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	03/31/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to maintain a safe environment, free of accident hazards for four Residents (#6, #10, #33, #77), out of eight independent smokers on the Popponesett Unit. Specifically, the facility failed to ensure the Residents' smoking materials were stored securely. Findings include:Review of the facility's policy titled Smoking Policy and Procedure, undated, indicated but was not limited to the following: - It is the policy of [Corporate Name] to provide a safe environment for residents, staff and visitors through the enforcement of a smoking policy designed to reduce risks to residents who smoke tobacco products, reduce the risks of passive smoking for others and reduce the risk of fire. - Independent Smoker: A resident who has been assessed by the IDT (interdisciplinary Team) to be able to smoke safely in the designated area without staff supervision. The Independent Smoker will adhere to all guidelines for safe smoking outlined in this policy and, if there are any infractions, will be re-assessed for safe smoking. The resident must keep all lighting materials at the designated secure area. - Tobacco products will be stored in a box on each unit. Each box will have a written list of residents who need safety measures taped inside the box. - Addendum A – Smoking Times: All lighting materials are kept at the nursing station and distributed per request by the staff. During the entrance conference on 3/25/26 at 8:40 A.M., the facility provided a list of smokers to the survey team which included Residents #6, #10, #33, and #77. During an interview on 3/25/26 at 9:05 A.M., Unit Manager (UM) #1 said the unit had eight independent smokers and one supervised smoker. UM #1 said there was a lock box on the wall for all smokers to store their cigarettes and lighting supplies. UM #1 said independent smokers have a key to their own lock boxes and are able to go out to the smoking unit throughout the day as they choose. UM #1 said nurses also have a key to the lock boxes are supposed to remind any of the smokers as they return from the smoking area to place their supplies back in their lock boxes. UM #1 said some of the independent smokers do not always put their supplies back in the lock boxes. A. Resident #6 was admitted to the facility in May 2025 with diagnoses including chronic obstructive pulmonary disorder (COPD) and nicotine dependence. Review of Resident #6's Minimum Data Set (MDS) assessment, dated 1/15/26, indicated he/she was (continued on next page)

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
	225689	A. Building B. Wing	03/31/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #6's medical record indicated a signed smoking agreement by the Resident and a facility representative on 5/3/25. On 3/25/26 at 4:17 P.M., the surveyor observed the smoking lock boxes on the unit. Resident #6's lock box had three packages of cigarettes and no lighting supplies. During an interview on 3/25/26 at 4:20 P.M., Resident #6 said he/she was an independent smoker. Resident #6 said there was a lock box on the unit for him/her to place his/her smoking supplies, including their lighter and cigarettes, in after use. Resident #6 said he/she does not always remember to use the lock box. Resident #6 said sometimes he/she places his/her supplies in his/her bag, which was observed to be on top of the Resident's bed. On 3/26/26 at 9:19 A.M., the surveyor observed Resident #6 in the smoking area, independently smoking a cigarette. Resident #6's lock box for smoking supplies on the unit contained one cigarette package. On 3/26/26 at 11:52 A.M., the surveyor observed Resident #6 in the smoking area, independently smoking a cigarette. Resident #6's lock box for smoking supplies on the unit was empty. At 11:58 A.M., Resident #6 returned to the unit from the smoking area. Resident #6 was observed to walk down the hallway to their room without placing any smoking supplies in their lock box. A nurse was observed at the nurses' station and did not request the Resident place any supplies in the lock box. On 3/27/26 at 8:10 A.M., Resident #6's smoking lock box on the unit contained one package of cigarettes and no other supplies. Review of Resident #6's comprehensive care plan for smoking included the following interventions: - All light materials are to be kept in designated secure storage at nurses' station. Review of Resident #6's smoking assessments, dated 5/29/25, 11/17/25, and 1/13/26, indicated he/she was safe to smoke independently and followed the facility's policy on smoking. B. Resident #10 was admitted to the facility in June 2024 with diagnoses including tobacco use and emphysema. Review of Resident #10's MDS assessment, dated 2/26/26, indicated he/she was cognitively intact with a BIMS score of 13 out of 15. Review of Resident #10's medical record indicated a signed smoking agreement by the Resident and a facility representative on 9/18/24. On 3/25/26 at 11:27 A.M., the surveyor observed that Resident #10's smoking lock box on the unit contained no smoking supplies or cigarette packages. On 3/25/26 at 4:03 P.M., the surveyor observed Resident #10 outside in the smoking area (continued on next page)

