #1 left Resident #1's room without saying anything. During a telephone interview on 05/05/25 at 2:05 P.M., Nurse #1 said that on 04/08/25 at approximately 11:15 A.M., she entered Resident #1's room looking for his/her roommate and when she opened the door, she saw CNA #1 slap the left side of Resident #1's face with her right hand. Nurse #1 said she was shocked and immediately exited the room leaving Resident #1 and CNA #1 alone in the room. Nurse #1 said she went to the Nurse Manager and reported the incident that she witnessed. Nurse #1 said that when she and the Nurse Manager returned to Resident #1's bedroom door, Resident #1 was already ambulating out of the room on his/her own. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	225663	A. Building B. Wing	05/05/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/05/25 at 11:30 A.M., the Director of Nursing (DON) said that on 4/08/25, Nurse #1 reported that she saw CNA #1 slap Resident #1 and initiated an internal investigation. The DON said when interviewing Nurse #1 about the incident she witnessed, Nurse #1 told her that she left CNA #1 alone in the room with Resident #1 after she witnessed the slap in order to go and speak with the Nurse Manager. The DON said Nurse #1 should have intervened, stayed with Resident #1 and asked CNA #1 to leave Resident #1's room after witnessing abuse. The Director of Nursing said that Nurse #1 was suspended as a result of her failure to intervene and received education before returning to work. On 5/05/25 the Facility was found to be in past non-compliance. The Facility provided the Surveyor with a plan of correction which addressed the concern as evidenced by: A. On 4/08/25, Nurse #1 and CNA #1 were suspended pending the outcome of the Facility's Internal Investigation of the allegation. B. The Director of Nursing conducted Skin and Pain Assessments for Resident #1 on 4/08/25 and reviewed and updated interventions on his/her ADL deficit care plan. C. The Social Worker met with Resident #1 on 4/09/25 to offer support and assess for change in mood/behavior. D. Starting on 4/08/25 and on-going, the Facility Director of Education or designee trained all staff on the expectations of when to report abuse and steps to assure resident safety. E. On 4/09/25, the Facility Social Worker/designee initiated interviews of all Facility residents regarding staff treatment and comfort/safety in the Facility. F. On 4/11/25, the Director of Nursing/designee initiated interviews of all staff members regarding observations of staff treatment of residents, including response to incidents/allegations. G. Starting 4/11/25, the Director of Nursing/designee conducted audits with ten staff members weekly for three weeks and subsequently monthly for two additional months, of their understanding of the Facility Abuse Policies and Procedures. H. The Quality Assurance Committee reviewed the Facility Performance Improvement Plan on 4/08/25 and will review progress during the July 2025 meeting. I. The Administrator and/or designee are responsible for overall compliance.