STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225689	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal of Cotuit	161 Falmouth Road Mashpee, MA 02649

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who on 05/22/25, slid off the bed onto the floor during care, the Facility failed to ensure that nursing immediately notified the Physician that he/she had experienced a fall.Findings include:Review of the Facility Policy titled, Notification of Changes, dated as revised May 2025, indicated that the Facility promptly consults the resident's physician when there is a change requiring notification including accidents resulting in injury and potential to require physician intervention.Review of the Facility Policy titled, Fall Prevention Program, dated as revised May 2025, indicated that a fall is an event in which an individual unintentionally comes to rest on the floor. The Policy indicated that when a resident experiences a fall the physician is to be notified.Resident #1 was admitted to the Facility in October 2023, diagnoses included Cerebral Palsy, contractures of the right and left hand, and the right and left knee, kyphosis, convulsions, periprosthetic fracture of the right knee, atrial fibrillation, osteoarthritis, congestive heart failure and hearing loss.Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 03/27/25, indicated that Resident #1 had impairments of both upper extremities and lower extremities, and was dependent on staff for activities of daily living.Review of Resident #1's Fall Risk Evaluation, dated 03/21/2025, indicated Resident #1 was at risk for falls.Review of the Report submitted by the Facility via Health Care Reporting System (HCFRS), dated 05/24/25, indicated that Resident #1 was transferred to the hospital on [DATE] and on 05/24/25, the Facility was notified that a CT scan of the pelvis revealed an acute comminuted fracture of the right femur (thigh bone) (hip fracture resulting from trauma). The Report indicated that during morning care on 05/22/25, Certified Nurse Aide (CNA) #1 rolled Resident #1 onto his/her left side when he/she raised his/her right leg, which crossed over the left leg, and caused his/her legs to slide off the bed. The Report indicated that CNA #1 was unable to reposition Resident #1 back into the bed, held onto his/her upper body and lowered him/her to the floor. The Report indicated that CNA #1 notified Nurse #1 and Resident #1 was transferred back to bed using a mechanical lift.During a telephone interview on 07/16/25 at 6:30 A.M., Certified Nurse Aide (CNA) #1 (which also included review of her written witness statement dated 05/30/25) said that on 05/22/25 at approximately 6:30 A.M., she was providing care to Resident #1 in bed without the assistance of another staff member, rolled him/her onto his/her left side, and his/her right leg crossed over the left leg causing him/her to slide off the bed. CNA #1 said that she held onto Resident #1's upper body and lowered him/her to the floor. CNA #1 said that she notified the nurse (exact name unknown) of the fall.During a telephone interview on 7/16/25 at 9:29 A.M., Nurse #1 said that she worked the 11:00 P.M. to 7:00 A.M (from 5/21/25 into 5/22/25) shift. Nurse #1 said that on 5/22/25 at approximately 6:30 A.M., CNA #1 notified her that Resident #1 had slid out of bed. Nurse #1 said that when she entered Resident #1's room, he/she was lying on the floor on his/her back. Nurse #1 said that Resident #1 denied being in pain and she told the CNA's to transfer him/her into bed. Nurse #1 said that she did not notify the physician of the fall.During a telephone interview on 7/16/25 at 9:21 A.M., Nurse #2 said that on 5/22/25 she worked the 7:00 A.M. to 3:00 P.M. shift and received change of shift report from Nurse #1. Nurse #2 said that Nurse #1 never reported to her that Resident #1 had fallen out of bed. Nurse #2 said that she did not notify the physician that Resident #1 had a fall because she was not aware that he/she had a fall.Review of Resident #1's medical record indicated that there was no documentation to support that Nurse #1 completed an incident report, or that she notified the Physician of a fall.During an interview on 7/15/23 at 2:50 P.M., the Director of Nurses (DON) said she expected that all Nurses would notify the Physician of any falls or incidents and follow the Facility Policy.

