STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225710	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Sudbury LLC	136 Boston Post Road Sudbury, MA 01776

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, and interviews, the facility failed to ensure that residents were treated with dignity during communal, shared dining experiences on one unit (Concord West, East and Split Units) out of two units observed, and that one Resident (#4) out of a total sample of 16 residents, was provided with a dignified dining experience when the Resident required assistance with eating. Specifically, the facility failed to:1. ensure that residents who resided on the Concord West, Concord East, and Concord Split nursing units were served their meals at the same time as other residents seated at the same table or seated in the dining room for meals.2. For Resident #4, provide assistance and supervision at mealtime as indicated on the Resident's care plan, resulting in an undignified dining experience for the Resident. Findings include: Review of the facility's policy titled Activities of Daily Living (ADLs), revised December 2025, included but was not limited to:*The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. -Care and services will be provided for the following activities of daily living:-Eating to include meals and snacks.-A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the facility's policy titled Promoting and Maintaining Resident Dignity, revised December 2025, included but was not limited to:*It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. -All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. -The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences. -Each resident will be provided with equal access to quality of care regardless of diagnosis, severity of condition or payment source. On 3/4/26 at 11:55 A.M. through 12:19 P.M., the surveyor observed the following during the lunch meal in the shared dining room for the Concord West, Concord East and Concord Split nursing units: -At 11:55 A.M.: 20 residents were present and seated at seven different round tables in the dining room. -At 12:00 P.M.: Table one positioned next to the entrance of the dining room had four residents seated at a round table, three residents had been served their lunch meal, and one resident had not been served a lunch meal. -At 12:09 P.M.: Table two had three residents seated at a round table, two residents had been served their lunch meal, and one resident had not been served a lunch meal. The resident seated at the table who was not served a lunch meal, was observed to reach over the table and remove a chocolate cake desert from one of the residents who had been served their meal. -At 12:17 P.M.: The resident seated at table one without a meal tray continued to wait for their lunch (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meal, when three residents seated at the same table had already started eating. On 3/5/26 at 7:44 A.M. through 8:12 A.M., the surveyor observed the following during the breakfast meal in the shared dining room for the Concord West, Concord East and Concord Split nursing units: -At 7:47 A.M.: Seven residents were present and seated at seven different round tables. One of the seven residents, seated at a round table was provided with their breakfast tray, and the remaining six residents did not have their meal trays. -At 7:52 A.M.: A second resident was served their breakfast meal. A resident was observed entering the dining room, sat at the same table with the second resident and looked at the second resident's breakfast meal.-At 7:53 A.M.: One resident stood up from their table, exited the dining room and asked a staff member in the hallway next to the meal cart about their breakfast meal. -At 7:55 A.M.: The resident was observed returning to the dining room after speaking to the staff member and was served their breakfast meal. -At 8:07 A.M.: two residents out of the eight residents seated in the dining room were served their breakfast meals 20 minutes after the other residents in the dining room were served their breakfast meals. During an interview on 3/5/26 at 8:20 A.M., Rehabilitation Staff (RS) #1 said that it had been a challenge updating the dining room tables so residents who eat in the dining room got their meals served at the same time. RS #1 said it was not a dignified dining experience when residents had to be waiting for 20 minutes after other residents in the dining room had already been served their breakfast meals. During an interview on 3/5/26 at 8:55 A.M., Nurse #5 said that the facility should have coordinated better with the kitchen and determined when the meal trucks arrived on the unit for the residents in the dining room to receive their meals at the same time. Nurse #5 also said that it was not dignified to serve some residents in the dining room their breakfast meal and other residents had to wait for their meals to be served. Nurse #5 said that residents seated at the same table should be served their meal at the same time and not have to wait and look at other residents eating their meals. Nurse #5 said that it would have been nice if residents who eat in the dining room receive their meals at the same time from the kitchen. During an interview on 3/5/26 at 9:38 A.M., the Assistant Director of Nurses (ADON) said that residents seated at tables together should be served their meal at the same time and should not have to watch their tablemates eat their meals. The ADON said that a hungry resident who does not have their meal could potentially choke should they attempt to eat their tablemate's food if the food is not what they are prescribed. The ADON further said that all residents seated in the dining room should be served their meal at the same time their tablemates were served their meals. 2. Review of the facility policy titled, Preparing the Resident for a Meal, dated December 2025 included but was not limited to the following: -Purpose - To prepare the resident and the environment in order to help make mealtime pleasant for the resident. -Preparation - Review the resident's care plan and provide for special needs of the resident. Review of the facility policy titled Promoting/Maintaining Resident Dignity, last revised December 2025 included but was not limited to the following: Policy - It is the practice of this facility to protect and promote resident rights and treat each resident (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. *Compliance: -All staff .to promote and maintain resident dignity and respect for resident rights. -Assist resident to participate in activities of choice. Resident #4 was admitted to the facility in February 2023 with diagnoses including need for assistance with personal care, weakness, unspecified lack of coordination, and Dementia. Review of Resident #4's Minimum Data Set (MDS) Assessment, dated 2/17/26, indicated: -was severely cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of three out of a total possible score of 15. -required partial to moderate assistance (helper does less than half the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort) for eating. -has not demonstrated rejection of care. Review of Resident #4's medical record included but was not limited to the following: -A Person-Centered Care Plan, revised 2/16/26, which indicated Resident #4 was at nutritional risk and required supervision during meals. -An active Care Kardex (brief summary of specific care needs for an individual) which failed to indicate that Resident #4 required supervision at meals. On 