STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225680	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alliance Health at Marina Bay	2 Seaport Drive Quincy, MA 02171

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on record review, observation, and interviews, the facility failed to maintain acceptable parameters of nutritional status for one Resident (#131) with an unplanned weight loss, out of a total sample of 30 residents. Specifically, the facility failed for Resident #131 to implement dietary recommendations/interventions after weight loss had been identified, and he/she continued to lose weight. Findings include: Review of the facility's policy titled Consultant Dietician, dated as last revised 11/1/2021, indicated but was not limited to the following:-The consultant Dietician has weekly regular hours of sufficient duration to provide consultation to staff regarding Residents' dietary needs and assistance with the revision and implementation of Nutritional Policies and Procedures.-The Registered Dietician (RD) will provide a comprehensive report to the Executive Director and the Director of Nurses (DON) following each visit. Resident #131 was admitted to the facility in September 2024 with diagnoses which included B-cell lymphoma and diabetes mellitus. Review of the Minimum Data Set (MDS) Assessment, dated 7/17/25, indicated Resident #131 scored 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had severe cognitive impairment. Additionally, the MDS indicated unknown/no for weight loss of 5% or 10% in the last six months. During an interview on 9/26/25 at 10:00 A.M., Resident #131's daughter said Resident #131 had been losing weight, was not eating, and needed assistance with feeding. She said he/she did not eat breakfast again today, and she requested staff help with feeding every meal as he/she is not eating and has difficulty with the utensils. On 10/1/25 at 9:15 A.M., the surveyor observed Resident #131 lying in bed asleep with a breakfast tray in front of them, uncovered, with food untouched, no staff was present offering assistance. Review of the Physician's Orders and Medication Administration Record (MAR) indicated but was not limited to the following:-No Added Salt (NAS), Diabetic (HCC) regular with thin liquid at Breakfast, Lunch, and Dinner (9/26/24) Review of the medical record indicated gradual weight loss over the last year. Specifically, the weight record indicated:-10/2/24: 186.6 pounds (lbs.)-3/31/25: 161.6 lbs. (down 13.4% in 6 months)-9/30/25: 150.5 lbs. (down another 7.18% in 6 months and 19.35% in 12 months) Review of the Dietary progress notes indicated but were not limited to the following:-4/30/25: late entry for week prior: significant weight loss since admission, could liberalize diet some, could offer Mighty Shake (calorie and protein fortified shake) once a day at supper.-8/16/25: weight loss 5.5% in six months, continues HCC, NAS Diet, does not like meals, agreed to have Magic Cup (calorie and protein fortified ice cream) two times daily, recommend Multivitamin with Mineral for overall health and Magic Cup twice a day.-9/24/25: Weight trending down again, 151 lbs. this week, would liberalize diet and could offer Glucerna (Diabetic fortified drink) supplement between meals.-9/30/25: 6.7% weight loss in six months, Recommend liberalizing diet to House related to slow weight loss and desire to eat, notified kitchen. Recommend Multivitamin with Minerals and add magic cup twice daily. Review of the Diet order failed to indicate the diet had been liberalized. Review of the Diet and Physician's orders failed to indicate Mighty Shake, Magic Cup, Multivitamin with Minerals, or Glucerna had been ordered/implemented. Review of the nursing and physician progress notes failed to indicate the RD recommendations had been reviewed and declined by the physician. During an interview on 10/2/25 at 11:53 A.M., Nurse #7 said dietary recommendations should be in the paper medical record. He said the RD writes and flags (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	them for the nurse to get approved by the physician. He said there were not any dietary orders/recommendations since January 2025 in his/her record. During an interview on 10/2/25 at 12:52 P.M., Unit Manager #4 said the RD emails recommendations and then nursing writes the orders. She said she doesn't always get the email, the reports are not consistent, and