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	03/31/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	independently smoking. Resident #10's lock box on the unit for smoking supplies was empty. On 3/26/26 at 9:19 A.M., the surveyor observed that Resident #10's smoking lock box on the unit contained no smoking supplies or cigarette packages. On 3/26/26 at 11:51 A.M., the surveyor observed that Resident #10's smoking lock box on the unit contained no smoking supplies or cigarette packages. On 3/26/26 at 11:52 A.M., the surveyor observed Resident #10 outside in the smoking area independently smoking. Resident #10's lock box on the unit for smoking supplies was empty. On 3/26/26 at 2:57 P.M., the surveyor observed Resident #10 outside in the smoking area independently smoking. Resident #10's lock box on the unit for smoking supplies was empty. On 3/27/26 at 7:56 A.M., the surveyor observed that Resident #10's smoking lock box on the unit contained one package of cigarettes and no other supplies. Review of Resident #10's comprehensive care plan for smoking included the following interventions: - All lighters/cigarettes will be turned into the nurse when not in use. Review of Resident #10's smoking assessments dated 6/2/25, 8/26/25, 11/17/25 and 2/9/26, indicated he/she was safe to smoke independently and followed the facility's policy on smoking. C. Resident #33 was admitted to the facility in November 2025 with diagnoses including tobacco use, weakness, and COPD. Review of Resident #33's MDS assessment, dated 2/26/26, indicated he/she had a moderate cognitive impairment as evidenced by a BIMS score of 13 out of 15. Review of Resident #33's medical record indicated a signed smoking agreement by the Resident and a facility representative on 12/22/25. On 3/25/26 at 9:05 A.M., the surveyor observed Resident #33 return to the unit from the smoking area and walk past the nurses' station. UM #1 asked the Resident to return his/her smoking supplies to their lock box across from the nurses' station. Resident #33 said he/she was getting a sweatshirt from their room and going back outside and continued walking down to his/her room. Resident #33 was not observed to return to the smoking area. During an interview on 3/25/26 at 9:19 A.M., Resident #33 said he/she had been smoking since they were a teenager and was safe to smoke as well as hold their smoking supplies. Resident #33 said he/she did not always put their smoking supplies, including lighters, back in their lock box on the unit. Resident #33 said, I am safe to keep my supplies because I have been smoking for a long time. On 3/25/26 at 10:26 A.M., the surveyor observed Resident #33 independently smoking in the smoking area. No supplies were noted in Resident #33's smoking lock box. On 3/25/26 at 11:37 A.M., the surveyor observed that Resident #33's smoking lock box on the unit (continued on next page)

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	03/31/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contained one package of cigarettes and no other smoking supplies, including a lighter. On 3/25/26 at 4:03 P.M., the surveyor observed that Resident #33's smoking lock box on the unit was empty. On 3/26/26 at 7:11 A.M., the surveyor observed Resident #33 return to the unit from the smoking area and go directly to his/her room without placing any supplies including packages of cigarettes or lighters in his/her smoking lock box. On 3/26/26 at 9:19 A.M., the surveyor observed Resident #33's smoking lock box on the unit to be empty. On 3/26/26 at 10:10 A.M., the surveyor observed Resident #33 leave the unit for the smoking area. Resident #33 did not take any items from their smoking lock box on the unit as it was empty. Resident #33 was observed to pull a lighter and cigarette from their jacket pocket as they entered the smoking area and began independently smoking. On 3/26/26 at 11:51 A.M., the surveyor observed that Resident #33's smoking lock box on the unit contained two packages of cigarettes and no other supplies. At 11:55 A.M., Resident #33 was observed to return to the unit from the smoking area, open his/her lock box, remove all smoking supplies and return to his/her room. The nurse seated at the nurses' station did not ask the Resident to return the supplies to the smoking lock box. On 3/27/26 at 7:56 A.M., the surveyor observed that Resident #33's smoking lock box on the unit contained one package of cigarettes and no other supplies. Review of Resident #33's comprehensive care plan for smoking included the following interventions: - All lighting materials are to be kept in designated secure storage at nurses' station. Review of Resident #33's smoking assessments, dated 11/20/25 and 2/17/26, indicated he/she was safe to smoke independently and followed the facility's policy on smoking. During an interview on 3/25/26 at 4:24 P.M., Certified Nursing Assistant (CNA) #4 said most of the residents on the unit who smoke are independent. CNA #4 said nurses have a key to the lock boxes for storage of smoking supplies. CNA #4 said nurses unlock the boxes for residents to gather and return their supplies before/after smoking. CNA #4 said all lock boxes should contain the residents' cigarettes and lighters. During an interview on 3/26/26 at 2:32 P.M., CNA #1 said residents who smoke independently on the unit have a code to the door to access the smoking area independently. CNA #1 said residents who smoke are supposed to put their cigarettes and smoking supplies back in their lock boxes when they return from the smoking area. D. Resident #77 was admitted to the facility in April 2025 with diagnoses including COPD and tobacco use. Review of Resident #77's MDS assessment, dated 4/25/25, indicated he/she had moderate cognitive impairment with a BIMS score of 11 out of 15. (continued on next page)