3/5/26 between 8:15 A.M. through 8:43 A.M., the surveyor observed Resident #4 lying in his/her bed. Certified Nurse Aide (CNA) #9 was observed to enter the Resident's room, deliver and set up a breakfast tray for Resident #4 then exit the room. The surveyor further observed Resident #4 pick up his/her spoon from the breakfast tray and begin eating ground sausage patty and pureed pancakes with syrup. Resident #4 spilled three consecutive bites of ground sausage and pureed pancake with syrup on his/her chest. Resident #4 then dropped the spoon on his/her bed and began to eat the pureed pancake with syrup and ground sausage with his/her fingers. During an interview on 3/5/26 at 8:28 A.M., CNA #9 said she was the CNA that set up Resident #4's breakfast tray. CNA #9 said that she knew what each resident needed for assistance because the Nurse gives her a report at the start of the shift. CNA #9 said that the facility used to have Care Kardex's for each resident, but the Care Kardex's were no longer available. CNA #9 said that Resident #4 was able to feed him/herself. On 3/5/26 at 8:43 A.M., CNA #8 was observed removing Resident #4's breakfast tray from the Resident's room. During an interview at the time, CNA #8 said he has worked in the facility for a long time and was familiar with Resident #4's care needs. CNA #8 said Resident #4 did not require supervision at meals but did require set up for all meal trays. CNA #8 said the facility does not have Care Kardex's anymore, but he knew what each resident needed because he has worked in the facility (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for a long time. During an interview on 3/5/26 at 9:09 A.M., the Director of Nursing (DON) said the CNA's have Care Kardex's in the facility's electronic charting system that the CNA's should follow for each resident. The DON said that each resident's Care Kardex informs staff of individualized care needs. The DON said that Resident #4 was care planned for supervision at meals which meant a staff member should observe the Resident at all times during meal consumption. During an interview on 3/5/26 at 9:48 A.M., the Director of Rehabilitation said Resident #4 required supervision during meals because of his/her need for assistance to manage utensils and verbal cueing. The Director of Rehabilitation said Resident #4's Care Plan indicated a need for supervised meals which meant that staff needed to be in the room with the Resident at all times during a meal. During an interview on 3/5/26 at 10:32 A.M., the DON said Resident #4 required supervision and assistance at mealtimes to provide cues and help during the meal. The DON said when Resident #4 had eaten with his/her fingers after dropping the spoon and spilled food on him/herself, it was a concern for an undignified dining experience for the Resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, and interviews, the facility failed to ensure that medication storage was maintained in a clean and sanitary manner for three medication carts (Concord East, Concord West, and Concord Split) out of three medication carts observed. Specifically, the Concord East, Concord West, and Concord Split medication carts were not maintained in a clean and sanitary manner, placing residents receiving medications from the carts at risk for contamination of medications and the spread of infections. Findings include: On 3/4/26 at 9:08 A.M., the surveyor and Nurse #1 observed the Concord East medication cart. The surveyor observed the medication cart was soiled externally at the top of the preparation surface, on both sides, front and back with a splattered, dried, brown substance. The surveyor also observed an open apple sauce container dated 3/4/26, and a water pitcher used for medication administration to residents on the top of the medication cart and a thick coating of dust to the lower-outer perimeter of the medication cart with dried splatters of brown and orange substances mixed in the dust. In the top medication storage drawer, a dried pool of white substance and three unidentifiable loose, white tablets, in addition to the over-the-counter medication bottles used for resident medication administration were observed. In the third drawer down on the right was a pool of partially dried, tacky brown liquid with other bottles of liquid medication used for resident medication administration. During an interview at the time, Nurse #1 said he was unaware of what the dried substances were inside and, on the cart, or when the medication carts get cleaned at the facility. Nurse #1 said the medication carts should be cleaned by the Nurses. On 3/4/26 at 9:16 A.M., the surveyor and Nurse #4 observed the Concord [NAME] medication cart. The surveyor observed the medication cart was soiled externally at the top of the preparation surface, both sides, and down the front with a dripped, dried, brown substance. There was a thick coating of dust to the lower-outer perimeter of the medication cart edge. On the top of the medication cart an open apple sauce container dated 3/4/26, an unopened nutritional protein shake, and a water pitcher used for medication administration to residents were observed. In the right top medication storage drawer, which contained over the counter medications for resident use was a small, dried pool of a white, chalky substance and two unidentifiable pink pills. In the bottom drawer on the right was a pool of dried, dark brown substance. During an interview at the time, Nurse #4 said she was unable to identify the spilled substances in or on the medication cart. Nurse #4 said she thought the night shift Nurses were responsible for cleaning the medication carts weekly on Tuesday's (last night) but the medication cart did not appear to have been cleaned. On 3/4/26 at 9:21 A.M., the surveyor and Nurse #6 observed the Concord Split medication cart to have spillage of white and brown substances down the bilateral sides of the cart and front facing drawers. In the left sided third drawer down was a partly dried, sticky brown pool of substance, and on the right drawer a dried chalky white pool of substance with other medication bottles that were used for resident medication administration. During an interview at the time, Nurse #6 said she was unaware of who was supposed to clean or when the medication carts were supposed to be cleaned but all Nurses should wipe up the spills. During an interview on 3/4/26 at 2:14 P.M., the Director of Nursing (DON) said the facility did not have a policy for medication cart cleaning, but there needed to be one. The DON said she had observed the medication carts and had concern for the lack of cleanliness. The DON said the dirty medication carts could result in contamination between different resident's medications and would need to be cleaned.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and record review, the facility failed to provide food and drink at safe and appetizing temperatures to residents from three of three breakfast meal carts on one unit (Concord West, East and Split Units) out of two total resident units.Specifically, the facility failed to provide food and drink at safe and appetizing temperatures for the breakfast meal for residents eating breakfast on the Concord East Unit, Concord [NAME] Unit, and in the shared Concord Unit Dining Room, increasing the residents' risks for reduced food/fluid intake and foodborne illness. Findings include:Review of the facility's policy titled Food: Quality and Palatability, last revised February 2023, indicated the following:-Food will be . served at a safe and appetizing temperature. -Proper (safe and appetizing) temperature means food should be at the appropriate temperature as determined by the type of food to ensure residents' satisfaction . Review of the facility's Food Committee Meeting Minutes, dated 2/19/26, indicated resident reported concerns over cold food and coffee. On 3/4/26, Surveyor #1 observed the following in the facility's Main Kitchen:-All hot food being served for breakfast was held at temperatures greater than 135 degrees Fahrenheit (F).