communication is difficult. She said the previous RD would write the orders, flag them in the medical record, and then the nurse would get the order approved by the physician. She said now there are three or four RDs and it is confusing. She said when she does get the email, they are long, as it is for the entire building. She said she did not have an email to correlate with the 4/30/25, 8/16/25, or the 9/24/25 RD notes. She said she found one from 4/23/25 and one from 10/1/25 that referenced Resident #131. Review of the 4/23/25 RD email with recommendations indicated a recommendation to discontinue current diet and start HCC, No Salt Packet. Review of the medical record including physician orders/MAR and progress notes failed to indicate the Diet change had been implemented or that the physician declined the recommendation. During an interview on 10/2/25 at 12:52 P.M., Unit Manager #4 said she did not have an email dated 4/30/25 regarding the Mighty Shake, dated 8/16/25 regarding the Magic Cup and Multivitamin, or dated 9/24/25 regarding liberalizing the diet or the Glucerna. Additionally, she said she had not read the 10/1/25 email yet. Review of the 10/1/25 RD email with recommendations indicated a recommendation to liberalize Diet to House, patient not eating. Orders need updated: Magic Cup is on order list please. Please visit Resident #131, does not like meals, please see to help with menu choices. The 10/1/25 RD email failed to include the repeated recommendation for a Multivitamin with Minerals as noted in the RD progress notes dated 8/16/25 and 9/30/25. Review of the medical record including physician orders and progress notes failed to indicate the Diet change, the Magic Cup, or Multivitamin with Minerals had been implemented or that the physician declined the recommendations. During an interview on 10/2/25 at 2:38 P.M., the DON said the RD emails the recommendations for the Unit Manager to write the orders. She said the system is confusing as they get so many emails and it clearly is not working if the recommendations made in the progress note do not match the email and the recommendations are getting missed and not ordered. During an interview on 10/2/25 at 3:18 P.M., RD #1 said at the end of every day they (the RDs) send an email report with all the findings, recommendations, and tray card changes. She said the report has information from the visits and eval/assessments done that day. She said the report is not generated from the eval/assessment or their progress note. She said they must type it all again. The surveyor reviewed the RD progress notes and emails with RD #1. RD #1 said the 4/30/25 email should have had the Mighty Shakes on it, and it did not. She said she had an email from 8/16/25, but those recommendations were never implemented, and they did not match what was written in the progress note. RD #1 said the 9/24/25 progress note indicated the same August recommendations were again repeated. She was unable to provide an email regarding this visit and said she should have caught the fact the recommendations were being repeated and had not been implemented. She said the diet change and Magic Cup recommendations were repeated on 9/30/25, are in the 10/1/25 email, but have not been done yet, but the Multivitamin recommendation was not included in the email. She said there must be a better system to communicate recommendations because we are missing things from the notes to the emails, and the orders are not getting implemented from the emails.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, records reviewed, and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5% when two out of three nurses observed during a medication pass made five errors out of 27 opportunities, resulting in a medication error rate of 18.52%. Specifically,1. For Resident #161, Nurse #3 prepared his/her medications, failed to identify the Resident and attempted to administer the medications to Resident #162; and,2. For Resident #93, failed to administer the correct does of Calcium plus Vitamin D; and3. For Resident #143, failed to administer the correct form of Vitamin B.Findings include:Review of the facility's policy titled Medication Administration-General Guidelines, last revised 1/2024, indicated but was not limited to:-Medications are administered as prescribed in accordance with good nursing principles and practices.