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	01/08/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to accurately document in the medical record for two Residents (#6 and #10) out of 26 total sampled residents. Specifically:1.) For Resident #6, the nurse inaccurately documented a wound dressing change was completed multiple times when it was not.2.) For Resident #10, the nurses inaccurately documented a topical medication was applied multiple times when it was not.Findings include:Review of the facility policy titled 'Charting and Documentation', revised July 2017, indicated: -Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 1.) Resident #6 was admitted to the facility in December 2025 with diagnoses including heart failure and peripheral vascular disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/15/25, indicated Resident #6 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. This MDS also indicated Resident #6 had two stage three pressure ulcers and one stage four pressure ulcer. During an interview on 1/6/26 at 7:53 A.M., Resident #6 was unable to provide the surveyor information regarding his/her left buttock wound. On 1/7/26 at 11:27 A.M., The Assistant Director of Nursing (ADON) said she had been responsible for assessing Resident #6's left buttock wound every week. The ADON said Resident #6 used to have a wound on his/her left buttock, but it had healed in December. The surveyor observed Resident #6's left buttock with the ADON. There was no wound on Resident #6's left buttock. The ADON showed the surveyor the healed, discolored skin and said this was where the left buttock wound had been located but it healed on 12/29/25. There was no dressing located on this area on the left buttock during this observation. Review of Resident #6's active physician's order, initiated 12/11/25, indicated: -LEFT BUTTOCK: NORMAL SALINE CLEANSE/PAT DRY APPLY CALCIUM ALGINATE F/B BORDER FOAM DRESSING every day shift every 2 day(s), initiated 12/11/25. Review of Resident #6's Treatment Administration Record (TAR), dated 12/30/25 to 1/7/26, indicated the physician's order for LEFT BUTTOCK: NORMAL SALINE CLEANSE/PAT DRY APPLY CALCIUM ALGINATE F/B BORDER FOAM DRESSING was documented as completed by Nurse #1 with (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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the following wound description of the left buttock: -12/31/25: left buttock dressing change completed, and Nurse #1 noted scant serous (a clear fluid which leaks out of wounds) drainage. -1/2/26: left buttock dressing change completed, and Nurse #1 noted scant serous drainage. -1/4/26: left buttock dressing change completed, and Nurse #1 noted scant serous drainage. -1/6/26: left buttock dressing change completed, and Nurse #1 noted scant serous drainage. Review of Resident #6's assessment titled 'Pressure Injury Record', completed by Assistant Director of Nursing, dated 12/8/25 to 12/29/25, indicated -left buttock pressure ulcer resolved on 12/29/25. During an interview on 1/7/26 at 12:16 P.M., the ADON said Nurse #1 should not have documented a dressing being applied because the left buttock pressure ulcer was healed. The ADON further said the physician's order for the wound treatment to Resident #6's left buttock should have been discontinued but wasn't. During an interview on 1/7/26 at 12:40 P.M., Nurse #1 said Resident #6's left buttock pressure ulcer had been healed since 12/29/25. Nurse #1 said there was no drainage. Nurse #1 said she did not apply any wound dressing to Resident #6's left buttock wound since it healed and should not have documented that she did. Nurse #1 said her documentation on the TAR indicating that Resident #6's left buttock wound dressing change had been completed and noting the presence of scant serous drainage was inaccurate. During an interview on 1/7/26 at 1:07 P.M., the Director of Nursing (DON) said the nurse should not have documented a dressing change was completed or that drainage was present if it was not. 2. Resident #10 was admitted to the facility in December 2025 with diagnoses including acquired absence of right leg below knee and muscle weakness. Review of Resident #10's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored 12 out of 15 on the Brief Interview for Mental Status indicating he/she was moderately cognitively impaired. The MDS further indicated the Resident required maximum assistance with activities of daily living. On 1/6/26 at 10:29 A.M., the surveyor observed Resident #10 sitting in his/her room, the Resident had a right prosthetic leg. Review of Resident #10's current physician order dated 12/7/25, indicated the following: -Skin prep to bilateral heels every day and evening shift. Review of Resident #10's Treatment Administration Record (TAR), dated 12/7/25 to 1/7/26 indicated the nurses had signed off the treatment of skin prep had been applied to bilateral heels twice a day. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/8/26 at 8:46 A.M., Nurse #1 said the Resident had a right below knee amputation and the application of skin prep to right heel was documented in error. During an interview on 1/8/26 at 8:54 A.M., Nursing supervisor #1 said documentation of skin prep to right heel was inaccurate as the Resident does not have a right heel. During an interview on 1/8/26 at 9:42 A.M., the Director of Nursing said if the nurses documented that skin prep was applied to the Resident's right heel that was inaccurate documentation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal laws. Specifically, the facility failed to ensure medications were stored in the original, labeled containers when two nurses stored multiple pre-poured medications in uncovered, unlabeled medication cups within the medication carts.Findings include:Review of the facility policy titled 'Medication Labeling and Storage', revised February 2023, indicated:-Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. -Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. Medications are labeled accordingly.-Controlled substances and other drugs subject to abuse are separately locked in permanently affixed compartments. On 1/7/26 at 8:25 A.M., the surveyor observed the Dove Unit medication cart with Nurse #2 which contained three uncovered and unlabeled medication cups containing pre-poured medications. Nurse #2 said she pre-poured these medications, even though she had not attempted to administer them to the residents. Nurse #2 said she pre-poured the medications so they would be ready when it was time to administer them later. Nurse #2 said the following were in each uncovered, unlabeled medication cup:-In the first medication cup, there was an ativan pill (a controlled substance) mixed with various other pills melting in applesauce, making it difficult to identify the pills. This was not in a separately locked compartment.-In the second cup, there was another ativan pill melting in apple sauce, making it difficult to identify the pill. Nurse #2 said this was for a different resident. This was not in a separately locked compartment.-In the third cup, there was a pink liquid medication. Nurse #2 said this was poured earlier because it's supposed to be refrigerated so she gets it early so it's in her cart when she needs it.Nurse #2 said she knew she shouldn't have pre-poured medications in advance because it was against the law. On 1/7/26 at 1:17 P.M., the surveyor observed the Cardinal Unit medication cart #1 with Nurse #3 which contained one uncovered and unlabeled medication cup containing four pills. Nurse #3 said she prepared the medications earlier in the shift, but the resident was not ready to take the medications, so she saved them to administer later. Nurse #3 said she should have discarded them because they shouldn't be stored this way in the medication cart but did not. During an interview on 1/7/26 at 1:30 P.M., the Director of Nursing (DON) said she would expect the nurses to follow their medication storage policy regarding how to store medications in the medication cart.