-Cold beverages being served for breakfast were held at temperatures less than 41 degrees F.-steam coming from the steam table where hot foods were held from the start to finish of the tray line process (7:35 A.M. through 8:16 A.M.).-Loaded breakfast carts left the Main Kitchen as follows: >7:44 A.M. to the Concord Unit Main Dining Room. >7:58 A.M. to the Concord East Unit. >8:16 A.M. to the Concord [NAME] Unit. On 3/4/26 at 8:05 A.M., when all resident meal trays were passed, surveyor #2 completed a breakfast meal test tray in the Concord Unit Dining Room as follows:-Milk 60 degrees F, not cold.-Orange juice 56 degrees F, not cold.-Coffee 124 degrees F, not hot.-Scrambled eggs 118 degrees F, not hot. On 3/4/26 at 8:31 A.M., once all resident meal trays were passed, surveyor #3 completed a breakfast meal test tray on the Concord East Unit as follows:-Pureed bread 101 degrees F, not hot.-Pureed eggs 110 degrees F, not hot.-Pureed ham 84 degrees F, not hot.-Pureed oatmeal 91 degrees F, not hot.-Milk 60 degrees F, not cold.-Orange juice 60 degrees F, not cold. On 3/4/26 at 8:39 A.M., once all resident meal trays were passed, surveyor #1 completed a breakfast meal test tray on the Concord [NAME] Unit as follows:-Toast 62 degrees, spongy, one side lightly toasted and one side not toasted.-Scrambled eggs 110 degrees, not hot.-Cooked ham slice 80 degrees, not hot.During an interview at the time, the Food Service Director (FSD) said she was concerned that the hot foods were not served hot to the residents during the breakfast meal on 3/4/26. During interviews at the Resident Group Meeting on 3/4/26 at 11:00 A.M., four Residents (#8, #18, #19, and #23) out of eight residents present for the meeting said food that was supposed to be served hot was not hot when served. During an interview on 3/4/26 at 1:45 P.M., surveyor #1 discussed the results of the three breakfast meal test trays and the FSD said food items should be served to residents at a safe and appetizing temperature. The FSD said it was important for foods meant to be served hot to be served hot, and foods/beverages meant to be served cold be served cold.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observations, interviews, and record review, the facility failed to provide an environment that was free from physical restraints imposed for discipline or convenience for one Resident (#5) out of a total sample of 16 residents. Specifically for Resident #5, the facility failed to ensure that the Resident's freedom of movement or activity was not limited, that he/she was capable of unlocking his/her wheelchair, and was evaluated for the least restrictive restraint when staff locked his/her wheelchair brakes to restrict the Resident's movements while he/she was seated in the wheelchair. Findings include: Review of the facility policy titled Use of Restraints, revised December 2025 included but was not limited to the following: -Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. -Physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the residents' body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. -Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted. -Prior to placing a resident in restraint, there shall be a pre-restraint assessment. -Restraints shall only be used upon the written order of a physician after obtaining consent from the resident and/or representative. Resident #5 was admitted to the facility in November 2017 with diagnoses including Dementia and difficulty walking. Review of the Minimum Data Set (MDS) Assessment, dated 2/12/26, indicated Resident #5: -was unable to participate in a Brief Interview of Mental Status (BIMS) because he/she was rarely/never understood. -had not demonstrated wandering behaviors. Review of Resident #5's medical record failed to indicate evidence of: -A pre-restraint assessment. -A Physician's order for restraint. Review of Resident #5's Person-Centered Care Plan indicated: -Focus - Impaired cognition with behaviors that included wandering and limited language. -Interventions - Engage Resident in simple, structured activities. Monitor for physical/nonverbal indicators of discomfort or distress. -Focus - Behavior symptoms of wandering. -Interventions - Redirect the Resident by taking him/her on a walk together, then sitting in a common area. -No evidence of a Resident Centered Restraint Care Plan. On 3/3/26 between 3:29 P.M. through 4:00 P.M., the surveyor observed Resident #5 seated in a wheelchair in the Concord Unit activity room. Resident #5 was forward leaning and perched to the front edge of the wheelchair seat. The Resident's wheelchair was observed with both the left and right sided brakes locked. Resident #5 was scooting in the wheelchair with the brakes locked, using his/her feet and hip thrusts to move the wheelchair forward towards the exit of the activity room. Resident #5 paused his/her forward movement occasionally and rocked side to side then continued to scoot the wheelchair to the exit of the activity room and entered the hallway using his/her feet and hip thrusts. Nurse #1 was observed at that time to ask Resident #5 where he/she was going. Resident #5 repeated to Nurse #1 where are you going. Nurse #1 then unlocked the Resident's wheelchair brakes, wheeled Resident #5 to a table in the activity room and relocked the Resident's left and right sided brakes. During an interview at the time Nurse #1 said Resident #5 was unable to make his/her needs known. Nurse #1 said that Resident #5 is able to propel the wheelchair independently with his/her feet. Nurse #1 said he locks the brakes on Resident #5's wheelchair to keep the Resident safe and to prevent the Resident from moving out of the activity room so that the Resident could be watched. Nurse #1 then offered Resident #5 a glass of water which he/she declined. Nurse #1 then returned to his medication cart in the hallway and Resident #5 immediately began to scoot away from the table in the locked wheelchair with his/her feet and attained a forward-facing position towards the activity room exit. Resident #5 then continued to scoot forward with his/her feet and hip thrusts which caused the back wheels of the wheelchair to lose contact with the floor several times. Activity Staff #1 was observed to approach Resident #5 at the activity room exit, said hello to the Resident and asked the Resident where he/she was going. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5 did not respond, and Activity Staff #1 then unlocked the Resident's wheelchair brakes, returned the Resident to the same activity room table where he/she had been placed by Nurse #1 and relocked the Resident's left and right sided wheelchair brakes. During an interview at the time Activity Staff #1 said that Resident #5 was able to move themselves around the unit in the wheelchair. Activity Staff #1 said Resident #5 was not able to tell staff what he/she needed but can sometimes point to something he/she wants. Activity Staff #1 said she locks the Resident's wheelchair brakes so that the Resident cannot move too much, and the staff would know where the Resident was. Resident #5 then began to scoot the wheelchair away from the activity room table and toward the exit with the wheelchair brakes locked. Resident #5 was observed at the activity room exit and was greeted by CNA #5 in the hallway. CNA #5 asked Resident #5 if he/she needed to use the bathroom. Resident #5 nodded his/her head yes and CNA #5 then took Resident #5 to the bathroom. During an interview on 3/3/26 at 4:38 P.M., CNA #5 said that she had worked in the facility for many years and provided care for Resident #5. CNA #5 said that when Resident #5 was restless it usually meant that he/she needed the bathroom. CNA #5 said that when she had taken Resident #5 to the bathroom around 4:00 P.M., Resident #5 had a bowel movement. CNA #5 said that Resident #5's wheelchair brakes should not be locked because Resident #5 was able to move the wheelchair independently and locking the brakes would hold the Resident back from moving. During an interview on 3/4/26 at 2:14 P.M, the Director of Nursing (DON) said if Resident #5 was unable to unlock his/her wheelchair brakes then the wheelchair brakes being locked would be considered a restraint. The surveyor and the DON approached Resident #5 seated in a locked wheelchair in the Concord Unit activity room and the DON asked Resident #5 to unlock the wheelchair brakes. Resident #5 was unable to unlock the wheelchair brakes. The DON said that the locked wheelchair was a restraint that limited the resident's movement because the Resident was able to move the wheelchair themselves when the brakes were not locked.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure that one Resident (#59) out of a total sample of 16 residents had been provided the right to participate in the care plan process.Specifically, for Resident #59, the facility failed to ensure that the Resident was invited to participate in the initial and quarterly care plan meetings that were conducted as required for him/her or provide rationale why Resident #59 did not participate in the care planning meetings. Findings include: Review of the facility policy for Care Planning - Interdisciplinary Team, December 2025 indicated:-The Resident, the Resident's family and/or the Resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the Resident's care plan.-Care plan meetings are scheduled at the best time of the date for the Resident and family when possible.-If it is determined that the participation of the Resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record. Resident #59 was admitted to the facility in February 2025, with diagnoses including Heart Failure (HF) and Chronic Obstructive Pulmonary Disease (COPD). Review of the MDS (Minimum Data Set) assessment dated [DATE], indicated Resident #59:-was moderately cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 11 out of 15.-was English speaking.-makes himself/herself understood and usually understands others. During an interview on 3/3/26 at 10:06 A.M., Resident #59 said that he/she had never been invited to a care plan meeting. Review of Resident #59's clinical record indicated no documented evidence that the Resident participated in the care planning process with the interdisciplinary team (IDT) during the Resident's care plan meeting reviews held on 2/17/25, 6/12/25, 11/11/25, and 2/2/26.Further review of the clinical record failed to indicate the rationale as to why the Resident did not or could not participate in any care plan meetings, or refusals to participate in the meetings in 2025 and 2026. During an interview on 3/5/26 at 10:32 A.M., the Director of Nursing (DON) said that Resident #59 had not been invited to attend his/her care plan meetings and should have been invited because it was a Resident's right to be invited to attend their care plan meetings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225710	A. Building B. Wing	03/05/2026

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview, and record review, the facility failed to provide foot care and treatment in accordance with professional standards of practice for one Resident (#9) out of a total sample of 16 residents.Specifically, for Resident #9, the facility failed to provide toenail care as required to assist the Resident in maintaining good foot health and also schedule podiatry services as ordered when two Podiatry visits occurred in the facility after the Resident was admitted , putting him/her at risk of podiatric complications. Findings include: Review of the facility policy titled Activities of Daily Living (ADLs) -revised December 2025, indicated:-Care and services will be provided for.bathing, dressing, grooming and oral care.-A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. Resident #9 was admitted to the facility in September 2025 with diagnoses including Transient Ischemic Attack (TIA), Anoxic Brain Damage and Gastrostomy. Review of Resident #9's most recent Minimum Data Set (MDS) Assessment completed 12/10/25, indicated:-that a staff assessment was completed for the Brief Interview for Mental Status (BIMS) because the Resident was rarely or never understood. -was severely cognitively impaired.-was dependent on staff for all ADLs. Review of Resident #9's medical record indicated:-Physician's order for Podiatry Consult as needed, dated 9/10/25.-Request for Podiatry Services Form, signed by the Resident's Guardian (someone with the legal authority to make decisions on behalf of another person) on 9/12/25.-Foot care had been provided to the Resident daily at their hour of sleep (HS) every evening shift. On 3/3/26 at 10:44 A.M., the surveyor observed Resident #9's toenails were untrimmed with the free edge of most of the toenails on both feet grown significantly past the nail bed. On 3/4/26 at 11:12 A.M., the surveyor observed Resident #9's toenails remained untrimmed with the free edge of most of the toenails on both feet grown significantly past the nail bed. During an interview on 3/4/26 at 12:56 P.M., the Director of Nursing (DON) said that Resident #9 should have been seen by Podiatry because the Resident's Guardian had signed the consent for Podiatry when he/she was admitted and that he/she should have been placed on the Podiatry list to be seen but had not been seen. The DON said that Podiatry had been to the facility twice on 12/19/25 and 2/24/26 since his/her admission to the facility and the Resident had not been seen on either of the two dates.

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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 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 provide respiratory care and services consistent with professional standards of practice for one Resident (#13) out of a total sample of 16 residents. Specifically, for Resident #13, the facility failed to ensure that the Resident's oxygen concentrator (device used to deliver supplemental oxygen) cabinet and filter were cleaned and maintained as required, placing the Resident at risk for infection, impaired oxygen delivery and equipment malfunction. Findings include: Review of the Manufacturer User Manual for the Invacare Platinum 10 XL oxygen concentrator provided by the facility indicated: -Warning: *Keep the openings free from lint, hair and the like. -Maintenance: *The Invacare concentrators are specifically designed to minimize routine preventive maintenance. Only qualified personnel should perform preventive maintenance on the concentrator. -Cleaning the cabinet filter: *There are two cabinet filters one located on each side of the cabinet. 