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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was assessed as being at risk for falls, had physical limitations in both upper and lower extremities due to contractures, and was dependent on staff for mobility including bed mobility, the Facility failed to ensure they developed an individualized comprehensive plan of care that included the number of staff members required during care, to appropriately meet his/her care needs. Findings include:Review of the Facility's Policy titled, Comprehensive, Person-Centered Care Plans, dated as revised May 2025, indicated the Facility will develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The Policy further indicated that the comprehensive care plan would include resident specific interventions that reflect the resident's strengths and needs as identified in the resident's comprehensive assessment.Resident #1 was admitted to the Facility in October 2023, diagnoses included Cerebral Palsy, contractures of the right and left hand, and the right and left knee, kyphosis, convulsions, periprosthetic fracture of the right knee, atrial fibrillation, osteoarthritis, congestive heart failure and hearing loss.Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 03/27/25, indicated that Resident #1 had impairments of both upper extremities and lower extremities, and was dependent on staff for activities of daily living, including bed mobility and turning and repositioning.Review of Resident #1's Fall Risk Evaluation, dated 03/21/2025, indicated Resident #1 was at risk for falls.Review of Resident #1's Certified Nurse Aide Activities of Daily Living Flowsheet for May 2025 indicated he/she was dependent on staff for personal hygiene and toilet hygiene. The Flowsheet indicated staff provided varying levels of staff assistance (one or two) with rolling left and right (positioning and bed mobility).Review of Resident #1's Activities of Living (ADL) Care Plan, reviewed and revised with the Quarterly MDS, dated [DATE], indicated he/she required extensive to total dependence with activities of daily living and was dependent on staff with bed mobility, personal hygiene and toileting/incontinence care.However, although Resident #1's ADL Care Plan indicated that he/she was totally dependent on staff with ADL's, there was no documentation to support the level of staff assistance (number of staff required) related to bed mobility, personal hygiene and toileting/incontinence care.Review of the Report submitted by the Facility via Health Care Reporting System (HCFRS), dated 05/24/25, indicated that during morning care on 05/22/25, Certified Nurse Aide (CNA) #1 rolled Resident #1 onto his/her left side when he/she raised his/her right leg which crossed over the left leg and caused his/her legs to slide off the bed. The Report indicated that CNA #1 was unable to reposition Resident #1 back into the bed, held onto his/her upper body and lowered him/her to the floor. The Report indicated that CNA #1 notified Nurse #1 and Resident #1 was transferred back to bed using a mechanical lift. The Report indicated that Resident #1 was transferred to the hospital on [DATE] and on 05/24/25, the Facility was notified that a CT scan of the pelvis revealed an acute comminuted fracture of the right femur (hip fracture resulting from trauma). During a telephone interview on 7/16/25 at 6:30 A.M., CNA #1 said that Resident #1's care plan just states that Resident #1 is dependent with bed mobility and personal hygiene but does not indicate the number of staff required to provide assistance, so she believed he/she was a one person assist with care. CNA #1 said that Resident #1 was a one person assist with care most of the time. CNA #1 said that Resident #1 usually holds onto the side rail when she turns him/her in bed. CNA #1 said that if she needed the assistance of another staff member, she would ask another CNA to help her. During an interview on 7/15/25 at 11:50 A.M., CNA #2 said that Resident #1 was very heavy and required the assistance of two staff with all care, including turning, repositioning, and bed mobility. CNA #2 said that she reviews the resident care plans daily and said she could not recall exactly what Resident #1's care plan stated but said she knows he/she required the assistance of two staff members with all care.During an interview on 7/15/25 at 12:11 P.M., CNA #4 said that Resident #1 was very heavy and required the assistance of two staff with all care, including turning, repositioning, and bed mobility. CNA #2 said that she reviews the resident care plans daily and said she believes the care plan stated that he/she required the assistance of two staff members with all care.During a telephone interview on 7/16/25 at 6:51 A.M., CNA #3 said that Resident #1 usually requires the assistance of one staff because he/she can assist with turning in bed. CNA #3 said that sometimes he/she needs assistance from another staff member and will get someone else to help her with bed mobility and personal

