STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225774	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newbridge on the Charles Skilled Nursing Facility	7000 Great Meadow Road Dedham, MA 02026

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 observations and interview, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed to ensure medications for Residents #24 and #62 remained in view of the nurse and were not left unattended and unsecured during the medication administration pass. Findings include:Review of the facility's policy titled Automated Dispensing Machine (ADM), dated as last revised 9/29/25, indicated but was not limited to the following:-ADMs are used to provide access to medications and to ensure medication security.-Only authorized personnel may remove medications. Review of the facility's policy titled Medication Administration, dated as last revised 7/28/25, indicated but was not limited to the following:-Medications are administered by or under the supervision of nursing in accordance with Federal or State laws and regulations.-The Nurse will remain with the patient until the medications are administered. On 5/12/26 at 9:10 A.M., the surveyor observed Nurse #1 prepare and administer medications for Resident #24 as follows:-Nurse #1 poured the following medications into the medication cup: Levothyroxine 50 micrograms (mcg) (for thyroid), Aspirin 81 milligrams (mg) (for heart), Atorvastatin 40mg (for cholesterol), Ezetimibe 10mg (for cholesterol), Proscar 5mg (for prostate), Metoprolol Extended Release 50mg (for blood pressure), and Senna 2 tabs (for bowels).-Nurse #1 left the cup of pills on top of the medication cart in the hallway and entered Resident #24's room. The medication cart was facing outward to the hallway, her back was to the doorway/medication cart, the medications were not in view, and unsecured.-Nurse #1 exited Resident #24's room and walked around the corner to the nurses' station to remove Tylenol (for pain) from the ADM. The cup of pills remained on top of the medication cart not in view and unsecured.-Nurse #1 returned to the medication cart and poured Tylenol 1000mg into the medication cup with the other pills.-Nurse #1 left the cup of pills on top of the medication cart in the hallway and entered Resident #24's room. The medication cart was facing outward to the hallway, her back was to the doorway/medication cart, the medications were not in view, and unsecured.-Nurse #1 returned to the medication cart, entered Resident #24's pain level in the computer, entered Resident #24's room and administered the medications. On 5/13/26 at 9:20 A.M., the surveyor observed Nurse #1 prepare and administer medications for Resident #62 as follows:-Nurse #1 removed Eliquis 2.5mg (anticoagulant/blood thinner), Metoprolol 25mg, Saccharomyces Boulardii 120mg (probiotic), Norvasc 5mg (for blood pressure), Vitamin B12 500mcg, Enteric Coated Aspirin 81mg, Vitamin D3 1000 units, Prilosec 20mg (for reflux), and Torsemide 10mg (diuretic for fluid) from the ADM, placed the pills in a plastic cup, and walked to Resident #62's room with the cup of pills on top of the medication cart.-Nurse #1 entered Resident #62's room to scan his/her name band. Nurse #1 left the cup of pills on top of the medication cart in the hallway. The medication cart was facing outward to the hallway, she was around the corner in the room, not in view of the doorway or medication cart, the medications were not in view, and unsecured.-Nurse #1 exited Resident #62's room and walked around the corner to the nurses' station to remove Oxycodone (narcotic pain medication) from the ADM. The cup of pills remained on top of the medication cart, not in view and unsecured.-Nurse #1 returned to 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication cart with Oxycodone 2.5mg, took the cup of pills off the medication cart, entered Resident #62's room and administered the medications. During an interview on 5/13/26 at 9:55 A.M, Nurse #1 said she should not have left the pills on top of the medication cart unattended. She said she probably should have taken them with her in and out of the room, and when she went to the nurses' station to get pain medication from the ADM. During an interview on 5/13/26 at 11:57 A.M., the Director of Nurses (DON) said medications should be removed from the ADM, brought to the resident's room on the medication cart, and then administered. She said they should not be left on the medication cart unsecured and out of the nurse's view for any period of time, especially to walk back to the nurses' station to remove additional medication. She said she should have brought the cup of pills with her or locked them in the individual lock box at the entrance to the resident's room.