STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225683	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stone Rehabilitation and Senior Living	277 Elliot Street Newton Upper Falls, MA 02464

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations and interview the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections on two of two units. Specifically:1.The facility failed to disinfect vital sign machines between residents.2. The facility failed to ensure staff opened personal milk cartons in a sanitary manner.Findings include: 1. On 3/11/26 at 6:48 A.M., the surveyor observed a nurse taking vital signs on a resident. The Nurse then exited the room with the vital signs tower, and without disinfecting the tower or equipment, entered another resident's room and took their vital signs. At 6:51 A.M., the nurse exited the second resident's room after checking vital signs, and without disinfecting the vital signs tower, entered the room of a third resident and obtained vital signs on the resident. At 6:53 A.M., the nurse exited the third resident's room, and without disinfecting the vital signs tower, entered the room of a fourth resident and obtained vital signs on that resident. At 6:56 A.M., the nurse exited the fourth resident's room, and without disinfecting the vital signs tower, entered the room of a fifth resident and obtained vital signs on that resident. On 3/11/26 at 6:56 A.M., the surveyor observed that the vital signs tower did not have disinfecting wipes readily available in its basket that was attached to it. During an interview on 3/11/26 at 10:35 A.M., Nurse #1 said that the vital signs towers are used on all residents and should be wiped down in between all residents. During an interview on 3/11/26 at 12:42 P.M., Nurse #3 said that after each resident you use the vitals machine on, it needs to be wiped down and disinfected before it is used on another resident. During an interview on 3/11/26 at 1:01 P.M., Infection Preventionist and the Director of Nurses said that the vital signs tower should be wiped down and disinfected between each resident. 2. On 3/10/26 at 8:21 A.M., the surveyor observed Certified Nurse's Aide #2 use her ungloved finger two times to open milk carton's spouts, sticking her bare, potentially contaminated finger into the spout, potentially contaminating the milk. On 3/10/26 at 8:27 A.M., the surveyor observed Certified Nurse's Aide #3 use her ungloved finger two times to open milk carton's spouts, sticking her bare, potentially contaminated finger into the spout, potentially contaminating the milk. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Stone Rehabilitation and Senior Living	277 Elliot Street Newton Upper Falls, MA 02464

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/10/26 at 8:30 A.M., the surveyor observed Certified Nurse's Aide #4 use her ungloved finger to open a milk carton's spout, sticking her bare, potentially contaminated finger into the spout, potentially contaminating the milk. During an interview on 3/11/26 at 1:01 P.M., the Director of Nursing said that the spout of the milk cartons should not be touched when opening them for infection control reasons. During an interview on 03/11/2026 1:14 P.M., Certified Nurse's Aide #5 said that fingers should not be used to open the spout of the milk cartons for infection control reasons.

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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 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 observation, record review and interview, the facility failed to develop and implement a comprehensive person- centered care plan for two Residents (#34 and #66) out of a total sample of 21 residents. Specifically,1.For Resident #34 the facility failed to develop a comprehensive person-centered care plan within seven days of completing the Admission/ 5-day Minimum Data Set assessment.2. For Resident #66 the facility failed to implement the use of ted stockings (compression stockings) and Geri-sleeves (used to protect fragile skin). Findings include: Review of facility policy, titled Care Plans, undated, indicated the following: -An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. 1. Our facility's Care Planning/ Interdisciplinary Team, in coordination with the resident. his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. Residents will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical physical, mental and psychosocial needs. 3. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (Admission, Annual or Significant Change in Status). 4. For newly admitted residents, the comprehensive care plan must be completed within seven days of the completion of the comprehensive assessment (MDS admission assessment) or no more than 21 days after admission. 1. Resident #34 was admitted to the facility in January 2026 with diagnoses that included metabolic encephalopathy, sleep apnea, dysphagia, urinary tract infection and pneumonitis due to inhalation of food and vomit. Review of the admission Minimum Data Set (MDS) assessment, dated 1/30/26, and completed on 2/9/26, indicated a Brief Interview for Mental Status score of 8 out of a possible 15, indicating moderate cognitive impairment. Review of Section V (which focuses on the Care Area Assessment Summary, guiding staff to evaluate triggered care areas and develop individualized care plans) in the admission MDS, completed on 2/9/26 indicated the following care areas were triggered with a care plan decision of yes: -Functional Abilities (Self Care and Mobility). -Cognitive Loss/ Dementia. -Urinary Incontinence and Indwelling Catheter. -Dehydration/ Fluid Management. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Falls. -Communication. -Nutritional Status. -Pressure Ulcer Injury. Review of the Resident's care plan on 3/10/26 (29 days after the completion of the MDS and 42 days after the Resident was admitted) failed to indicate that a comprehensive person-centered care plan was developed. Further review of the Resident's care plan on 3/10/26 included only the following focuses: -ACTUAL SKIN BREAKDOWN: Resident has actual skin breakdown - Left lateral fifth toe, dated 2/9/26. -ADVANCED DIRECTIVES: [Resident] has Advanced Directives: Health Care Proxy Activated 1/29/26; DNR/DNI, no dialysis, dated 1/29/26, -NUTRITION: [Resident} is at risk for alteration in nutrition due to low albumin level and admitted with sacral wound. He/she is on a mechanically altered diet which may not appeal to him/her. He/she has a history of dementia and is at risk for malnutrition, dated 2/5/26. -POTENTIAL FOR DISCHARGE PLANNING: [Resident] will be assessed for the potential for a safe discharge back to the community after meeting his/her goals here, dated 1/29/26. During an interview on 3/11/26 at 10:34 A.M., Nurse #1 said that the facility initiates baseline care plans in the electronic medical record, and there are no paper care plans in the chart. He said that he does not have access to update the resident's care plan and that the Unit Manager does that. During an interview on 3/11/26 at 11:28 A.M., Unit Manager #1 said that all care plans were in the electronic medical record and that no baseline care plans were on paper in the paper record. During an interview on 3/11/26 at 11:51 A.M., the Minimum Data Set (MDS) Nurse said that care plans were developed collaboratively with the team to ensure that all necessary care areas make it to the care plan. He said that within 21 days of admission a Resident's comprehensive care plan should be developed. He said that the active care plan as of 3/10/26 was not a comprehensive care plan. The care plan was reviewed together, and he said that outside of the above four mentioned focuses, all other focuses were added to the care plan today (3/11/26). During a follow up interview on 3/11/26 at 12:46 P.M., Unit Manager #1 said that care plans were developed by supervisors or Unit Managers, but the whole team had a part in it. She said she was not sure how soon after admission the comprehensive care plan should be developed. She said that she worked on care plans today and may have added to the care plan today. During an interview on 3/11/26 at 1:33 P.M., the Director of Nurses said comprehensive care plans should be developed within a week of each resident's admission. She said that all supervisors work on developing the care plan, but mainly the nurse managers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility policy titled Care Plans, not dated, indicated that the resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies. Resident #66 was admitted to the facility in February 2022 with diagnoses including Parkinson's Disease, dementia and stroke. Review of the Minimum Data Set assessment, dated 12/26/25, indicated that Resident #66 was moderately cognitively impaired and scored a 12 out of 15 on The Brief Interview for Mental Status exam. Further review indicated that Resident #66 was totally dependent on staff for all ADLs (Activities of Daily Living). Review of the care plan indicated a focus of ADL (activities of daily living) care and with an intervention to apply ted stockings in a.m., remove at bedtime as tolerated. Further review indicated a focus of Actual Skin Breakdown with an intervention for Geri-sleeves to bilateral upper extremities every shift. On 3/10/26 at 7:57 A.M., the surveyor observed Resident #66 lying in bed. The surveyor observed Resident #66 without ted stockings on or Geri-sleeves on. On 3/10/26 at11:32 P.M., the surveyor observed Resident #66 lying in bed. The surveyor observed Resident #66 without ted stockings on or Geri-sleeves on. On 3/10/26 at 2:32 P.M., the surveyor observed Resident #66 lying in bed. The surveyor observed Resident #66 without ted stockings on or Geri-sleeves on. On 3/11/26 at 10:45 A.M., the surveyor observed Resident #66 lying in bed. The surveyor observed Resident #66 without ted stockings on or Geri-sleeves on. Review of the Certified Nurse's Aide ADL documentation dated 3/1/26 through 3/10/26, failed to indicate Resident #66 refused care. Review of the progress notes failed to indicate Resident #66 refused care. During an interview on 3/11/26 at 1:20 P.M., Certified Nurse's Aide (CNA) #2 said that the CNA's were supposed to follow the care plan. She then said that there was a Kardex (a document indicating level of care a resident requires) that the CNA's use to determine anything the resident requires. Review of the Kardex, not dated, failed to indicate Resident #66 required the use of Geri-sleeves or teds stockings. During an interview on 3/11/26 at 1:00 P.M., the Director of Nursing said that when a resident refuses care, the nursing staff should be documenting the refusals in the medical record. During an interview on 3/11/26 at 1:15 P.M., Unit Manager #2 said that staff did not document in the medical record when a resident refused care. She then said that if a resident refused an intervention on the care plan repeatedly then that intervention was discontinued. Unit Manager #2 was not able to state how nursing would know if a resident was repeatedly refusing care if the refusals were not documented in the medical record.