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	03/31/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #77's smoking assessments, dated 9/26/25 and 12/22/25, indicated he/she was safe to smoke independently and followed the facility's policy on smoking. Review of Resident #77's comprehensive care plan for smoking included the following interventions: - I need help budgeting my cigarettes and will allow staff to keep cigarettes in med room. One baggie containing six cigarettes given per day. - I will return my cigarettes and lighter to lock box after when finished smoking. Further review of Resident #77's medical record did not indicate that the facility's smoking agreement was reviewed with the resident on admission. On 3/26/26 at 7:22 A.M., the surveyor observed the smoking lock boxes on the unit. Resident #77's lock box did not contain any cigarettes or lighting supplies. The surveyor observed Resident #77 walk by the lock boxes and go to the smoking area. Resident #77 pulled a cigarette and lighter from his/her coat pocket and proceeded to light the cigarette. Resident #77 was noted to return from the smoking area at 7:26 A.M. Resident #77 asked UM #1 for his/her cigarettes. UM #1 gave the Resident a clear plastic bag containing six cigarettes. Resident #77 carried the bag of cigarettes to his/her room. On 3/26/26 at 7:53 A.M., the surveyor observed Resident #77 returning to the smoking area. Resident #77's lock box for smoking supplies was empty. Resident #77 was noted to pull a lighter from his/her coat pocket and light a cigarette. Resident #77 returned to the unit from the smoking area. Resident #77 did not return smoking supplies to his/her lock box. Resident #77 proceeded to return to his/her room. During an interview on 3/26/26 at 10:10 A.M., Certified Nursing Assistant (CNA) #1 said most of the residents on the unit who smoke are independent. CNA #1 said nurses check a few times a day to see if residents return their cigarettes and lighters to the lock boxes. CNA #1 said she was not responsible for reminding or monitoring that residents were using their lock boxes. CNA #1 said nurses would remind residents to place their smoking items in their lock boxes on return from the smoking area. CNA #1 said all lock boxes should contain the residents' cigarettes and lighters. During an interview on 3/26/26 at 10:30 A.M., Nurse #1 said residents who smoke independently on the unit have a code to the door to access the smoking area independently. Nurse #1 said residents who smoke were supposed to put their cigarettes and smoking supplies back in their lock boxes when they return from the smoking area. Nurse #1 said the facility had too many independent smokers who can go out several times a day. Nurse #1 said it was hard to keep track of who was coming in or going out to the smoking area. Nurse #1 said she was not responsible for reminding the residents to put their smoking items in their lock boxes. Nurse #1 said UM #1 would remind the residents to put their smoking items in their lock boxes if she was in the area. On 3/27/26 at 7:45 A.M., the surveyor observed Resident #77's smoking lock box on the unit which contained no smoking supplies or cigarette packages. On 3/27/26 at 8:07 A.M., the surveyor observed Resident #77 outside in the smoking area independently smoking. Resident #77's lock box on the unit for smoking supplies was empty. During an interview on 3/27/26 at 10:06 A.M., the Director of Nurses (DON) said residents who smoke (continued on next page)

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	03/31/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sign a smoking policy. Review of Resident #77's medical record did not include a signed smoking policy. The DON said it should have been obtained the day of admission by the admitting nurse. The DON said residents who independently smoke were given a key to a lock box in which they should house their smoking supplies when not out in the designated smoking area. The DON said staff are responsible for ensuring residents use their lock boxes after smoking. During an interview on 3/27/26 at 11:05 A.M., the Administrator said she was aware that not all independent residents who smoke were using their lock boxes. The Administrator said she and the Activity Director held a meeting in January with the residents who smoke. The Administrator said the smoking policy was reviewed and the residents acknowledged they understood the process. The Administrator said the expectation was for any staff member to monitor and/or cue residents to return their smoking supplies to their lock boxes upon returning from the smoking area.

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	03/31/2026

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on observation, interview, and document review, the facility failed to coordinate an assessment with the Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) program for one Resident (#3), out of a total sample of 19 residents. Specifically, the facility failed to initiate a new PASRR Level II Assessment following the addition of a schizoaffective disorder diagnosis to the clinical record. Findings include:Review of the MassHealth Nursing Facility Bulletin 186, dated June 2024, included but was not limited to the following:-Post admission Screening: For residents who experience a Significant Change or are newly identified as having a condition that may impact their PASRR status, the appropriateness of their nursing facility placement, or their need for Specialized Services.Review of the facility's policy titled Resident Assessment-Coordination with PASARR Program, dated as revised December 2025, indicated but was not limited to the following: -The Social Services Director shall be responsible for keeping track of each resident PASARR screening status and referring to the appropriate authority.-Any resident who exhibits a newly evident or serious mental disorder or related condition will be referred promptly to the state mental health authority for a level II resident review. Examples include: A resident whose related condition was not previously identified and evaluated through PASARR.Resident #3 was admitted to the facility in January 2026 with diagnoses which included history of falls, compression fractures, dementia, anxiety and depression.Review of the Minimum Data Set (MDS) assessment, dated 2/10/26, indicated Resident #3 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was moderately cognitively impaired, and he/she did not have a diagnosis of schizophrenia. Review of the MDS assessment, dated 2/18/26, indicated Resident #3 had a diagnosis of schizophrenia.Review of the Diagnosis List in the electronic medical record indicated the diagnosis of schizoaffective disorder was added to Resident #3's profile on 2/13/26. During an interview on 3/30/26 at 3:43 P.M., Social Worker (SW) #1 stated she oversees the PASARR process. If a resident has a new diagnosis of schizoaffective disorder, she would alert the appropriate authority for a new PASARR II to be completed. Social Worker #1 said she was unaware of the new diagnosis and did not make the referral as she should have.During an interview on 3/30/26 at 4:14 P.M., the Director of Nursing (DON) said a level II PASARR screen should have been completed when Resident #3 acquired the new diagnosis, and it was not done.

