STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225773	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Ponds	400 Linden Ponds Way Hingham, MA 02043

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of Resident Council Minutes, a resident group meeting, and interviews, the facility failed to ensure grievances brought forward from the Resident Council were addressed and promptly resolved to ensure the residents felt their concerns were acted upon timely and included the facility response to the group.Findings include:Review of the facility's policy titled Resident or Family Group Meeting, dated as revised February 2022, indicated but was not limited to:The group approved staff person:-Types up group meeting minutes and distributes to department heads as applicable.-If any concerns are conveyed in the resident group meeting, department heads respond to the group approved designated staff member within 2 weeks with a written action plan.-Action plans and minutes are submitted to the Administrator for signature. Review of January 2026 Resident Council Minutes, dated 1/14/26, indicated but was not limited to:-Food is mediocre and residents would like more variety of proteins and desserts-Aides should have their names in large print letters on the front of their shirts because residents could not identify them-Residents would like music in the living room-Concern with missing laundry items Review of February 2026 Resident Council Minutes, dated 2/4/26, indicated but was not limited to:-Food is mediocre and residents would like more variety of proteins and desserts-Residents would like music in the living room Review of the March 2026 Resident Council Minutes, dated 3/26/26, indicated but was not limited to:-Some of the Certified Nursing Assistants (CNA) do not talk to the residents while providing care Further review of the January, February, and March 2026 Resident Council Minutes failed to indicate any action plans had been submitted and failed to include feedback provided to the residents. During a group meeting held on 4/29/26 at 10:40 A.M., the surveyor met with 11 residents during a Resident Council Meeting. The following concerns were voiced:-Complaints brought up during Resident Council Meetings were not addressed and therefore unresolved.-In most cases there was no follow-up to the concerns brought up during their monthly meetings and they would like feedback on the concerns brought forward.-Resident #3 stated he/she had brought up concerns regarding a lack of medical care at the February meeting, and he/she never received any follow up.-Resident # 35 said the lack of follow up is common and you need to have a big mouth if you want anyone to follow up. During an interview on 4/29/26 at 11:45 A.M., Senior Programmer #1 (SP #1) and Senior Programmer #2 (SP #2) said they are the designated staff members responsible for assisting the residents with arranging their monthly council meetings and staying with the residents during the meetings. SP #2 said at the conclusion of the meetings she types up the minutes and then stores them on a shared drive that can be accessed by the other staff members. SP #2 said the notes are not distributed to department heads. SP #1 and SP #2 said they do not follow up with department heads regarding concerns brought forward but if there were any significant concerns they would alert their Program Manager (PM). SP #1 and SP #2 said they did not know what happens with the concerns once they alert the PM. They said they did not receive follow up on the concerns and they did not report back to the Resident Council at the next meeting regarding the concerns brought forward at the previous meeting. During an interview on 4/29/26 at 11:58 A.M., the PM said the follow-up she has done from Resident Council concerns had been verbal communication with other department heads. When asked specifically about the follow-up from the food concerns raised in January and February, she said she could not recall what the (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	specific follow-up was. The PM was unable to provide the surveyor with any action plans. During an interview on 4/29/26 at 3:05 P.M., the Administrator stated she was not aware that SP#1 and SP #2 were not following up with the Resident Council regarding issues brought forward at the previous meeting. She stated her expectation is that if a group concern is brought up at a meeting there would be follow-up provided at the next meeting.

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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. Based on observation, interviews, and record review, the facility failed to adhere to infection control standards of practice to prevent contamination and the potential spread of infections for two Residents (#14 and #3), out of a total sample of 17 residents. Specifically, the facility failed:1. For Resident #14, to implement Contact Precautions (infection control measures used to prevent the spread of infection through direct or indirect contact with residents or contaminated surfaces); and2. For Resident #3, to implement Enhanced Barrier Precautions (EBP, infection control measures using gowns and gloves during high-contact care to prevent the spread of multidrug-resistant organisms (MDROs) in nursing homes) when providing Foley catheter care.Findings include:Review of the facility's policy titled Infection Prevention and Control: Preventing Transmission of Infectious Agents, dated 10/2022, indicated, but was not limited to, the following:-Staff will follow appropriate precautions in order to prevent the transmission of infectious agents.-Transmission-Based Precautions are for employees and residents who are known or suspected to be infected or colonized with infectious agents, including certain epidemiological pathogens, which require additional control measures to effectively prevent transmission. -Enhanced Barrier Precautions expand the use of personal protective equipment (PPE) in skilled-nursing/long-term care and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for MDROs to transfer to staff hands and clothing.