STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225781	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Hills Pediatric Center	22 Hillside Avenue Groton, MA 01450

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on records reviewed, interviews, and observations, for one of three sampled residents (Resident #1), who was developmentally delayed and had a known history of placing toys in his/her mouth, the facility failed to ensure they developed and implemented a comprehensive individualized care plan specific to his/her oral fixations, associated risks and need for supervision, that included interventions, goals and outcomes. Findings include:Review of the Facility's policy, titled admission Assessment, with a review date of 05/2025, indicated the following:-An initial assessment of all new residents will be conducted by each discipline and re-assessments will be conducted when a change occurs and at specified intervals during the resident's stay.-The purpose is to obtain the necessary information to develop and maintain an individualized interdisciplinary plan of care with appropriate education and training about his or her illness and care needs.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 01/21/26, indicated Resident #1 was seated in a Common Room on 01/20/26 playing with a battery powered doll when facility staff requested emergent assessment from the resident's Nurse Practitioner for concerns of choking/gagging and possible AA battery ingestion. The Report indicated that the toy's rear Velcro pouch was opened, the back cap of the battery pack was off, and one of the two AA batteries was missing.The Report indicated a search of Resident #1's person and environment were conducted, and the missing battery was not located. Resident #1 was transferred to the Hospital Emergency Department (ED) for an evaluation and treatment.Review of Resident #1's Hospital Records indicated a battery was in his/her abdomen and was removed via endoscopy (a procedure that uses a scope to examine the digestive tract).Resident #1 was admitted to the facility in January 2016, diagnoses included mitochondrial disorder resulting in developmental and intellectual delay and hypotonia (decreased muscle tone).Review of Resident #1's Comprehensive Care Plans, indicated there was no documentation to support that he/she had an individualized plan of care that included or addressed the following:-Behavior of placing items in his/her mouth.-Risk of choking due to behaviors associated with oral seeking tendencies.-Specific level of staff supervision required to maintain his/her safety.On 02/17/26 at 9:28 A.M., the Surveyor observed Resident #1 in his/her classroom, seated on a therapeutic ball, with a toy rubber ring in his/her mouth.During an interview on 02/17/26 at 1:00 P.M., the Minimum Data Set (MDS) Nurse #1 said Resident #1 was well known to him/her, that he/she was very sensory seeking and often had a toy that he/she could gum.During an interview on 02/17/26 at 1:39 P.M, Nurse Practitioner (NP) #1 said Resident #1 was well known to her, that he/she put items in his/her mouth all the time and she believed it was part of his/her disease.During an interview on 02/17/26 at 2:52 P.M., Certified Nurse Aide (CNA) #2 said Resident #1 was well known to him/her and that he/she was always putting things including toys or his/her fingers in his/her mouth.On 02/17/26 at 4:00 P.M., the Surveyor observed Resident #1 in the Common Room, seated in his/her wheelchair, with a toy rubber carrot in his/her mouth.During a telephone interview on 02/18/26 at 1:42 P.M., MDS Nurse #1 said it (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
	225781	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Hills Pediatric Center	22 Hillside Avenue Groton, MA 01450

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was the MDS department who generated and updated the residents' care plans. MDS Nurse #1 said that they do not typically include a resident's level of supervision or specific behaviors in the comprehensive care plan.During an in-person interview on 02/17/26 at 11:36 A.M., and a telephone interview on 02/18/26 at 11:47 A.M., the Assistant Director of Nursing (ADON) said that Resident #1 has always required direct supervision when he/she was in his/her wheelchair. The ADON said the MDS Department creates the residents' care plans and that the goal is to have the nursing staff play a role in creating and updating the care plans moving forward.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225781	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Hills Pediatric Center	22 Hillside Avenue Groton, MA 01450