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	03/31/2026

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 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, interview, and record review, the facility failed to develop, implement and individualize a comprehensive care plan for one Resident (#4), out of a total sample of 19 residents. Specifically, the facility failed to ensure a comprehensive care plan related to Resident #4's use of hearing aids to support a communication deficit was developed and implemented. Findings include:Review of the facility's policy titled Comprehensive Care Plans, dated November 2019 and revised May 2025, indicated but was not limited to the following:-It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.-The comprehensive care plan will describe, at a minimum, the following:-The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. -The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment.Resident #4 was admitted to the facility in February 2026 with diagnoses including unspecified sensorineural hearing loss (hair cells in the cochlea or auditory nerves are damaged causing hearing loss).Review of Resident #4's Minimum Data Set (MDS) assessment, dated 3/2/26, indicated he/she was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 5 out of 15. Furthermore, the MDS assessment indicated Resident #4 was highly impaired for hearing and utilized hearing aid(s) and was dependent on staff's assistance for daily living needs.During an interview on 3/25/26 at 9:15 A.M., the surveyor observed Resident #4 lying in bed yelling for his/her hearing aids. The surveyor observed the hearing aids on a charging device located on a bedside table out of the Resident's line of sight. Resident #4 indicated he/she needed to have the hearing aids while awake to communicate with others.Review of Resident #4's medical record indicated but was not limited to the following:-2/26/26: History and Physical progress note indicated Resident was hard of hearing; orientation was difficult to assess due to hearing impairment.-2/27/26: Nurse progress note indicated Resident was hard of hearing and had bilateral hearing aids.-2/28/26: Nurse progress note indicated Resident had bilateral hearing aids at bedside.-3/3/26: Physician progress note indicated Resident is difficult to truly assess due to hearing loss.Review of Resident #4's Physician orders failed to indicate orders for Resident #4's hearing aid devices.Review of Resident #4's comprehensive care plans failed to indicate a communication care plan was developed or implemented to include hearing aids device needs.During an interview on 03/31/26 at 10:08 A.M., Nurse #4 said she was the admitting nurse for Resident #4 and was aware of the Resident being hard of hearing and wearing hearing aids. Nurse #4 reviewed Resident #4's medical record and said the Resident does not have a care plan in place for his/her communication impairment and use of hearing aids. Nurse #4 said she should have put a care plan in place for Resident #4 and did not do it. Nurse #4 said all nurses are responsible for updating a care plan however, the leadership team which includes the unit managers, Assistant Director of Nursing (ADON), Director of Nursing (DON), and the MDS nurse are the ones that usually put in the care plans. Nurse #4 said as the admitting nurse she should have taken care of it and it was an oversight.During an interview on 3/31/26 at 10:20 A.M., Unit Manager (UM) #2 said she usually creates the care plan as well as the ADON, DON, and MDS nurse as needed. UM #2 said the Resident did not have a care plan in place for his/her hearing impairment and use of hearing aids. UM #2 said Resident #4 should have had them in place and somehow it was an oversight and not done. During an interview on 3/31/26 at 10:45 A.M., the DON said Resident #4 should have had a communication care plan in place for his/her hearing deficit to include hearing aids and did not.

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	03/31/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services that met professional standards of practice for two Residents (#6 and #3), out of a total sample of 19 residents. Specifically, the facility failed to:1. Ensure Resident #6 had an occlusive dressing at bedside as ordered by the physician; and2. Ensure Resident #3, who had a diagnosis of schizoaffective disorder added after admission, had supporting documentation in the medical record. Findings include:Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following: -The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. - In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. 1. Resident #6 was admitted to the facility in May 2025 with diagnoses including end stage renal disease and dependence on renal dialysis. Review of Resident #6's Minimum Data Set (MDS) assessment, dated 1/15/26, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Furthermore, the MDS assessment indicated he/she was on dialysis. Review of Resident #6's Physician's Orders indicated but were not limited to: - 5/2/25: may go to Dialysis Center Monday, Wednesday, Friday; may be transported by ambulance service. - 5/14/25: maintain occlusive dressing supplies at bedside in the event the catheter dislodges; every shift. - 1/13/26: remove post dialysis dressing to fistula site every Tuesday, Thursday, Saturday. On the following dates and times, the surveyor failed to observe occlusive dressing supplies at Resident #6's bedside: - 3/25/26 at 10:21 A.M. and 11:45 A.M. - 3/26/26 at 9:30 A.M. (continued on next page)

