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	04/06/2026

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 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 record review, the facility failed to provide safe and secure medication storage for one Resident (#32) out of a total sample of 17 residents. Specifically, for Resident #32, the facility staff failed to ensure that Preparation H ointment was safely stored and secured when the medication was left on the nightstand of the Resident who was unable to self-administer, and readily accessible to wandering residents and unauthorized staff and visitors. Findings Include: Review of the facility policy titled Storage of Medications, revised 8/2020, included but was not limited to the following: -Medications and biologicals are stored safely, securely, and properly .the medication supply is accessible only to licensed nursing personnel .or staff members lawfully authorized to administer medications. -Medication supplies are locked when they are not attended by persons with authorized access. Resident #32 was admitted to the facility in June 2023 with diagnoses including Hemorrhoids. Review of the Minimum Data Set (MDS) Assessment, dated 3/10/26 indicated Resident #32: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) of 15 points out of a total possible 15 points. -was non-ambulatory. -was dependent for chair/bed-to-chair transfer. -required substantial/maximal (helper does more than half the effort) assistance for personal hygiene. -was dependent for toilet hygiene and lower body dressing. Review of Resident #32's April 2026 Physician's orders included but was not limited to: -Preparation H 0.25 -14-74.9% ointment, apply rectal [sic] twice a day as needed (PRN), start date 3/5/26. On 4/1/26 at 7:50 A.M., the surveyor observed Resident #32 lying in bed, and a tube of Preparation H 0.25 -14-74.9% ointment was on the Resident's nightstand. During an interview at the time, Resident #32 said he/she was groggy to talk now and asked the surveyor to return to his/her room later. There were no staff members present in the room or in the area at the time. On 4/1/26 at 2:09 P.M., the surveyor observed Resident #32 lying in bed and the tube of Preparation H 0.25 -14-74.9% ointment remained on his/her nightstand. During an interview at the time, Resident #32 said that he/she needed the ointment on occasion. Resident #32 said that he/she needed the Nurses to apply the ointment because he/she was unable to apply the ointment himself/herself. Resident #32 said the Nurses leave the ointment there (on the nightstand) sometimes. During an interview on 4/1/26 at 2:10 P.M., Unit Manager (UM) #1 said Resident #32 did not have a Physician's order to self-administer medications. UM #1 said the nursing unit was a locked unit and had residents who lived on the unit that wandered in and out of other residents' rooms. UM #1 said that Resident #32 should not have medications kept at the bedside. The surveyor and UM #1 observed the tube of Preparation H 0.25 -14-74.9% ointment remained on Resident #32's nightstand. UM #1 said medications were not to be kept at the bedside when not in accordance with physician's orders because of the risk of unauthorized people and wandering residents potentially having access to the medication. UM #1 said she thought a Nurse must have left the tube of Preparation H 0.25 - 14-74.9% ointment tube on the Resident's nightstand by accident. During an interview on 4/2/26 at 7:42 A.M., the Director of Nursing (DON) said she was made aware of the tube of Preparation H 0.25 -14-74.9% ointment that was left at the Resident's bedside and said the medication should not have been left in the Resident's room. The DON (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she was aware of the Unit having residents that wander. The DON said only Nurses have permission to administer medications and the unsecured medication was a risk because the medication could be accessed by unauthorized people such as other residents, staff, visitors, housekeeping, and maintenance.