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure assistance with Activities of Daily Living (ADLs) was provided for one Resident (#34) out of a total sample of 21 residents. Specifically, for Resident #34 the facility failed to provide supervision/ touching assistance with meals as per the plan of care.Findings include:Resident #34 was admitted to the facility in January 2026 with diagnoses that included metabolic encephalopathy, sleep apnea, dysphagia (difficulty swallowing) and pneumonitis due to inhalation of food and vomit. Review of the Minimum Data Set (MDS) assessment, dated 1/30/26, indicated a Brief Interview for Mental Status score of 8 out of a possible 15, indicating moderate cognitive impairment. Further review of the MDS indicated supervision or touching assistance was required for eating. Further review indicated that rejection of care was not a behavior exhibited by the resident. On 3/10/26 at 8:39 A.M., the surveyor observed Resident #34 sitting up in his/her wheelchair and eating breakfast alone in his/her room. On 3/11/26 at 8:09 A.M., the surveyor observed the Resident lying flat in bed, his/her breakfast tray was left on the bedside table but not set up for the Resident to eat. During a continuous observation on 3/11/26 from 8:14 A.M. to 8:27 A.M., the surveyor observed a staff member set the Resident up to eat breakfast by elevating the head of the bed to approximately 45 degrees and then the staff member left the room. Review of the Resident's care plan failed to indicate the level of assistance required by the Resident for eating. Review of the CNA (Certified Nurse's Aide) resident care plan book located at the nurse's station indicated a rehab communication form, undated, that indicated min (minimal) assist for feeding and up in w/c (wheelchair) for all meals. Review of the Speech Therapy Discharge summary dated [DATE] indicated the following:-Continue with 1:1 supervision for meals for safety. Review of the Certified Nurse Aide Task documentation failed to indicate that assistance was provided with meals/ eating on 3/8/26, 3/9/26, 3/10/26. During an interview on 3/11/26 at 11:22 A.M., CNA #1 said that she has never seen or used a care card or Kardex in the facility. She said that the Nurses and CNAs use verbal report to communicate the needs of the residents, for example if they are a Hoyer lift or need assistance with meals. During an interview on 3/11/26 at 12:43 P.M., Unit Manager #1 said that CNAs primarily communicate with nurses through verbal report at the beginning of each shift to know the type of assistance each resident requires. She said they will also write things on the assignment sheet such as if someone requires total lift. She said that the need for assistance with meals would be communicated through verbal report. She said that sometimes Resident #34 refuses to get out of bed and that refusals should be documented in the medical record. During an interview on 3/11/26 at 1:31 P.M., the Director of Nurses said that when someone requires supervision, that means that someone should be with the resident the whole time that they were eating if they remain in their room. She said that the facility does use a care card or Kardex system on paper to indicate the level of assistance a resident requires, and staff should be utilizing and following that.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, the facility failed to provide care and maintenance of a Peripherally Inserted Central Catheter (PICC: a flexible tube inserted through a vein in one's arm and passed through to the larger veins near the heart, used to deliver medications intravenously [IV]), consistent with professional standards of practice for one Resident (#6), out of a total sample of 21 residents. Specifically, for Resident #6, the facility failed to ensure that the insertion site was able to be visualized. Findings include:Review of facility policy titled PICC Line Management, undated, indicated the following:-Nurse should inspect PICC line site evert shift and report to MD/NP any signs of infiltration, infection, increased redness or swelling, pain or any other issues.-PICC line dressings should be changed at least weekly with a transparent dressing.Resident #6 was admitted to the facility in February 2026 with diagnoses that included encounter for orthopedic aftercare, broken internal left hip prosthesis and history of falling. Review of the Minimum Data Set (MDS) assessment, dated 2/9/26, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS further indicated the presence of a PICC line. On 3/10/26 at 8:08 A.M., the surveyor observed a PICC line dressing dated 3/9/26. The insertion site of the PICC line was not visible due to gauze placed under the transparent dressing. On 3/11/26 at 8:13 A.M., the surveyor observed a PICC line dressing dated 3/9/26. The insertion site of the PICC line was not visible due to gauze placed under the transparent dressing. Review of physician's orders indicated the following:-Observe Site: every shift with intermittent therapy or when not in use, dated 2/4/26.