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	03/31/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #6's Treatment Administration Record for March 2026 indicated nursing staff ensured occlusive dressing supplies were at the bedside every shift from 3/1/26 to 3/26/26. During an interview on 3/25/26 at 11:45 A.M., Resident #6 said nursing staff do not keep any dressings at his/her bedside. During an interview on 3/26/26 at 12:28 P.M., Nurse #1 said Resident #6 had an arteriovenous (AV) fistula (surgically created connection between the artery and vein to provide the safest long-term access for hemodialysis). Nurse #1 said Resident #6 used to have dressings at his/her beside when he/she was on a different unit at the facility but did not currently have an occlusive dressing in their room. Nurse #1 said Resident #6 did have an order for an occlusive dressing at the bedside and it was checked off each shift by the nurse indicating it was in the room. During an interview on 3/26/26 at 12:28 P.M., Unit Manager #1 said the occlusive dressing for Resident #6 should have been discontinued because he/she had an AV fistula site for access. Unit Manager #1 said she would contact the physician to discharge the orders. During an interview on 3/26/26 at 2:29 P.M., Unit Manager #1 said she heard back from the physician, and they wanted to keep the occlusive dressing at the bedside. Unit Manager #1 said an occlusive dressing should have been at the bedside as ordered. During an interview on 3/26/26 at 2:55 P.M., the Director of Nursing (DON) said she would expect an occlusive dressing to be at Resident #6's bedside as ordered by the physician. 2. Review of the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV, last revised March 2022, indicated but was not limited to the following: -Disorder class: Schizophrenia Spectrum and other psychotic disorders: Two or more of the following, each present for a significant portion of time during a 1-month period. -Delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior. Resident #3 was admitted to the facility in January 2026 with diagnoses which included history of falls, compression fractures, dementia, anxiety, and depression. Review of the MDS assessment, dated 2/10/26, indicated Resident #3 scored 11 out of 15 on the BIMS indicating he/she was moderately cognitively impaired, and he/she did not have a diagnosis of schizoaffective disorder. Review of the MDS assessment, dated 2/18/26, indicated Resident #3 had a diagnosis of schizophrenia. Review of the Diagnosis List in the electronic medical record indicated the diagnosis of Schizophrenia was added to Resident #3's profile on 2/13/26. Review of the medical record failed to indicate why the diagnosis was added to his/her profile less than one month after admission. Review of the medical record failed to indicate Resident #3 had this diagnosis on admission and failed (continued on next page)

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	03/31/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to indicate supporting documentation of the diagnosis had been provided to the facility to facilitate adding the diagnosis to his/her profile. Review of the comprehensive care plan failed to indicate behavioral symptoms for the diagnosis of schizoaffective disorder. During an interview on 3/30/26 at 11:18 A.M., Unit Manager (UM) #1 said she added the diagnosis to Resident #3's medical record because she received a verbal order from the physician to do so. She said there is no documentation in the record supporting the diagnosis. Further review of the medical record failed to indicate any supporting documentation of the diagnosis from any historical medical provider. During an interview on 3/30/26 at 3:43 P.M., Social Worker (SW) #1 said she does not know where the diagnosis came from. During an interview on 3/30/26 at 4:14 P.M., the DON said a new diagnosis of schizoaffective disorder requires documentation in the medical record of specific behaviors. The DON said the medical record does not have the proper documentation for the diagnosis.

