STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225727	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Rehab & Skilled Nursing Ctr - Natick	3 Vision Drive Natick, MA 01760

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews, for three of three sampled residents (Resident #1, #2, and #3), who were cognitively impaired, and therefore were unable to give consent, the facility failed to ensure they were treated in a dignified and respectful manner, when on 7/13/25 during the day shift, although none of the residents had an appointment scheduled with a hairdresser, staff found that they all had been given haircuts, with Resident #1's hair being visually uneven, and the facility was unable to determined when or who cut their hair. Findings include:Review of the Facility Policy titled Resident Rights and Responsibilities, dated as revised 9/05/25, indicated the Facility will protect and promote the rights of each resident as set forth in the Resident [NAME] of Rights, which includes the right to be treated with respect and dignity. Resident #1 was admitted to the Facility in July 2022, diagnoses included Alzheimer's Disease, dementia, and hypertension. Resident #1 was cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of 5 out of 15 (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). Resident #2 was admitted to the Facility in December 2024, diagnoses included dementia, congestive heart failure and atrial fibrillation. Resident #2 was cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of 4 out of 15.Resident #3 was admitted to the Facility in June 2023, diagnoses included Alzheimer's disease, and cervical disc degeneration. Resident #3 was cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of 1 out of 15. Review of the Facility's Investigation Report, dated 7/15/25, indicated that Resident #1 was found to have an uneven haircut on 7/13/25 by the staff on the 7:00 A.M. to 3:00 P.M. shift. The Report indicated that staff reported Resident #1's unusual haircut to the Manager on Duty, an environmental audit was conducted on the unit, and no scissors or hair were found. The Report further indicated that Resident #2 and Resident #3 were also found to have had their haircut, that housekeeping found a small amount of hair in Resident #2's bathroom on the morning of 7/13/25 and that the facility was unable to determine who had cut the residents' hair. During an interview on 9/16/25 at 12:00 P.M., Certified Nurse Aide (CNA) # 1 said that on the morning of 7/13/25 (exact time unknown), he saw Resident #1 with an unusual haircut, and that it was uneven. CNA #1 said when he had Resident #1 on his assignment the day before on (7/12/25) his/her hair was fine, and that he immediately notified the Nurse. During an interview on 9/16/25 at 12:26 P.M., the Director of Social Services said that she had been in the building on 7/12/25, saw Resident #1 and that he/she had his/her regular hairstyle. During an interview on 9/16/25 at 12:17 P.M., the Moving Coordinator (who was the Manager on Duty on 7/12/25 and 7/13/25), said she was notified by staff on 7/13/25 about Resident #1's hair being found cut and uneven, that she conducted an environmental audit and was unable to find scissors or hair. During an interview on 9/16/25 at 1:24 P.M., the Director of Nurses (DON) said that she participated in the investigation of the three residents who were found with haircuts and said they would not have been able to give consent for haircuts due to their cognitive deficits. The DON said they still did not know who did the haircuts. The DON said the facility began education of all staff on residents' rights and dignity. During an interview on 9/16/25 at 1:10 P.M., the Administrator said that a thorough investigation had been done, and the facility was unable to determine who performed the haircuts on the three residents, without proper consent. On 9/16/25, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 07/16/25, which addressed the area(s) of concern as evidenced by: A. Resident #1, #2, and #3 were offered complimentary haircuts at the facility hair salon.B. On 7/13/25, the Facility immediately conducted an environmental audit; scissors were found on an adjacent unit in a resident's room, and the scissors were removed. C. On 7/14/25, a Facility wide audit was initiated by the Nursing Administration on all residents monitoring their hair and would continue weekly times one month.D. On 7/14/25, Nursing and Certified Nurse Aide (CNA) staff education was initiated by the Director of Nurses on the Resident Rights Policy.E. On 7/13/25, an AD HOC Quality Assurance Performance Improvement (QAPI) meeting was conducted, concern areas were discussed. F. On 7/16/25, the Facility completed the Education of all nursing staff on the Residents Rights Policy, which included haircuts without consent.G. The results of the audits will be reviewed at the next monthly QAPI meeting on 10/22/25. H. The Director of Nursing and/or Designee are responsible for overall compliance.