1. Remove each filter and clean at least once a week depending on environmental conditions. NOTE: Environmental conditions that may require more frequent cleaning of the filters include but are not limited to: high dust, smoking, air pollutants, etc. *On a weekly basis, wash the air intake gross particle filter, located on the back of the unit. 2. Clean the cabinet filters with a vacuum cleaner or wash in warm soapy water and rinse thoroughly.3. Dry the filters thoroughly before reinstallation. -Cleaning the cabinet:1.UNPLUG the concentrator when cleaning. To avoid electrical shock, DO NOT remove cabinet. 2.Clean the cabinet with a mild household cleaner and nonˆabrasive cloth or sponge. Resident #13 was admitted to the facility in February 2022 with diagnoses including Heart Failure and Dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #15 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of a total possible score of 15. Review of Resident #13's current Physician orders indicated: -Oxygen two liters per minute (LPM - flow rate for oxygen delivery) as needed every shift for shortness of breath (SOB), effective 9/18/25. Review of Resident #13's Person-Centered Care Plan, revised 2/16/26, indicated: -I am [sic] oxygen therapy at two liters per minute (as needed, continuous [sic]) with interventions that included maintaining supplemental oxygen via nasal cannula (NC - a soft flexible, plastic tube applied in the nares for oxygen delivery). On 3/3/26 at 8:48 A.M., the surveyor observed Resident #13 lying in bed with oxygen being delivered at 2 LPM via NC from the oxygen concentrator. The oxygen tubing was observed to be dated 3/3/26 on a piece of white tape. The oxygen concentrator cabinet had a large area of dried white substance across the top and down the front and there were copious dried brown particles of debris observed on the front and sides of the oxygen concentrator cabinet. The oxygen concentrator filters on the left and right side of the oxygen concentrator cabinet walls were coated in layers of thick, fuzzy, gray dust. On 3/4/26 at 7:53 A.M., the surveyor observed Resident #13's oxygen concentrator remained unchanged from the prior observation on 3/3/26. During an interview at the time, Nurse #4 said that she was assigned to Resident #13 and the oxygen concentrator cabinets and the filters should be cleaned and wiped down every week by the Nurses when the oxygen tubing was changed. Nurse #4 said that oxygen tubing was supposed to be changed by the night shift on Tuesdays. The surveyor and Nurse #4 observed the Resident's oxygen concentrator and Nurse #4 said that tubing had been changed by the night Nurse because it was dated 3/3/26 but it did not appear that the oxygen concentrator cabinet and filters had been cleaned. Nurse #4 said that the filters were coated in dust and the white substance looked like Ensure drink. Nurse #4 said the brown particles on the cabinet appeared to be food of some type and Resident #13 was at risk for exposure to germs that could cause infection due to the dirty oxygen concentrator and filters. During an interview on 3/4/26 at 7:59 A.M., the Infection Preventionist (IP) said all oxygen tubing should be changed once a week on Sundays in the facility. The IP said she thought the housekeeping and maintenance departments were responsible for cleaning the oxygen concentrators but was unsure how often that was done. The IP (continued on next page)

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	225710	A. Building B. Wing	03/05/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said that it was important for Resident #13 to have a clean oxygen concentrator due to bacteria contamination and infection risk. The IP further said that the dried white substance on the oxygen concentrator looked like vanilla Ensure and the dried brown debris were crumbs of food. During an interview on 3/4/26 at 11:23 P.M., the Director of Nursing (DON) said that she was not aware if there was a set cleaning schedule for the oxygen concentrators in the facility. The DON said that cleaning schedules would need to be addressed. The DON said that dirty concentrator filters could affect Resident #13 because the delivery of oxygen could be impaired or cause overheating that could cause a fire.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observations, interviews, and record review, the facility failed to provide effective pain management consistent with professional standards of practice, for one Resident (#73) out of a total sample of 16 residents. Specifically, for Resident #73, the facility failed to: -ensure that ordered Oxycodone (opioid pain medication) medication was available for administration to manage the Resident's chronic pain when the pharmacy medication was not confirmed by the Nurse resulting in the oxycodone medication being unavailable for administration to the Resident for approximately 21 hours. -ensure alternative and/or emergency pain management instructions were obtained from the NP/Physician to treat the Resident's persistent pain in a timely manner, when an alternative STAT dosage of oxycodone medication had to be ordered by the Physician for pain relief more than two hours after the Resident was administered scheduled Acetaminophen which did not relieve the Resident's pain. Findings include: Review of the facility policy titled Reconciliation of Medications on Admission, last revised December 2025, indicated the following:-Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications . for the purpose of preventing unintended changes or omissions at transition points in care. -Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, ., during the admission . process. Review of the facility policy titled Pain Assessment and Management, last revised December 2025, indicated the following: - .pain management .is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. -Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. -Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. -Possible behavioral signs of pain: >negative verbalizations and vocalizations such as groaning, crying, screaming. >facial expressions such as grimacing, frowning, clenching of jaw, etc. >behavior such as resisting care, . > .inability to perform ADLs due to the presence of pain. >insomnia. -Possible physiological signs of pain: >somnolence. -Monitor the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain . Resident #73 was admitted to the facility in March 2026 with diagnoses including Osteoarthritis and Right Hip Pain. Review of Resident #73's February 2026, Hospital Discharge Summary indicated: -sustained a right femoral neck (hip) fracture and underwent a total hip arthroplasty (THA: replacement) in October 2025. -underwent a palliative care consult, and palliative care was providing support to the Resident. -has right lower extremity pain and required pain regimen adjustment. -has Osteoarthritis at multiple joints. -Oxycodone HCl 2.5 mg/2.5 mL oral syringe was ordered to be administered PRN every four hours for moderate (4-6/10 [pain scale of four to six out of ten]) pain. -was to be discharged from the hospital to the facility. Review of Resident #73's Nursing admission Assessment, dated 3/2/26, indicated: -Pain level using a numeric scale was two out of 10 (2/10) at 2:15 P.M. that same day (3/2/26). -Resident's verbal pain scale was reported as moderate and expressed right hip pain as throbbing. -The Resident reported repositioning and PRN pain medication alleviated the pain. -The Resident reported his/her pain affected ADLs and physical activity/mobility. -Pain treatment included PRN Oxycodone 2.5 mg BID (twice daily) for moderate to severe pain. Review of Resident #73's Pain Interview, dated 3/2/26, indicated the Resident had occasional pain rated at a level of 6/10 or was hurting in the last five days that: -made it hard to sleep at night. -limited day-to-day activities. Review of Resident #73's Pain Care Plan, initiated 3/2/26, indicated: -Has potential for increased pain related to OA, physical deconditioning, and fall with THA. -Goal was to verbalize adequate relief of pain or ability to cope with incompletely relieved pain. -Administer analgesia as per orders; give a half hour before treatments or care. -Anticipate need for pain relief and respond immediately to any complaint (continued on next page)