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	03/31/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to implement recommendations from the Occupational Therapy assessments for contracture management for one Resident (#32), out of a total sample of 19 residents. Findings include:Resident #32 was admitted to the facility in October 2024 with diagnoses which included: traumatic brain injury, swan neck deformity of right fingers (a condition where the middle joint of the finger bends backward and the fingertip joint bends down, creating a swan-like shape) and right ring finger trigger finger (a condition where a finger or thumb catches, clicks, or locks in a bent position). Review of the Minimum Data Set (MDS) assessment, dated 1/1/26, indicated Resident #32 scored 7 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had severe cognitive impairment. Review of the consultation, to the hand specialist, dated February 2026, indicated but not limited to:-right middle and right ring finger triggering-right fingers swan neck deformity-performed steroid shot in right ring finger-OT referral for eval for figure eight splint right ring and middle finger Review of the Occupational Therapy Evaluation, dated 3/3/26, indicated Resident #32 was referred to therapy for evaluation due to new onset of pain, decrease in range of motion (ROM) and decrease in strength. Patient required skilled occupational services to fabricate, establish a splint wearing schedule, for a figure eight to right middle finger and right ring finger, and train caregivers on donning/doffing (putting on/taking off) splint to reduce pain and increase ROM of the right hand. Review of the Occupational Therapy Discharge summary, dated [DATE], indicated the following:-Patient currently fitted for a figure eight splint to right ring finger and middle finger, tolerating well, nursing staff trained with orthotic wear schedule. Review of the Orthotic wearing schedule, dated 3/17/26 indicated the following:-Application instructions, slip onto finger with openings on top of hand (see attached pictures)-Wearing schedule, on: morning before breakfast and off: night before bed-Store orthotic between uses in plastic bag, labeled Review of the Physician's Order Summary report March 2026 indicated there were no orders for Resident #32 to don/doff figure eight splint to right ring finger and middle finger to reduce pain and increase ROM of the right hand. On 3/26/26 at 7:40 A.M., the surveyor observed Resident #32 sitting in the dayroom. Resident #32 was not wearing his/her figure eight splint to right ring finger and middle finger. During an interview on 3/26/26 at 2:07 P.M., Certified Nursing Assistant (CNA) #1 said she regularly cares for Resident #32. She said she was with Rehab when they demonstrated how to put on the figure eight splint to right ring finger and middle finger. CNA #1 said she was not aware staff were to apply the splint. During an interview on 3/26/26 at 2:10 P.M., Nurse #1 said if a resident is seen by rehab and they recommend any splints, they tell us, and we get the physician's orders for treatment. She said Resident #32 does not have any orders for a figure eight splint to right ring finger and middle finger. She said if there is no order then the nurses would not know to put the figure eight splint to right ring finger and middle finger on the resident. On 3/27/26 at 7:53 A.M., the surveyor observed Resident #32 sitting in the dayroom. Resident #32 was not wearing his/her figure eight splint to right ring finger and middle finger. During an interview on 3/27/26 at 9:15 A.M., the Director of Rehab said Occupational Therapist (OT) #2 was unavailable for interview as she was out of the country. She reviewed the Occupational Therapy Discharge summary, dated [DATE], and said there should have been follow-up with the nurses on the use of the figure eight splint to right ring finger and middle finger. The Rehab manager said nursing staff would have been educated by the rehab staff to don/doff any splinting devices. Nursing staff would sign off on the Orthotic Wearing Schedule. The schedule would be given to the primary nurse to obtain a physician's order for donning/doffing. The Rehab manager said that education for Resident #32's splint would be placed in the education book on the floor for staff to review. The Rehab manager said there was no follow up on education or an order obtained. During an interview on 3/27/26 at 12:06 P.M., Nurse #2 said she was educated and took the (continued on next page)

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	03/31/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information from OT #2. Nurse #2 said she would have gotten a physician's order for the splint. Nurse #2 reviewed the medical record and did not see an order for the figure eight splint to right ring finger and middle finger. Nurse #2 said she did not know why she did not follow through with contacting the physician. During an interview on 3/27/26 at 12:12 P.M., Unit Manager (UM) #1 said she was unaware that Resident #32 was discharged from Occupational Therapy and needed an order for splinting of his/her right ring finger and middle finger. UM #1 said the nurse receiving the Orthotic Wearing Schedule should have obtained a physician's order so nursing would know when to don/doff the splint. During an interview with the Director of Nurses (DON) on 3/27/26 at 1:36 P.M., the DON said once Rehab makes a recommendation and it is communicated to the nurses, the nurses should follow-up with obtaining physician's orders if that is what they want. The DON said the order should have been obtained by the nurse receiving the education. As of the end of the survey, the OT who performed the most recent OT evaluation was not available to the surveyor for interview.

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	03/31/2026

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 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 record review and interview, the facility failed to ensure a person-centered plan of care with individualized interventions for trauma-informed care was developed for one Resident (#5), out of a total sample of 19 residents. Specifically, the facility failed to assess and implement care plan interventions for Resident #5 with a history of post-traumatic stress disorder (PTSD) and a history of a traumatic event. Findings include:Review of the facility's policy titled Trauma Informed Care Policy, last reviewed 11/2024, indicated but was not limited to the following:- [Corporate Name] remains committed to providing the highest quality of care. This commitment includes recognizing events in our residents' past that may have been traumatic and that may continue to have a negative, upsetting or emotionally difficulty impact on their lives.- To that end, a screening process will allow each facility to determine whether a resident might need or wish more specialized counseling or care.- As part of the admission process a specific assessment will be done consisting of several questions that are worded to assess past experiences and not trigger the episode.- If a resident has a history of trauma that is documented or if they have triggered from the assessment, the SW (social worker) and IDT (interdisciplinary team) need to immediately formulate a plan of care to assist the resident in coping within the facility with whatever issue has been identified. - The plan of care needs to be specific and include anything that has been shared that can trigger a memory of the incident.- Staff education should be done to identify any resident reactions that may indicate past trauma and what to do with that information. Resident #5 was admitted to the facility in January 2026 with diagnoses including dementia and PTSD. Review of Resident #5's Minimum Data Set (MDS) assessment, dated 1/29/26, indicated he/she had a moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 8 out of 15. Review of Resident #5's Social Service admission and Cultural Assessment, dated 2/3/26, indicated he/she had a diagnosis of PTSD and was involved in a traumatic accident in his/her adult life. Review of Resident #5's comprehensive care plans failed to indicate he/she had a history of a traumatic life event and/or PTSD. During an interview on 2/25/26 at 4:22 P.M., Certified Nursing Assistant (CNA) #4 said she was not aware of any resident on the unit with a diagnosis of PTSD or any related triggers/restrictions in their care. CNA #4 said she did not know if Resident #5 had PTSD or if he/she required any specific care interventions. During an interview on 3/26/26 at 11:23 A.M., the Social Worker said an assessment is completed for residents on admission related to trauma informed care. The Social Worker said she uses the assessment to determine if a resident has a history of trauma or a PTSD diagnosis. The Social Worker said any information identified during the assessment is put into the care plan for all staff to be able to identify. The Social Worker said Resident #5 did not have a care plan specific to his/her diagnosis of PTSD and/or traumatic life event. During an interview on 3/26/26 at 11:31 A.M., the Director of Nursing (DON) said all residents are assessed by social services on admission for trauma. The DON said if they trigger for a traumatic experience or a diagnosis such as PTSD a care plan should be developed. The DON said Resident #5 should have had a care plan in place for their known diagnosis of PTSD and traumatic life event.