-Five Rights- Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered.-A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: -When the medication is selected; -When the dose if removed from the container; and finally, -Just after the dose is prepared and the medication is put away.-Medications are administered in accordance with written orders of the prescriber.-Residents are identified before medication is administered using two methods of identification. Methods of identification include:-Checking photograph attached to medical record.-Calling resident by name (except in residents with cognitive impairment).-Having the resident verify his/her last name.-If necessary, verifying resident identification with other facility personnel.Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated but was not limited to the following:Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers.1. On 9/30/25 at 9:39 A.M., the surveyor observed Nurse #3 prepare the following medications for Resident #161:-Multivitamin 1 tablet-Vitamin D3 25 micrograms (mcg) 1 tablet-Metoprolol Succinate (used to treat high blood pressure) 25 milligrams (mg) 1 tabletNurse #3 entered Resident #161's room went over to Resident #162's bed and told him/her that he brought them their morning medications. Nurse #3 failed to check two forms of identification for Resident #162.Resident #162 asked Nurse #3 what medications they were receiving.Nurse #3 told Resident #162 he/she was receiving two vitamins and a blood pressure medication. Resident #162 asked Nurse if he/she was going to get their Haldol (an antipsychotic medication).Nurse #3 exited the room and reviewed the medications for Resident #161. He looked at the surveyor and said he did not see Haldol on their medication list.The surveyor asked Nurse #3 if he had intended to administer medication in the medication cup to Resident #162. Nurse #3 said yes, he was.The Surveyor asked Nurse #3 to verify whom he had prepared the medications for. He said he had prepared the medications for Resident #161.The surveyor asked Nurse #3 to verify the name of the Resident he had prepared the medications for again. The surveyor asked Nurse #3 to look at the name on the Medication Administration Record (MAR). Nurse #3 looked at the name on the MAR and asked the surveyor if he messed up. Nurse #3 then said he prepared the medications for Resident #161 not Resident #162.During a follow-up interview on 9/30/25 at 11:29 A.M., Nurse #3 said when administering medication, you must identify the resident who you are administering medication to. He said he had not verified the resident to whom he to attempted to administer medication to.During an interview on 9/30/25 at 11:42 A.M., the Director of Nursing (DON) said Nurse #3 should have followed the Five Rights when administering medications and should have used two identifiers to identify the correct resident.2. On 9/30/25 at 10:06 A.M., the surveyor observed Nurse #2 prepare and administer medications to Resident #143 including:-Vitamin B12 Complex (a supplement containing the eight essential B vitamins (B1-B12) that support energy metabolism, nerve function, and red blood cell production)Review of Resident #143's Physician's Orders indicated but was not limited to:-Vitamin B-12 (a vitamin used for keeping nerve and blood cells healthy, and for making DNA) 500 mcg, give (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one tablet daily, dated 9/16/25During an interview on 9/30/25 at 10:27 A.M., Nurse #2 reviewed Resident #143's physician's orders and said she had administered the wrong form of Vitamin B-12 to Resident #143 and should have verified the order prior to administering the medication.3. On 9/30/25 at 8:16 A.M., the surveyor observed Nurse #4 prepare and administer medications to Resident #93 including:-Calcium 600mg + Vitamin D3 10 mcg (400 units)Review of Resident #93's Physician's Orders indicated but was not limited to:-Calcium 600mg +Vitamin D3 5mcg (200 units), give 1 tablet twice daily, dated 9/19/25During an interview on 9/30/25 at 12:02 P.M., Nurse #4 said she had grabbed the wrong bottle this morning and should have verified the dose prior to administering the medication.During an interview on 9/30/25 at 11:42 A.M., the DON said when the nurses were preparing medications, they must follow the 5 Rights and verify that they were preparing and administering the correct medication and the correct dose of the medication.