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on records reviewed, interviews, and observations, for one of three sampled residents (Resident #1), who had a known history of placing toys in his/her mouth, and required direct supervision by staff while in his/her wheelchair, the facility failed to ensure he/she was provided with the necessary level of staff supervision to prevent him/her from ingesting an object not made for consumption. On 01/20/26, Resident #1 was able to access, remove and swallow a battery from a musical toy. Resident #1 was transferred to the Hospital, testing confirmed he/she had a battery in his/her abdomen, and he/she underwent an endoscopy (a procedure that uses a scope to examine the digestive tract) to remove the battery. Findings include:Review of the facility's policy titled Incidents, with a review date of 05/2025, indicated the purpose of the policy was to ensure prompt and appropriate treatment to any resident sustaining and incident or accident and to prevent a recurrence.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 01/21/26, indicated Resident #1 was seated in a Common Room on 01/20/26 playing with a battery powered doll when facility staff requested emergent assessment from the resident's Nurse Practitioner for concerns of choking/gagging and possible AA battery ingestion. The toy's rear Velcro pouch was opened, the back cap of the battery pack was off, and one of the two AA batteries was missing.The Report indicated a search of Resident #1's person and environment were conducted, and the missing battery was not located. Resident #1 was transferred to the Hospital Emergency Department (ED) for an evaluation and treatment.Review of Resident #1's Hospital Records indicated a battery was in his/her abdomen and was removed via endoscopy.Review of the Facility's Investigation and Fact-Finding Review Report, dated 01/21/26, indicated the following conclusions from Resident #1's incident on 01/20/26:-The toy in question was not safe. The screw to the battery compartment was either missing or failed.-There was documentation to support that he/she required direct supervision while in his/her wheelchair and on that day [01/20/26] it appeared direct supervision was not provided.-Resident #1 had a history of mouthing toys and while some of his/her toys were sewn shut by his/her parents/guardians, this specific toy relied on a screw and Velcro, and the screw was either missing or failed.Resident #1 was admitted to the facility in January 2016, diagnoses included mitochondrial disorder resulting in developmental and intellectual delay and hypotonia (decreased muscle tone).On 02/17/26 at 9:28 A.M., the Surveyor observed Resident #1 in his/her classroom, seated on a therapeutic ball, with a toy rubber ring in his/her mouth.Review of Resident #1's Bedside Bulletin (instructions for direct care staff), dated as initiated 03/07/24, indicated he/she required direct supervision when he/she was in his/her wheelchair.During an interview on 02/17/26 at 3:32 P.M., Nursing Supervisor (NS) #1 said Resident #1 was well known to her and he/she often put things in his/her mouth. NS #1 said following Resident #1's incident, she [along with other staff] conducted an audit of his/her toys and found that about half of the toys were sewn shut on the back [if battery powered] and half of the toys were not. NS #1 said there was no clear process in place to determine if the facility staff or Resident #1's parents and/or guardians were responsible for sewing his/her toys shut prior to bringing them into the facility. NS #1 said that any toys Resident #1's parents and/or guardians allowed him/her to have, the facility did as well.NS #1 said that at the time of Resident #1's incident on 01/20/26, he/she required direct staff supervision when he/she was in his/her wheelchair, but said it was not clear if that meant 1:1 supervision or if someone could be in his/her vicinity to keep an eye on him/her.During an interview on 02/17/26 at 2:52 P.M., Certified Nurse Aide (CNA) #2 said Resident #1 was well known to him and often placed his/her toys in his/her mouth. CNA #2 said that at the time of Resident #1's incident on 01/20/26, he was assigned to provide 1:1 supervision for Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225781	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Hills Pediatric Center	22 Hillside Avenue Groton, MA 01450

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 0689 Level of Harm - Actual harm Residents Affected - Few	#2, and that Resident #1 was assigned to CNA #1. CNA #2 said when providing 1:1 supervision to Resident #2, staff cannot take their eyes off him/her, so although he could see Resident #1, he was not supervising him/her.CNA #2 said he was in the Community Room with Resident #2 and other residents (including Resident #1) were also in the Room. CNA #2 said Resident #1 was seated in his/her wheelchair and playing with a battery-operated doll that he/she had played with in the past. CNA #2 said Resident #1 gagged/coughed and looked like he/she may be choking, CNA #2 called for the nursing staff.CNA #2 said Resident #1 stopped coughing and he noticed that the door to the battery compartment on the doll was open and one of the two AA batteries was missing. CNA #2 said that some of Resident #1's toys were designed for a toddler's strength and dexterity, and that Resident #1 was quick and strong.CNA #2 said the nursing staff attempted to find the battery on Resident #1's person and environment but were unable to locate it and Resident #1 was transferred to the Hospital ED.CNA #2 said direct supervision could be defined as 1:1 supervision or it could mean a staff member would need to be arm's length away from the resident.Review of Certified Nurse Aide #1's witness statement, dated 01/21/26, indicated Resident #1 was on her assignment on 01/20/26 and she observed Resident #1 playing with his/her musical doll in the Community Room and left him/her there to attend to her other assigned residents. The Surveyor was unable to interview CNA #1 as she did not respond to the Department of Public Health's telephone or letter requests for an interview.During an interview on 02/17/26 at 1:39 P.M, Nurse Practitioner (NP) #1 said Resident #1 was well known to her and he/she put items in his/her mouth all the time and she believed it was part of his/her disease.Nurse Practitioner #1 said she was on duty at the time of Resident #1's incident on 01/20/26 and that nursing staff called for her to assess Resident #1 due to fear that he/she may have swallowed a battery. Nurse Practitioner #1 said she immediately went to the Common Room and Resident #1 did not appear to be in acute distress but because she and the nursing staff could not locate the missing AA battery, Resident #1 was transferred to the Hospital ED for evaluation.Nurse Practitioner #1 said the screw on the toy doll's battery pack should have kept the battery pack closed but that Resident #1 was very strong.During an in-person interview on 02/17/26 at 11:36 A.M., and a telephone interview on 02/18/26 at 11:47 A.M., the Assistant Director of Nursing (ADON) said that Resident #1 has always required direct supervision when he/she was in his/her wheelchair. The ADON said they are in the process of clarifying the definitions of different levels of supervision but said direct supervision for Resident #1 meant he/she required a staff member's supervision [present with him/her] when he/she was in his/her wheelchair.The ADON said that Resident #1's family brings toys in for him/her and that unless the toy is electronic, they are not inspected by the nursing staff.During a telephone interview on 02/18/26 at 1:49 P.M., the Administrator said that Resident #1 should have had direct supervision by a staff member when he/she was in his/her wheelchair and that the facility's investigation of Resident #1's incident on 01/20/26 indicated there had been a lapse in his/her required level of direct staff supervision. The Administrator said the facility did not have a policy to define different levels of staff supervision at the time of Resident #1's incident.