-Transmission-Based Precautions include:Contact Precautions: Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. -Enhanced Barrier Precautions may be used during high contact resident activities for those residents considered high risk for MDROs such as:*Infection or colonization with an MDRO when Contact Precautions do not otherwise apply.*Wounds and/or indwelling medical devices (eg. Urinary catheter).Review of the Centers for Disease Control and Prevention (CDC) Contact Precautions sign indicated providers and staff must: put on gloves before room entry and discard gloves before room exit, put on gown before room entry and discard gown before room exit, use dedicated disposable equipment and clean and disinfect reusable equipment before use on another person.Review of the CDC Enhanced Barrier Precautions sign indicated providers and staff must wear gloves and a gown for high-contact resident care activities, including: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy), and wound care.1. Resident #14 was admitted to the facility in October 2021 with diagnoses including psoriasis (a chronic skin disease characterized by itchy, scaly patches on the skin), dementia, and skin abscess (a skin infection).Review of Resident #14's Minimum Data Set (MDS) assessment, dated 2/16/26, indicated the Resident was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of Resident #14's Care Plan indicated, but was not limited to, the following:-Positive (+) MRSA and MDRO Proteus mirabilis (a bacteria primarily associated with urinary tract infections) left buttock-Maintain Contact Precautions-3/23/26 Erythromycin 250 every 6 hours x14 days superimposed cellulitis related to psoriasis. Maintain contact precautions.-4/13/26 Continue Contact Precautions due to ongoing psoriatic plaque treatment (tx) and intertrigo flareReview of Resident #14's Progress Notes, indicated, but was not limited to, the following:-2/2/26: Resident cultures continue to be pending - aerobic showing Methicillin-Resistant Staphylococcus aureus (MRSA, a type of bacteria that causes skin infections and is resistant to many antibiotics), placed on contact precautions. -2/3/26: Resident's wound was cultured and resulted positive for MRSA and MDRO.Review of Resident #14's Wound Culture report for specimen obtained 1/28/26 indicated the wound culture grew out bacteria including Veilonella dispar (a bacteria normally found in the oral cavity, gastrointestinal tract, and genitourinary tract in humans but can become pathogenic in some individuals), Multi-Drug Resistant Proteus mirabilis, MRSA, and Enterococcus faecalis (a bacteria normally found in the gastrointestinal tract that is capable of causing serious (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infections). The surveyor made the following observations:-4/28/26 at 8:29 A.M.: CDC Contact Precautions sign posted outside of Resident #14's room with a PPE storage cart located below-4/28/26 at 9:06 A.M.: Certified Nursing Assistant (CNA) #1 in Resident #14's room assisting the Resident with breakfast. CNA #1 was not wearing any PPE.-4/28/26 at 9:09 A.M.: Activities Assistant #3 entered Resident #14's room. Activities Assistant #3 did not perform hand hygiene or don (put on) PPE when entering the room.-4/28/26 at 9:17 A.M.: CNA #1 in Resident #14's room sitting in a chair beside the Resident's bed. CNA #1 was not wearing any PPE.-4/28/26 at 11:58 A.M.: CNA #1 in Resident #14's room assisting the Resident in completing his/her dining order. CNA #1 was not wearing any PPE. -4/29/26 at 8:35 A.M.: Contact precautions sign posted outside of Resident #14's room with PPE storage cart located below.-4/29/26 at 9:44 A.M.: CNA #5 in Resident #14's room assisting the Resident with breakfast. CNA #5 was not wearing any PPE.-4/29/26 at 10:22 A.M.: CNA #5 in Resident #14's room assisting the Resident with morning activities of daily living. CNA #5 was not wearing any PPE.-4/19/26 at 11:50 A.M.: Nurse #1 and CNA #5 in Resident #14's room. Nurse #1 and CNA #5 were not wearing any PPE.During an interview on 4/28/26 at 11:54 A.M., CNA #1 said Resident #14 required Contact Precautions and that staff should wear gloves and gowns when providing care.During an interview on 4/28/26 at 11:58 A.M., Nurse #1 said Resident #14 required Contact Precautions but she was not sure why. Nurse #1 said staff needed to wear gloves and gowns only when providing care.During an interview on 4/28/26 at 3:58 A.M., the Director of Nursing (DON) said Resident #14 had had a MRSA-positive abscess and had multiple psoriatic lesions and required Contact Precautions. During an interview on 4/29/26 at 12:04 P.M., Resident #14 said some of the staff wore gowns and gloves when providing care, but some of the staff did not. During a follow-up interview on 4/30/26 at 9:16 A.M., the DON said it was her expectation that all staff implement Contact Precautions and don PPE when entering Resident #14's room.2. Resident #3 was admitted to the facility in June 2025 with diagnoses including history of bladder cancer and urinary retention. Review of Resident #3's MDS assessment, dated 1/26/26, indicated Resident #3 was moderately cognitively impaired as evidenced by a BIMS score of 12 out of 15. Further review of the MDS assessment indicated Resident #3 had an indwelling urinary catheter. Review of Resident #3's Physician's Orders indicated, but was not limited to, the following:-Indwelling urinary Foley: Maintain Enhanced Barrier Precautions due to Foley catheter (order date 10/15/25)The surveyor made the following observations:-4/28/26 at 10:15 A.M.: EBP sign hanging outside Resident #3's room with a PPE storage cart located below. CNA #1 came from the bathroom in Resident #3's room to the doorway of the room, where a trolley containing a trash container was located. CNA #1 was wearing gloves and carrying a urinary catheter drainage bag containing a small amount of yellow urine and disposed of the drainage bag in the trash container. CNA #1 said she was assisting Resident #3 with a shower at that time. The surveyor did not observe CNA #1 wearing a gown.During an interview on 4/28/26 at 11:54 A.M., CNA #1 said Resident #3 no longer required EBP anymore.During an interview on 4/30/26 at 9:16 A.M., the DON said it was her expectation that all staff implement EBP when providing high-contact care to Resident #3.