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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. Based on record review and interview, the facility failed to implement written policies and procedures for an allegation of abuse for one Resident (#5), out of a total sample of 30 residents. Specifically, the facility failed to initiate their abuse policy after an allegation of abuse was documented and reported on 5/1/25. Findings include:Review of the facility's policy titled Abuse Prohibition, last revised 10/11/22, indicated but was not limited to:-The facility will provide an environment in which the resident is free from abuse, neglect, mistreatment, misappropriation of resident property, or exploitation, including but not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint that is not required to treat the resident's medical symptoms.-Identifying events, occurrences, patterns, and trends of potential abuse for residents.-Performing internal facility investigations of alleged violations and identification of staff members responsible for investigating incidents and the reporting of the same to proper authorities.-Protecting residents from harm during an investigation of alleged abuse.-Reporting of all alleged violations of resident abuse to appropriate state agencies utilizing the proper online reporting system with the simultaneous development of corrective actions determined as part of the internal facility investigation to prevent further occurrences of abuse.- It will be the facility's responsibility to identify, correct, and intervene in situations where Abuse, Mistreatment, Neglect, Exploitation, Harm, Willful Acts and/or Misappropriation of Resident Property occur.-The following require an incident report, supervisory follow-up and a comprehensive internal facility investigation which shall be performed with subsequent timely notification to the appropriate agencies as warranted.-Abuse/Potential Abuse -Willful infliction of injury (physical abuse) -Intimidation (Verbal Abuse)-Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, or assault and battery. This presumes that instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.-Willful: the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.-Verbal: Use of Oral, written, or gestured language that willfully includes derogatory terms to residents or their families.-Mental: includes humiliation.-Any incidents of actual suspected abuse must have an incident report completed in addition to the incident report the supervisory personnel are responsible to ensure that the internal investigation regarding the incident occurs timely and appropriate interventions are put into place to ensure resident safety or protect the resident from additional harm.-These interventions will include the obtaining of statements from witnesses of incidents, the outcome of the supervisory investigation and the timely notification of administrative personnel regarding the incident to ensure that a comprehensive internal facility investigation is completed in a timely fashion and appropriate staff interventions are included in the resident's comprehensive plan of care.-The executive director shall assume the overall responsibility to ensure that incident reports are accurately completed and personnel statements are obtained timely to ensure proper completion of the internal facility investigation. The executive director shall ensure that the appropriate agencies are notified in writing as warranted of abuse allegations in all investigatory findings by utilizing the state documentation tool. The initial report shall be submitted to the department immediately but not later than two hours after the allegation is made. A final report will be submitted to DPH within five business days of the incident. If alleged violation is verified, appropriate corrective action will be taken.-All alleged violations of incidents included within the definition of abuse, mistreatment, neglect, involuntary seclusion or misappropriation of resident property shall be reported to the Department of Public Health, Division of Health Care Quality upon receipt of the facility's report of basic findings. The facility must then begin an internal investigation of the incident. Resident #5 was admitted to the facility in March 2025 with diagnoses of cerebral infarction (stroke) and aphasia (a language disorder that can occur after a stroke, affects a person's ability to communicate, including speaking). Review (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the Minimum Data Set (MDS) assessment, dated 7/4/25, indicated Resident #5 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 5 out of 15, and was non-verbal but able to make himself/herself understood and he/she was able to understand others. Review of Resident #5's progress note, dated 5/1/25 at 2:10 P.M., written by Nurse #1, indicated but was not limited to:Witnessed on several occasions Resident's roommate being indirectly very verbally abusive to the Resident. Stating out loud when Resident requests to go back to bed that of course he/she does, he/she just wants to lay there like a lump and do nothing He/she just lays there and sh**s the [expletive] bed, and I have to sit here and smell it. His/her family member comes in and screws up the TV every time. He/she leaves the [expletive] TV on all night, and I can't sleep. Resident in ear