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), who on 5/22/25 sustained a fall, the Facility failed to ensure care and treatment provided by nursing met professional standards of practice. When after Nurse #1 was notified by Certified Nurse Aide (CNA) #1 that Resident #1 slid out of bed and was on the floor in his/her room, Nurse #1 instructed the CNA's to put Resident #1 back to bed. There was no supporting documentation including assessments or nurse progress notes in Resident #1's medical record related to the fall, no incident report, and the oncoming shift nurse and the Physician were also not notified of the fall. The next day, Resident #1 was noted with swelling to his/her right hip/thigh area and was transferred to the Hospital Emergency Department (ED) for evaluation and was diagnosed with a right hip and femur (thigh bone) fractures and was admitted . Findings Include:Pursuant to Massachusetts General Law (M.I.T.), chapter 112, individuals are given the designation of Registered Nurse and Practical Nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CRM) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered Nurse and Practical Nurse respectively. The regulations stipulate that both the Registered Nurse and Practical Nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the Registered Nurse and Practical Nurse incorporate into the plan of care and implement prescribed medical regimens. The Rules and Regulations 9.03 define Standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. Review of the Facility's Policy titled, Fall Prevention Program, dated as revised May 2025, indicated that a fall is an event in which an individual unintentionally comes to rest on the floor. The Policy indicated that when a resident experiences a fall, the facility will:-assess the resident;-complete a post-fall assessment;-complete an incident report;-notify the physician and family;-review the resident's care plan and update as indicated;-document all assessments and actions;-obtain witness statements in the case of injury.Review of the Facility's Policy titled, Incidents and Accidents, dated as revised May 2025, indicated the following:-it is the policy of the facility for staff to report, investigate and review any accidents or incidents that occur on facility property;-licensed staff will report incident/accidents;-a fall is an accident that requires an incident/accident report;-any injuries will be assessed by the licensed nurse;-the supervisor or designee will be notified of the incident/accident;-the nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or other findings and obtain orders, if indicated;-the nurse will enter the incident/accident information into the appropriate form and will document all pertinent information;-documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions.Resident #1 was admitted to the Facility in October 2023, diagnoses included Cerebral Palsy, contractures of the right and left hand, and the right and left knee, kyphosis, convulsions, periprosthetic fracture of the right knee, atrial fibrillation, osteoarthritis, congestive heart failure and hearing loss.Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 03/27/25, indicated that Resident #1 had impairments of both upper extremities and lower extremities, and was dependent on staff for activities of daily living.Review of Resident #1's Fall Risk Evaluation, dated 03/21/2025, indicated Resident #1 was at risk for falls.Review of the Report submitted by the Facility via Health Care Reporting System (HCFRS), dated 05/24/25, indicated that during morning care on 05/22/25, Certified Nurse Aide (CNA) #1 rolled Resident #1 onto his/her left side when he/she raised his/her right leg which crossed over the left leg and caused his/her legs to slide off the bed. The Report indicated that CNA #1 was unable to reposition Resident #1 back into the bed, held onto his/her upper body and lowered him/her to the floor. The Report indicated that CNA #1 notified Nurse #1 and Resident #1 was transferred back to bed using a mechanical lift. The Report indicated that Resident #1 was transferred to the hospital on [DATE] and on 05/24/25, the Facility was notified that a CT scan of the pelvis revealed an acute comminuted fracture of the right femur (thigh bone) (hip fracture resulting from trauma). The Report indicated that during change of shift report, Nurse #1 reported to Nurse #2 that Resident #1 needed a wider bed because his/her leg was hanging over the edge of bed during care. The Report indicated that Nurse #1 did not report to Nurse #2 that Resident #1 had a fall. The Report indicated that (on 5/23/25) a CNA reported to Nurse #2 that Resident #1's right upper leg was swollen, and Nurse #2 did not notice any difference in the size of his/her upper legs and