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	225710	A. Building B. Wing	03/05/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of pain. -Evaluate the effectiveness of pain interventions .; review for compliance, alleviating of symptoms, dosing schedules, and resident satisfaction with results, impact on functional ability, and impact on cognition. -Notify physician if interventions are unsuccessful or if current complaint is a significant change from Resident's past experience of pain. Review of Resident #73's March 2026 Physician Orders indicated: -Monitor for behaviors: refusal of care, yelling (3/2/26). -Monitor for pain every shift for surveillance (3/2/26). -Acetaminophen Oral Tablet 500 mg; give two tablets by mouth two times a day for pain (3/2/26; scheduled at 8:00 A.M. and 8:00 P.M.). -Acetaminophen Tablet 325 mg; give two tablets by mouth as needed for pain daily (3/2/26). -Oxycodone HCL Oral Tablet 5 mg, give 2.5 mg by mouth as needed for pain twice daily (3/2/26). Review of Resident #73's March 2026 Medication Administration History Report indicated: -Two tablets of 500 mg (total 1000 mg) each Acetaminophen Oral Tablets were administered to the Resident on: >3/2/26 at 7:31 P.M. (scheduled for 8:00 P.M.) >3/3/26 at 9:38 A.M. (scheduled for 8:00 A.M.) -no documentation of PRN Acetaminophen being administered to the Resident between 7:31 P.M. on 3/2/26 and 9:38 A.M. on 3/3/26. -no documentation of PRN Oxycodone being administered to the Resident on 3/2/26. -documentation of the first dose of Oxycodone (5 mg STAT dose) being administered to the Resident was on 3/3/26, documented at 12:05 P.M. Review of Resident #73's Nursing Progress Note, dated 3/3/26 and written at 6:07 P.M. by Nurse #1, indicated:-the Resident was groaning in pain that morning and was asking for his/her pain medication (oxycodone 2.5 mg) but the oxycodone 2.5 mg was not available from the pharmacy.-Nurse #1 got a script from the Physician and faxed the script to the pharmacy.-Nurse #1 also got a one-time order of oxycodone 5 mg from the facility E-Kit which was administered while awaiting the pharmacy delivery.-The 2.5 mg tabs (of oxycodone) were delivered from the pharmacy that afternoon.-At the time of the Nursing Progress Note at 6:07 P.M., the Resident rated his/her pain at 2/10. Review of Resident #73's March 2026 Medication Administration Record (MAR) indicated:-pain level of 2/10 documented on the 11:00 P.M. to 7:00 A.M. (Night) shift 3/2/26 - 3/3/26 by nursing staff.-pain level of 0/10 was documented for the 7:00 A.M. - 3:00 P.M. (Day) shift on 3/3/26.-pain level of 8/10 was documented for the 3:00 P.M. - 11:00 P.M. (Evening) shift on 3/3/26. On 3/3/26, between 10:43 A.M. and 11:18 A.M., the surveyor observed the following: -Resident #73 was positioned in bed, turned toward his/her right side and with his/her head resting on the quarter siderail. The surveyor observed the Resident rub his/her left leg and face repeatedly, then grasp the quarter siderail with his/her left hand and repeatedly call out, oh, oh, oh! -At 10:44 A.M., a staff member entered the Resident's room, and the surveyor heard the staff member ask the Resident what was wrong. The Resident replied, What is wrong with them here? I told everyone and no one does anything! I have a terrible headache and every time I lift my head, I am dizzy!. -At this time, the surveyor observed Resident #73 begin crying and the staff member offered the Resident pillows for repositioning. The surveyor then observed Resident #73 yell out, That's not going to help! I need more than pillows!. At this time, the staff member exited the Resident's room and the Resident continued to call out, oh, oh, oh! Oh, my head!. -At 10:52 A.M., the surveyor observed Certified Nurse Aide (CNA) #1 in the hallway outside of the Resident's room, say to another staff member, I think [he/she] is in pain. [He/she] is new. Do you want me to go clean [him/her] now?. -At 10:53 A.M., the surveyor observed CNA #1 enter Resident #73's room. CNA #1 said, I am going to wash you up and the Resident said he/she did not want to wash up. CNA #1 said, I am going to help you wash up and the Resident said, I don't want you to wash me up! I need pain medication!. CNA #1 exited the room and said, I tried. I'm going to someone else, then proceeded down the hallway and entered another resident's room. -At 11:00 A.M., the surveyor observed Resident #73 call out, Ahhh, oh, oh, ow, oh!. The surveyor observed the Resident rolled toward his/her right side, head resting on the quarter siderail. -At 11:04 A.M., the surveyor observed Resident #73 roll onto his/her back and bang on the bedside table, which was positioned next to the bed, with his/her left hand. -Between 11:06 A.M. and 11:17 A.M., the surveyor observed a housekeeper enter, clean, mop, and exit Resident #73's room as Resident #73 continued to intermittently call out, oh, oh, oh!. -At 11:18 A.M., the surveyor observed (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #73 call out, help, help and the Resident was crying. During an interview on 3/3/26 at 11:20 A.M., Nurse #1 said that Resident #73 was in a lot of pain that morning. Nurse #1 said that the Resident was recently ordered for 2.5 mg of PRN Oxycodone and that the ordered medication was not available to be administered to the Resident. When the surveyor asked about the E-Kit (Emergency kit) oxycodone, Nurse #1 said the E-Kit oxycodone were 5 mg tablets and could not be broken for the 2.5 mg dose ordered for the Resident. Nurse #1 said that he administered the Resident's scheduled Acetaminophen earlier that morning and that the scheduled Acetaminophen did not alleviate the Resident's pain. Nurse #1 said he offered the Resident a PRN dose of Acetaminophen, and the Resident declined the administration of the PRN dose because Acetaminophen was not effective to treat his/her pain. Nurse #1 said the facility had not yet obtained the Resident's ordered PRN Oxycodone medication since ordered for the Resident on 3/2/26. Nurse #1 said he spoke with the Physician this morning (after 7:00 A.M.) to alert the Physician that the Resident was in pain and the ordered PRN Oxycodone medication had not been obtained from the pharmacy. Nurse #1 said the Physician instructed him to call the pharmacy for a STAT delivery of the Oxycodone, which he did, and the pharmacy was unable to deliver the Oxycodone for another four hours. Nurse #1 said the facility placed another call to the Physician and was awaiting a return call from the Physician to obtain alternative orders to treat Resident #73's pain. On 3/3/26, between 11:21 A.M. and 11:46 A.M., the surveyor observed the Resident still positioned in bed. -At 11:26 A.M., the surveyor observed Resident #73 call out, oh Jesus! Oh, oh!. -At 11:34 A.M., the surveyor observed Resident #73 call out, ow, ow! Ahhh! Oh, oh, help, help!. -At 11:41 A.M., the surveyor observed Resident #73's call