shot with all of these comments with eyes bulging as if scared. I witnessed this behavior again today. Resident pointed at roommate and made a hand gesture as if talking then pointed at himself/herself. I asked him if his/her roommate was yelling at him. He/she nodded yes. When roommate was out of the room I spoke with Resident and acknowledged that these comments seemed to very much upset him/her. He/she nodded yes. Nurse #1 offered him/her if another room was available would he/she like to be moved. He/she wrote down on notepad I'd move. Nurse manager made aware and was trying to get in touch with the Health Care Proxy for approval. Review of the Health Care Facility Report System (HCFRS, a system used in Massachusetts by facilities to report suspected abuse/misappropriation) on 9/29/25 failed to indicate the facility reported the incident to the state agency. During an interview on 10/21/25 at 11:18 A.M., Nurse #1 said Resident #5 had a room change in May related to a roommate issue. Nurse #1 reviewed the note she had written on 5/1/25 and said Resident #142 had indirectly and directly verbally abused Resident #5. She said Resident #142 would get anxious and take their anxiety out on Resident #5. Nurse #1 said this was not the first time Resident #142 made comments to or about Resident #5. She said Resident #5 was alert and she could tell by his/her facial expressions that he/she would become scared and/or upset by Resident #142's comments. She said she would ask Resident #5 if he/she was scared or upset and he/she would nod yes. She said she reported the incident from 5/1/25 to the Director of Social Service and to the Unit Manager. During an interview on 10/1/25 at 11:28 A.M., the Director of Social Service said Resident #5 would communicate/answer questions by nodding or shaking their head to answer yes/not questions or would write down information on a pad of paper. He reviewed the note dated 5/1/25 and said in a situation like this where there was no immediate danger to the residents, the facility would offer the resident a room change which was made for Resident #5. He said Resident #5 was offered a room change because his/her roommate was being loud towards them. He said he followed up with Resident #5 after the room change and he/she said they were relieved because there would be no more yelling toward him/her. He said Resident #142 did not speak to Resident #5 like this every day but intermittently, it had only happened maybe two times prior to the 5/1/25 incident. He said any incident of abuse or alleged abuse needed to be reported to the Administrator or Director of Nursing and an investigation initiated. He said this incident would not be considered a resident-to-resident altercation because it had only happened intermittently and sometimes roommates just do not get along. He reviewed Resident #5's medical record and said he had not written a note regarding the incident that occurred on 5/1/25 but did write a note on 5/6/25 as follow-up to Resident #5 room change. Review of Resident #5's medical record indicated he/she had a room change on 5/2/25. During an interview on 10/1/25 at 11:46 A.M., the Administrator said any incidents of abuse or alleged abuse needed to be reported in HCFRS within two hours unless an investigation concluded that abuse had not occurred. She reviewed the note Nurse #1 wrote on 5/1/25 and said in an incident like this the facility would offer the Resident a room change and remove them from the situation. She said if the facility had thought the incident that occurred on 5/1/25 was considered abuse then it would have been reported in HCFRS, and investigation would have been initiated immediately. The surveyor asked the Administrator if this incident was considered abuse because Resident #5 was upset by the situation and was scared of Resident #142. She asked (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the surveyor to return later so she could follow up with the team. During a follow-up interview on 10/1/25 at 2:11 P.M., the Administrator said she followed up with the Director of Social Services and he was involved with the incident that day. She said the incident was discussed the next day in morning meeting. She said when the Director of Social Services followed up with Resident #5 after the incident he/she was in a pleasant and calm mood. She said she could not provide the surveyor with an investigation because the facility had not considered this incident as abuse, and the incident did not rise to the level of an investigation but if it had then the facility would have followed their policy. Review of Resident #5's medical record on 10/1/25 at 3:00 P.M., indicated the Director of Social Service had written a late entry note in Resident #5's medical record on 10/1/25 at 12:46 P.M, regarding the incident which occurred on 5/1/25. During an interview on 10/2/25 at 1:31 P.M., the Staff Development Coordinator said any incident of alleged abuse must be reported immediately and an investigation must be initiated to determine if the alleged abuse occurred or not. On 10/2/25 at 2:12 P.M., the Director of Nursing said the Director of Social Services spoke with Resident #5 and at that time Resident #5 said he was not afraid of Resident #142. She said Resident #142 was a nice person and had not threatened Resident #5. She said the facility started an investigation but determined abuse had not occurred when the Director of Social Services spoke to Resident #5. She said in the facility's mind the incident that occurred between Resident #5 and Resident #142 was not abuse. At the time of exit the facility did not provide the survey team with an investigation of the incident between Resident #5 and Resident #142. Refer to F609