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	03/31/2026

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 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, interview, and document review, the facility failed to ensure medications with a shortened expiration date upon opening were properly labeled once opened, in one medication storage room out of two medication storage rooms observed. Findings include:Review of the facility's policy titled Storage of Medications, dated as revised 8/2020, indicated but was not limited to the following: -Medications and biologicals are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. -Certain medications or package types, such as multidose injectable vials require an expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency. -When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. -The nurse shall place a date opened sticker on the medication and record the date opened and the new date of expiration. On 3/26/26 at 10:30 A.M., the surveyor observed the medication storage room with Nurse #4 on Santuit Unit and made the following observations: Three bottles of Tuberculin (used in skin tests to detect infection with Mycobacterium Tuberculosis - a contagious disease that affects the lungs) multi dose vials, opened and in use with no opened date. During an interview on 3/26/26 at 3:38 P.M., Nurse #4 said the bottles were open and in use and she did not know when they were opened. She said they should have been labeled with an opened date. During an interview on 3/30/26 at 4:14 P.M., the Director of Nursing (DON) said multi-dose vials have a shortened expiration date and should be labeled with the open and discard date upon opening to ensure they are not used after expiration.

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	03/31/2026

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview, the facility failed to ensure two Residents (#7 and #12), out of a total sample of five residents reviewed for immunizations, were screened for eligibility to receive the recommended influenza vaccination, residents/residents' representatives were educated on the benefits and potential side effects of the vaccines, were offered and administered (if applicable) the seasonal vaccine in a timely manner, and appropriately documented in the Resident's medical record.Findings include:Review of the facility's policy titled Influenza Vaccine, dated 5/2023, indicated, but was not limited to, the following:-All residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza.-Beginning no later than October 1st and continuing through March 31st each year, the influenza vaccine shall be offered to residents, unless the vaccine is medically contraindicated or the resident has already been immunized.-Prior to the vaccination, the resident (or resident's legal representative) will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's medical record.-A resident's refusal of the vaccine shall be documented on the Informed consent for influenza vaccine and placed in the resident's medical record.1. Resident #7 was admitted to the facility in March 2021 with diagnoses including type two diabetes and hypertension.Review of Resident #7's medical record indicated a Guardian (someone appointed by the court responsible for making decisions for another person) had been appointed on 6/17/21.Review of Resident #7's Immunization Consent indicated that the Resident's Guardian had consented to annual influenza vaccine administration on 5/18/22.Review of Resident #7's medical record failed to indicate the Resident had received the 2025-2026 influenza vaccine after the Guardian had consented to the administration.During an interview on 3/20/26 at 2:32 P.M., the Infection Control Nurse (ICN) said she is responsible for all residents' immunization tracking. The ICN said Resident #7 did not receive the influenza vaccination and there was no documentation education was provided or that the Resident refused administration of the vaccine.2. Resident #12 was admitted to the facility in August 2025 with diagnoses including heart disease.Review of Resident #12's medical record failed to include documentation that indicated the Resident was provided education regarding the benefits and potential side effects of the influenza vaccination and either consented to receive or refused vaccination for the 2025-2026 influenza season.During an interview on 3/20/26 at 2:40 P.M., the ICN said Resident #12 did not receive the vaccination this season. The ICN said there was no documentation in the Resident's medical record indicating education was provided or that the Resident consented to or refused administration of the vaccine for the 2025-2026 season.During an interview on 3/31/26 at 8:42 A.M., the Director of Nursing (DON) said there should have been documentation for both Resident #7 and Resident #12 in their medical records indicating administration of the vaccine or refusal. The DON said there should be a consent and documented education for every resident.