light lit and the Resident called out, Ahhh, oh, oh, oh, .help, oh, ow, ow!. -At 11:42 A.M., the surveyor observed Nurse #1 enter Resident #73's room with a medicine cup, turn off the Resident's call light, and administer the medication to the Resident. -At 11:46 A.M., the surveyor observed Nurse #1 exit Resident #73's room. During an interview at the time, Nurse #1 said Resident #73's Physician provided an order for a one-time 5 mg dose of Oxycodone to be administered to the Resident until the Resident's ordered PRN Oxycodone doses were available. Nurse #1 said he administered the one-time 5 mg dose of Oxycodone to the Resident at 11:42 A.M. On 3/3/26 at 1:00 P.M., the surveyor observed Resident #73 was positioned in bed, on his/her back and head slightly elevated. The surveyor observed that Resident #73 was not calling out and crying. Resident #73 said he/she had chronic pain in different areas of his/her body and he/she had been experiencing headaches for many years since a young age, had experienced back pain for many years due to OA, and experienced pain in his/her right hip over the last few months related to right hip fracture and hip replacement. Resident #73 said he/she had been asking for PRN Oxycodone since approximately 7:00 P.M. the previous evening (3/2/26) and that the Nurse working at that time (Nurse #2) said the PRN Oxycodone was not available. Resident #73 said Nurse #2 approached him/her before leaving between 11:00 P.M. and 11:30 P.M. on 3/2/26 and said that she did not know when the Resident's PRN Oxycodone would be available. Resident #73 said the pain he/she experienced overnight (3/2/26 to 3/3/26) was very bad. Resident #73 said it was difficult for him/her to rate the pain he/she experienced overnight between 3/2/26 and 3/3/26 because he/she had different types of pain, between the pain in his/her head, back, and hip. Resident #73 said he/she just knew that he/she felt miserable due to the pain. Review of Resident #73's Physician Progress Note, dated 3/3/26, indicated: -Osteoarthritic changes are seen. -Range of motion (ROM) of right hip is reduced due to pain. -One extra dose of Oxycodone 5 mg will be administered today (3/3/26) and it will be taken from the emergency [kit]. On 3/3/26 at 2:13 P.M., the surveyor placed a call to Nurse #2 (the Nurse who faxed the Pharmacy order) and left a voicemail. Nurse #2 did not return the surveyor's call by the end of the survey period. During an interview on 3/3/26 at 4:20 P.M., the Director of Nursing (DON) said Nurse #2 was required to ensure the prescription for Resident #73's PRN Oxycodone was transmitted via fax to the pharmacy when the Resident was admitted to the facility and that the orders were verified with the on-call NP. The DON said Nurse #2 should have also called the on-call NP for alternative instructions to treat Resident (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#73's pain when the Resident reported pain and his/her ordered PRN Oxycodone was not available. During an interview on 3/4/26 at 9:44 A.M., the DON said she spoke with the pharmacy, who verified they never received a prescription from the facility for Resident #73's ordered Oxycodone on 3/2/26. During an interview on 3/4/26 at 1:01 P.M., the DON said she spoke with Nurse #2 who was responsible for communicating with the pharmacy after Resident #73 was admitted to the facility. The DON said Nurse #2 faxed the prescription for the ordered Oxycodone to the pharmacy but did not receive a fax confirmation and never contacted the pharmacy to follow-up on whether the pharmacy received the prescription. The DON said Nurse #2 thought the Resident was comfortable because the Resident had fallen asleep around 8:00 P.M. on 3/2/26. The DON said Nurse #2 reported leaving the facility around 11:00 P.M. on 3/2/26 and had not contacted the on-call NP for alternative instructions to treat Resident #73's pain any time before she left the facility at the end of her shift. On 3/4/26 at 1:20 P.M., the surveyor placed a second call to Nurse #2 (the Nurse who faxed the Pharmacy order) and left another voicemail requesting a return call. Nurse #2 did not return the surveyor's call by the end of the survey period. During an interview on 3/4/26 at 1:24 P.M., the Physician said if Resident #73 reported pain during off-hours and the ordered pain medication was not available to be administered, the facility staff should have called the on-call NP to obtain instructions to treat the Resident's pain. The Physician said he spoke with Nurse #1 during the morning on 3/3/26 relative to the facility not having the Resident's ordered PRN Oxycodone. The Physician said he instructed Nurse #1 to call the pharmacy for a STAT delivery of the Resident's ordered Oxycodone and that he also ordered a one-time 5 mg dose of Oxycodone to be administered to Resident #73. During an interview on 3/4/26 at 1:32 P.M., CNA #2 said she provided care to Resident #73 during the 3:00 P.M. through 11:00 P.M. (evening) shift on 3/2/26. CNA #2 said Resident #73 was able to make his/her needs known and was able to verbally report pain. CNA #2 said Resident #73 was complaining of pain, pain, pain in his/her leg around supper time and that CNA #2 alerted Nurse #2. CNA #2 said Resident #73 continued to complain of pain around 7:00 P.M., and CNA #2 notified Nurse #2 again. CNA #2 said Nurse #2 told her she had already administered medication to the Resident. CNA #2 said she went to speak with the Resident, told the Resident Nurse #2 already administered pain medication and that maybe the Resident just needed to wait a little longer for the medication to work. CNA #2 said Resident #73 fell asleep a little after 8:00 P.M. and did not call CNA #2 for any assistance between 8:00 P.M. and the end of the shift at 11:00 P.M. During an interview on 3/4/26 at 2:06 P.M., CNA #5 said Resident #73 expressed having pain around 5:45 P.M. on 3/2/26 and she alerted Nurse #2. CNA #5 said Resident #73 expressed having pain again at 8:00 P.M. on 3/2/26. CNA #5 said she alerted Nurse #2 and that Nurse #2 said the Resident was not due for anything, that she already gave the Resident his/her medication and that she would explain this to the Resident. CNA #5 said the Resident fell asleep a little after 8:00 P.M. During an interview on 3/4/26 at 2:14 P.M., Nurse #1 said he followed up with Resident #73 after he administered the one-time 5 mg dose of Oxycodone on 3/3/26. Nurse #1 said that the Resident reported the medication administration to be effective and rated his/her pain at a 3/10 around 4:00 P.M. on 3/3/26. Nurse #1 said Resident #73 had no further episodes of calling out in pain and crying after the Oxycodone took effect on 3/3/26. The surveyor placed phone calls to Nurse #3 on 3/4/26 at 1:22 P.M. and CNA #4 on 3/4/26 at 1:58 P.M., who both worked the overnight (11:00 P.M. through 7:00 A.M.) shift from 3/2/26 through 3/3/26 and were assigned to care for Resident #73. Neither Nurse #3 nor CNA #4 returned the surveyor's call prior to the end of the survey period. During an interview on 3/5/26 at 10:30 A.M., the DON said Nurse #2 should have contacted the pharmacy regarding the Resident's ordered PRN Oxycodone when she did not receive a fax confirmation after attempting to fax the prescription to the pharmacy on 3/2/26. The DON said Nurse #2 should have contacted the on-call NP for alternative orders to treat Resident #73's pain on the evening of 3/2/26 when the Resident verbalized persisting pain after receiving scheduled Acetaminophen and the ordered PRN Oxycodone was not available from the Pharmacy. The DON said alternative orders to treat Resident #73's pain when the Resident's ordered PRN Oxycodone was not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225710	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Sudbury LLC	136 Boston Post Road Sudbury, MA 01776