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews, the facility failed to report an allegation of abuse to the state agency for one Resident (#5), out of a total sample of 30 residents.Findings include:Review of the facility's policy titled Abuse Prohibition, last revised 10/11/22, indicated but was not limited to:-Reporting of all alleged violations of resident abuse to appropriate state agencies utilizing the proper online reporting system with the simultaneous development of corrective actions determined as part of the internal facility investigation to prevent further occurrences of abuse.-The executive director shall assume the overall responsibility to ensure that incident reports are accurately completed and personnel statements are obtained timely to ensure proper completion of the internal facility investigation the executive director shall ensure that the appropriate agency agencies are notified in writing as warranted of abuse allegations in all investigatory findings by utilizing the state documentation tool the initial report shall be submitted to the department immediately but not later than two hours after the allegation is made a final report will be submitted to DPH within five business days of the incident if alleged violation is verified appropriate corrective action will be taken.-All alleged violations of incidents included within the definition of abuse, mistreatment, neglect, involuntary seclusion or misappropriation of resident property shall be reported to the Department of Public Health, Division of Health Care Quality upon receipt of the facility's report of basic findings. The facility must then begin an internal investigation of the incident. Resident #5 was admitted to the facility in March 2025 with diagnoses of cerebral infarction (stroke) and aphasia (a language disorder that can occur after a stroke, affects a person's ability to communicate, including speaking).Review of the Minimum Data Set (MDS) assessment, dated 7/4/25, indicated Resident #5 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 5 out of 15, and was non-verbal but able to make himself/herself understood and he/she was able to understand others.Review of Resident #5's progress note, dated 5/1/25 at 2:10 P.M., written by Nurse #1, indicated but was not limited to:Witnessed on several occasions Resident's roommate being indirectly very verbally abusive to the Resident. Stating out loud when Resident requests to go back to bed that of course he/she does, he/she just wants to lay there like a lump and do nothing He/she just lays there and sh**s the [expletive] bed, and I have to sit here and smell it. His/her family member comes in and screws up the TV every time. He/she leaves the [expletive] TV on all night, and I can't sleep. Resident in ear shot with all of these comments with eyes bulging as if scared. I witnessed this behavior again today. Resident pointed at roommate and made a hand gesture as if talking then pointed at himself/herself. I asked him if his/her roommate was yelling at him. He/she nodded yes. When roommate was out of the room I spoke with Resident and acknowledged that these comments seemed to very much upset him/her. He/she nodded yes. Nurse #1 offered him/her if another room was available would he/she like to be moved. He/she wrote down on notepad I'd move. Nurse manager made aware and was trying to get in touch with the Health Care Proxy for approval.Review of the Health Care Facility Reporting System (HCFRS-system used in Massachusetts by facilities to report suspected abuse/misappropriation) on 9/29/25, failed to indicate the facility submitted a report on 5/1/25 for an allegation of abuse.During an interview on 10/1/25 at 11:46 A.M., the Administrator said any incidents of abuse or alleged abuse needed to be reported in HCFRS within two hours unless an investigation concluded that abuse had not occurred. She said if the facility had thought the incident that occurred on 5/1/25 was considered abuse then it would have been reported in HCFRS, and investigation would have been initiated immediately. The surveyor asked the Administrator if this incident was considered abuse because Resident #5 was upset by the situation and was scared of Resident #142. She asked the surveyor to return later so she could follow up with the team.During a follow-up interview on 10/1/25 at 2:11 P.M., the Administrator said the incident from 5/1/25 was discussed the next day during morning meeting on 5/2/25 and the facility had not considered the incident as abuse and had not reported it in HCFRS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225680	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alliance Health at Marina Bay	2 Seaport Drive Quincy, MA 02171