-Observe Site: every 2 hours during continuous therapy, dated 2/4/26. Review of the March 2026 Treatment Administration Record indicated that every two-hour assessment of the insertion site was signed off as completed on 3/9, 3/10 and through 6:00 A.M., on 3/11/26. During an interview on 3/11/26 at 11:44 A.M. Nurse #2 said that there should not be gauze under the transparent dressing, and that when it is there you cannot observe the insertion site, which should be observed every shift. During an interview on 3/11/26 at 12:49 P.M., Unit Manager #1 said that PICC line dressings were completed weekly with transparent dressings. She said if gauze is placed under the dressing, you would still need to be able to observe the insertion site. She then said that depending on where the gauze was placed, you may be able to still assess it. Unit Manager #1 declined to assess Resident #6's PICC line site with the surveyor and said she would follow up regarding the site, but she did not. During an interview on 3/11/26 at 1:35 P.M., the Director of Nurses said that nurses should be assessing the insertion site of a PICC line every shift to ensure that there were no IV related complications such as bleeding or infection. She said that nurses could not assess the insertion site if there was a gauze under the dressing.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for one Resident (#73) out of a sample of 21 residents. Specifically, for Resident #73, the facility failed to provide oxygen to the Resident as indicated in the physician's orders.Findings include:Review of facility policy titled Oxygen Administration, undated, indicated the following:-Verify that there is a physician's order for this procedure unless needed for emergent reasons. Review physician's orders or facility protocol for oxygen administration. Resident #73 was admitted to the facility in February 2026 with diagnoses that included dementia, depression and acute respiratory failure with hypoxia. Review Resident #73's Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. Further review of the MDS indicated the use of continuous oxygen therapy. On 3/10/26 at 7:56 A.M., the surveyor observed the Resident awake in bed receiving oxygen at 3 liters per minute via nasal cannula. On 03/10/26 at 11:59 A.M., the surveyor observed the Resident sitting up in his/her wheelchair receiving oxygen via nasal cannula at 3 liters per minute. On 3/10/26 2:05 P.M., the surveyor observed the Resident receiving oxygen via nasal cannula at 3 liters per minute. On 3/11/26 at 6:48 A.M., and 8:25 A.M., the surveyor observed the Resident awake in bed receiving oxygen via nasal cannula at 3 liters per minute. On 3/11/26 at 10:40 A.M., the surveyor observed the Resident sleeping in bed receiving oxygen via nasal cannula at 3 liters per minute. Review of physician's orders indicated the following:-May administer Oxygen 2 Liter via NC (nasal cannula) Continuous. Check flow rate for accuracy q shift, dated 3/7/26.-May administer Oxygen 2 Liters via NC PRN (as needed) for O2 sats less than 90% on room air, dated 3/7/26. Review of the Resident's active care plan indicated the following, dated 2/13/26:-Impaired Gas Exchange: Resident at risk for impaired gas exchange r/t [this portion left blank with no diagnosis], with interventions that included to administer O2 (oxygen) as needed per MD/NP (physician/ nurse practitioner) order. Review of nursing progress notes indicated the following:-A nursing progress note dated 3/9/26 that indicated, in part: Patient continues on 3L with being 91%. Tolerated medication well whole with water. Participated in rehab today with being out of bed. [sic] -A nursing progress note dated 3/11/26 that indicated, in part: DX [diagnoses]: hypoxia/decondition/ CHF/polypharmacy- pt rec'd [patient received] in bed, alert/verbal. VSS [vital signs stable]. Presented on 3L o2 n/c [nasal cannula] . [sic] During an interview on 3/11/26 at 11:39 A.M., Nurse #2 said that Resident #73 was currently receiving 3 liters of oxygen. She then said if the order was for 2 liters, then the Resident should only be receiving 2 liters of oxygen. Nurse #2 said if staff assess the Resident to require more oxygen than was ordered, then they should notify the physician and get the orders changed. She said that physician's orders should be followed as written. She said that if a resident was receiving too much oxygen, it has the potential to cause carbon dioxide levels to rise. During an interview on 3/11/26 at 12:51 A.M., Unit Manager #1 said that the Resident should only receive 2 liters of oxygen as indicated in the physician's orders and if requiring more, then the physician should be called and updated and new orders obtained. During an interview on 3/11/26 at 1:38 A.M., the Director of Nurses said that oxygen should be administered per the physician's order.