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	available to be administered should have been in place before the Resident experienced persisting pain during the morning of 3/3/26 to avoid a delay in treatment for pain.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to adhere to infection control standards of practice for one Resident (#10) out of a total sample of 16 residents. Specifically, for Resident #10, the facility failed to ensure that Enhanced Barrier Precautions (EBP's - the use of protective gowns and gloves during high contact care activities that may provide opportunity for transmission of medication resistant organisms through staff hands and/or clothing), were appropriately utilized when providing high contact care for the Resident, to mitigate the risk of organism transmission and the spread of infection to the Resident and other residents within the facility. Findings include:Review of the facility policy titled Enhanced Barrier Precautions, revised December 2025, included but was not limited to:*Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. -Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents.-EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. >Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room).>Personal protective equipment (PPE: items such as gowns and gloves worn to prevent the spread of infection) is changed before caring for another resident>Face protection may be used if there is also a risk of splash or spray.-Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:>dressing>bathing/showering>providing hygiene>changing brief's or assisting with toileting>device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc).>wound care (any skin opening requiring a dressing).-EBPs are indicated (when contact precautions do not otherwise apply) for residents infected or colonized with the following:>ESBL (Extended-spectrum beta-lactamase - infections caused by bacteria resistant to many common antibiotics [penicillin and cephalosporins] that are difficult to treat). -EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. -EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. -Staff are trained prior to caring for residents on EBPs.-Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required.-PPE is available outside of the resident rooms. Resident #10 was admitted to the facility in February 2026 with diagnoses including Urinary Tract Infections (UTI), Dysfunction of Bladder, and Urinary Retention. Review of the Minimum Data Set (MDS) Assessment, dated 2/13/26, indicated Resident #10:-has moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of ten out of a possible 15 points.-has an indwelling suprapubic catheter (a flexible medical tube inserted directly into the bladder through a small incision in the lower abdomen, just above the pubic bone to drain urine). -had a Urinary Tract Infection (UTI) in the last 30 days. Review of Resident #10's Person-Centered Care Plan, initiated 3/3/26, indicated: -required Enhanced Barrier Precautions due to the use of a suprapubic catheter, MDRO History (Hx) of ESBL.-wear gowns with dressing, transferring, bathing/showering, providing hygiene, toileting, changing linens, toileting/incontinent care. Review of Resident #10's March 2026 Physician's orders indicated: -Maintain Enhanced Barrier Precautions (EBP) at all times when providing direct care every shift for foley (a flexible, indwelling tube inserted through the urethra into the bladder to drain urine, secured by a small, water-filled [NAME] at the tip), initiated 2/6/26. On 3/3/26 at 3:10 P.M. through 3:21 P.M., the surveyor observed the following: -PPE supply bin positioned outside Resident #10's door and no EBP signage posted. -Certified Nurse Aide (CNA) #6 entered the Resident's room and ambulated the Resident to the bathroom without donning a PPE gown. During an interview on 3/3/26 at 3:26 P.M., CNA #6 said that Resident #10 was on EBP for infection in the urine and she should have used a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gown when she was assisting the Resident to the bathroom, but she did not. CNA #6 said that the risk of not wearing a gown was spreading infection to Resident #10 and other residents. During a follow-up interview on 3/3/26 at 3:30 P.M., CNA #6 said that Resident #10 was on EBP for the use of the suprapubic catheter and she should have worn a PPE gown when she assisted the Resident to the bathroom. On 3/4/26 at 9:15 A.M., the surveyor observed CNA #7 enter Resident #10's room wearing gloves but no gown and assisted the Resident to the bathroom. CNA #7 was also observed leaving the Resident's room, did not discard gloves and/or perform hand hygiene and gathered clean towels from the hallway linen cart and re-entered the Resident's room and bathroom without donning a gown. On 3/4/26 at 9:27 A.M., Resident #10 was observed seated on the toilet in his/her bathroom with CNA #7 standing next to the Resident providing ADL care without wearing a PPE gown. The Resident's suprapubic catheter was observed hanging on the handrail in the bathroom. During an interview on 3/4/26 at 9:51 A.M., CNA #7 said that she provided morning care for Resident #10 and did not wear a PPE gown. CNA #7 said that she should have used a gown to protect herself and the Resident. CNA #7 also said that the risk of not wearing a gown was transferring infections to Resident #10 and other residents. During an interview on 3/4/26 at 10:10 A.M., the Director of Nursing (DON) said that staff providing direct care for Resident #10 should have had PPE on including a gown and gloves to protect Resident #10 from the transmission of infections.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review, and interview, the facility failed to provide notice of change in coverage by Medicare for one Resident (#75) out of a total sample of 16 residents.Specifically, the facility failed to issue a Notice of Medicare Non-Coverage to Resident #75 when the Resident had skilled days remaining, was being discharged from Part A services, and was leaving the facility immediately following his/her last covered skilled day. Findings include:Resident #75 was admitted to the facility in June 2025 for short term rehabilitation following a fall with hip fracture. Review of Resident #75's Social Service Progress Note, dated 6/13/25, indicated Resident #75's discharge plan was to return home. Review of the list of residents discharged from Medicare Part A services with skilled days remaining within the previous six months indicated Resident #75's last covered skilled day was 8/3/25. Review of Resident #75's Physician Progress Note, dated 8/4/25, indicated Resident #75 was being discharged home on 8/4/25. Review of Resident #75's Social Service and Nursing Progress Notes, dated 8/4/25, indicated the Resident was discharged home on 8/4/25. Review of Resident #75's clinical record failed to indicate any evidence that the facility issued a Notice of Medicare Non-Coverage (NOMNC) to the Resident. During an interview on 3/4/26 at 1:16 P.M., the Director of Clinical Operations said the facility did not have any evidence that a NOMNC was issued to Resident #75 when the Resident had skilled days remaining, was discharged from Medicare Part A services, and left the facility immediately following their last covered skilled day.