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to develop and implement a person-centered care plan for the use of psychotropic medications for one Resident (#163), out of a total sample of 30 residents. Specifically, the facility failed for Resident #163 to ensure a care plan had been developed for the use of Ativan/Lorazepam (anti-anxiety medication), to monitor for adverse effects/side-effects of the medication, and to monitor for targeted behaviors. Findings include: Review of the facility's policy titled Comprehensive Person-Centered Care Planning, dated as last revised 9/22/22, indicated but was not limited to the following:-The facility is required to develop a comprehensive person-centered care plan for each resident that is consistent with resident rights and includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs.-Reviewed and revised by the interdisciplinary team, after each assessment, including comprehensive and quarterly review assessments. Review of the facility's policy titled Psychotropic Medication Management, dated as last revised 4/28/25, indicated but was not limited to the following:-A Psychotropic drug is any drug that affects brain activities associated with mental processes and behaviors, including anti-anxiety drugs.-Ensure supportive diagnosis and target behaviors are documented.-Monitor target behaviors daily using a behavior monitoring tool-Care plan the psychotropic medication use, supportive diagnoses, goals of therapy, target behaviors, and pharmacological and non-pharmacological approaches, inclusive, but not limited to behavioral interventions. Resident #163 was admitted in August 2023 with diagnoses which include senile adjustment disorder with anxiety and insomnia. Review of the Minimum Data Set (MDS) Assessment, dated 9/23/25, indicated he/she scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) assessment indicating he/she had moderate cognitive impairment, and he/she had not received Anti-Anxiety medications during the review period. Review of the Comprehensive Care Plan failed to indicate he/she was taking psychotropic medication, to monitor for adverse effects/side-effects of the medication, and to monitor for targeted behaviors. Review of the active Physician's Orders indicated but were not limited to the following:-May continue Ativan x 14 days then reassess (9/27/25) (anti-anxiety medication) Review of the Medication Administration Records (MAR) from September 2025 through October 2025 indicated but were not limited to the following:-Lorazepam 0.5 milligrams (mg) every 4 hours as needed (PRN) (9/13/25-9/26/25)-Lorazepam 0.5mg every 4 hours PRN (9/26/25-9/27/25)-Lorazepam 0.5mg every 4 hours PRN (10/2/25-10/16/25) The physician's orders failed to indicate to monitor for adverse effects/side-effects of the medication or to monitor for targeted behaviors. During an interview on 10/2/25 at 11:53 A.M., Nurse #7 said there was not a care plan, but there should be. Additionally, he said the behavior monitoring and side effect monitoring should be on the MAR, and they were not. During an interview on 10/2/25 at 12:52 P.M, Unit Manager #4 said there should be a care plan in place and there was not one. She said they have a psychotropic medication template and then it should be personalized. She said the target behavior and side effect monitoring should be on the MAR and they were not. During an interview on 10/2/25 at 2:38 P.M., the Director of Nurses (DON) said the targeted behaviors and side effect monitoring should be on the MAR and they were not. She said the certified nursing assistants document to regular behavior sheets, but the nurses document the targeted behaviors for the psych meds on the MAR. Additionally, she said Resident #163 did not have a care plan in place and he/she should have one.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review, the facility failed to assess and develop a person-centered plan of care which included trauma informed approaches and identified triggers to avoid potential re-traumatization for one Resident (#160) with a history of trauma, out of a total sample of 30 residents.Findings include: Review of the facility's policy titled Trauma Informed Care Program, revision date 10/16/22, included but was not limited to the following:-Procedures: residents will be screened for past trauma and for signs/symptoms of traumatic stress upon admission, quarterly, annually, and as needed. -If the result of the screen indicates the presence of trauma or traumatic stress, further assessment will be completed. The interdisciplinary team, in collaboration with the resident and with the approved resident's representative will create a culturally sensitive plan of care to help prevent re-traumatization and to optimize quality of life. Individualized resident triggers will be identified as able.-These plans of care shall include the identified trigger, prevention, intervention, and treatment services that address traumatic stress. Resident #160 was admitted to the facility in July 2025 with diagnoses including post-traumatic stress disorder (PTSD).Review of Resident #160's Minimum Data Set (MDS) assessment, dated 7/9/25, indicated he/she had a moderate cognitive impairment as evidenced by a score of 11 out of 15 on the Brief Interview for Mental Status (BIMS).On 9/29/25 at 11:37 A.M., the surveyor observed Resident #160 in the dining room sitting in his/her wheelchair. The surveyor observed two other residents sitting at the opposite end of the table from Resident #160, one resident put their fist on the table repeatedly which resulted in a loud noise. Resident #160 attempted to stand up from their wheelchair and said, I don't like loud noises. Immediately following this observation, the surveyor witnessed another resident yelling out loudly and Resident #160 appeared startled and attempted to stand up from his/her wheelchair and said, stop yelling. Review of Resident #160's nursing progress notes, dated 7/10/25, indicated but was not limited to:-Resident kept saying everyone will die tonight and kept praying. This writer and CNA (Certified Nursing Assistant) kept the Resident on 1:1 supervision as he/she always tries to get up when he/she doesn't see someone looking over them inside the room.