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	03/31/2026

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to ensure two Residents (#7 and #12), out of a total sample of five residents reviewed for immunizations, were screened for eligibility to receive the recommended COVID-19 vaccination, residents/residents' representatives were educated on the benefits and potential side effects of the vaccine, were offered and administered (if applicable) the vaccine in a timely manner, and appropriately documented in the Resident's medical record. Findings include: Review of the facility's policy titled COVID-19 Vaccine Policy-Massachusetts, dated September 2025, indicated, but was not limited to, the following:-Before offering the vaccine, all residents or their representatives will receive education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine being offered.-CDC defines Up to Date as received all doses of the current vaccine.-The resident's medical record will include documentation that indicates: -The date the resident or resident representative was provided education regarding benefits and potential risks associated with COVID-19 vaccination. -The resident accepted or refused the vaccination due to medical contraindications, prior vaccination, or refusal. If refused, document if it was related to a medical contraindication. -Each dose of COVID-19 administered to the resident will be recorded in the immunization record.1. Resident #7 was admitted to the facility in March 2021 with diagnoses including type two diabetes and hypertension.Review of Resident #7's medical record indicated a Guardian (someone appointed by the court responsible for making decisions for another person) had been appointed on 6/17/21.Review of Resident #7's medical record failed to include documentation that indicated the Resident's Guardian was provided education regarding the benefits and potential side effects of the COVID-19 vaccination and either consented to receive or refused vaccination.During an interview on 3/20/26 at 2:32 P.M., the Infection Control Nurse (ICN) said she is responsible for all residents' immunization tracking. The ICN said Resident #7 did not receive the vaccination and there was no documentation education was provided to the Resident's Guardian or that the Guardian consented or refused administration of the vaccine.2. Resident #12 was admitted to the facility in August 2025 with diagnoses including heart disease.Review of Resident #12's medical record failed to include documentation that indicated the Resident was provided education regarding the benefits and potential side effects of the COVID-19 vaccination and either consented to receive or refused vaccination for the 2025-2026 season.During an interview on 3/20/26 at 2:40 P.M., the ICN said Resident #12 did not receive the vaccination this season. The ICN said there was no documentation in the Resident's medical record indicating education was provided or that the Resident consented to or refused administration of the vaccine for the 2025-2026 season.During an interview on 3/31/26 at 8:42 A.M., the Director of Nursing (DON) said there should have been documentation for both Resident #7 and Resident #12 in their medical records indicating administration of the COVID-19 vaccine or refusal. The DON said there should be a consent and documented education for every resident.

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	03/31/2026

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 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and staff interviews, the facility failed to ensure a functional, safe, and clean environment. Specifically, the facility failed to ensure residents and/or staff properly disposed of cigarette butts in designated smoking receptacles.Findings include:Review of the Centers for Medicare & Medicaid Services (CMS) circular letter, dated November 10, 2011, titled Smoking Safety in Long Term Care Facilities indicated but was not limited to the following: -Metal containers with self-closing covers into which ashtrays can be emptied must be readily available.Review of the facility's policy titled Smoking Policy and Procedure, undated, indicated but was not limited to:-It is the policy of [Corporate Name] to provide a safe environment for residents, staff and visitors through the enforcement of a smoking policy designed to reduce risks to residents who smoke tobacco products, reduce the risks of passive smoking for others and reduce the risk of fire.-Employees and residents must dispose of tobacco products in appropriate tobacco receptacles. Residents that are observed leaving tobacco products on the ground or are observed tossing, flicking or throwing tobacco products will be reassessed to determine if they should be considered unsafe smokers.On 3/26/26 at 7:26 A.M., the surveyor observed the designated smoking area and identified two tall receptacles for cigarette butts with numerous cigarette butts scattered across the pavement. The surveyor also observed several cigarette butts scattered in the mulch adjacent to the facility. Three chairs were positioned along the outer perimeter of the smoking area, each with several cigarette butts accumulated underneath. On 3/27/26 at 8:07 A.M., the surveyor conducted a subsequent observation of the designated smoking area and identified the same conditions.During an interview on 3/26/26 at 10:10 A.M., Certified Nursing Assistant (CNA) #1 said the residents are independent smokers and no one is assigned to go outside with them. CNA #1 said sometimes the maintenance staff would clean up the area. CNA #1 said CNAs were not assigned to clean up the area. During an interview and observation of the designated smoking area on 3/27/26 at 8:20 A.M., the Maintenance Director said he tries to go out one to two times a week to clean up the area. The Maintenance Director said he had placed a broom and dustpan outside for the residents to sweep up the area after use. The Maintenance Director said he did not have a cleaning schedule, or anyone assigned to maintain the area. During an interview on 3/27/26 at 10:19 A.M., the Director of Nurses (DON) said the Maintenance Director was responsible for maintaining the smoking area. The DON said she was not sure of a cleaning schedule or why the area had not been maintained. During an interview on 3/27/26 at 11:05 A.M., the Administrator said Maintenance and Activities would usually maintain the area. The Administrator said she was not sure why the area had not been maintained.