-Resident #160 had increased anxiety stating the explosion is going to happen soon. Review of Resident #160's medical record and assessments since admission failed to indicate he/she was assessed for their trauma including triggers and mitigation techniques and an assessment had been completed.Review of Resident #160's care plan failed to indicate a care plan had been established related to potential trauma and triggers were identified. During an interview on 10/1/25 at 8:56 A.M., Nurse #5 said she was aware the Resident was in the Army but didn't have any additional psychosocial information. She said the Resident can be combative with care, had periods of anxiety and agitation, and attempts to self-rise from his/her wheelchair if startled. She said she never thought about if his/her time in the Army contributed to his/her behavior or reactions to loud noises.During an interview on 10/1/25 at 2:35 P.M., Social Worker#1 said trauma assessments should be completed within 72 hours of admission. He said he was aware Resident #160 had served in the military and had a diagnosis of PTSD. He reviewed Resident #160's medical record and said a trauma assessment had not been completed for him/her. He said he had not completed Resident #160's trauma assessment or attempted to identify any triggers for him/her but should have.During an interview on 10/1/25 at 3:02 P.M., the Administrator said the expectation was for every resident to have been assessed for trauma, and she expected triggers to be identified and mitigation techniques established for a resident with PTSD.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interviews, the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure for Resident #163 that staff performed hand hygiene and donned (put on) gloves and/or used utensils while handling ready to eat food during breakfast service/meal preparation. Findings include:Review of the Food and Drug Administration (FDA) Food Code 2022 indicated:3-301 Preventing Contamination by Employees3-301.11 Preventing Contamination from Hands.(A) FOOD EMPLOYEES shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT. Review of the facility's policy titled Proper Food Preparation, dated as last revised 9/1/24, indicated but was not limited to the following:-All foods will be prepared in a manner to prevent cross-contamination.-Food will be handled as little as possible.-Plastic gloves and utensils will be used in the production and serving of all foods. Resident #163 was admitted to the facility in August 2023 with diagnoses which include dysphagia (difficulty swallowing), legal blindness, and macular degeneration right eye. Review of the Minimum Data Set (MDS) Assessment, dated 9/23/25, indicated he/she scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had moderate cognitive impairment. Additionally, he/she had moderate vision impairment, macular degeneration, and was legally blind. During an interview on 9/26/25 at 9:20 A.M., Resident #163 said they could not see well and did not know how they were supposed to eat the large biscuit, as it was hard and dry. During the interview, the Speech Therapist entered the room and Resident #163 asked her how he/she was supposed to eat the large biscuit. Should it be cut in half or just bite it? Resident #163 restated that it was big, hard, and dry. On 9/26/25, the surveyor observed the following:-At 9:20 A.M., the Speech Therapist picked up the biscuit from the plate with her bare hands, and while holding it, asked Resident #163 if they wanted some butter or jam to put on it. Resident #163 said that might help. The Speech Therapist put the biscuit back down on Resident #163's plate and wiped her hands off with a dry tissue from Resident #163's overbed table and exited the room to get butter and jam. -At 9:23 A.M., the Speech Therapist returned with butter and jam packets. She picked up the biscuit from the plate, using her bare hands, pushed her fingers into the biscuit and pulled the biscuit apart into two halves. The Speech Therapist proceeded to hold the biscuit halves in the palm of her bare hand and applied butter and jam with a knife to the biscuit. After placing the knife down, she touched the cups and utensils on the breakfast tray, and then the bed sheet, before she handed Resident #163 the biscuit and wiped her hands off with a dry tissue from Resident #163's overbed table. During an interview on 10/2/25 at 12:52 P.M., Unit Manager #4 said no food should be handled with bare hands. She said if something like a roll or biscuit need to be picked up, it should be done with gloves on or with the silverware. During an interview on 10/2/25 at 2:38 P.M., the Director of Nurses (DON) said if staff need to pick up food to assist with preparation, they should have gloves. She said they should never handle food with bare hands.