STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225343	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwood Healthcare	460 Washington Street Norwood, MA 02062

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. 43963 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had an activated Health Care Agent (HCA), the Facility failed to ensure that his/her HCA received written notice, including the reason for the change, when on 12/13/24 Resident #1's was moved to a new room without obtaining consent from and notifying his/her HCA of the room change. Findings include: Resident #1 was admitted to the Facility in December 2024 diagnoses include bilateral pulmonary embolisms (blood clots), left lower extremity deep vein thrombosis (blood clot), low back pain, and dementia. Review of Resident #1's Physician's Orders, dated 12/02/24, indicated that his/her Health Care Agent (HCA) had been responsible for his/her health care decisions. Review of Resident #1's Admission Minimum Data Set (MS) Assessment, dated 12/08/24, indicated he/she had moderate cognitive impairment. Review of Resident #1's Nurse Progress Note (written by the Nursing Supervisor), dated 12/13/24, indicated that he/she had been moved to a new room, appears comfortable and he/she was adjusting well. During a telephone interview on 02/05/25 at 11:11 A.M., Resident #1's HCA said that the facility was aware that his/her Health Care Proxy had been invoked and said as Resident #1's HCA, the Facility did not notify him of the room change on 12/13/24, the reason for the change, or the chance to appeal the Facility's decision. Review of Resident #1's Medical Record indicated that on or before 12/13/24, there was no documentation to support that Resident #1 and his/her HCA had been notified of and had agreed to a room change, met with a new roommate prior to the move, or were aware of the reason for the room change. During an interview on 02/11/25 at 1:32 P.M., the Social Worker (SW) said that she was aware that Resident #1's HCA was his/her responsible party. The SW said she was not aware that Resident #1 had his/her room changed on 12/13/24. (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SW said that she could not locate the appropriate paperwork required to properly move a resident's room in his/her medical record. During an interview on 02/11/25 at 12:51 P.M., the Nursing Supervisor said that he thought the SW had notified Resident #1's HCA of the room change and said he did not contact the HCA about his/her room change that happened on 12/13/24. During an interview on 02/11/25 at 4:26 P.M., the Assistant Director of Nurses (ADON, currently acting as the Director of Nurses (DON), said that he was not aware that on 12/13/24, Resident #1 had a room change. The ADON said the Social Service Department was responsible for completing the appropriate paperwork and also provide the resident/responsible party with the opportunity to appeal the decision related to the room change. The ADON said it is the Facility's expectation that before moving a resident's room, the resident and/or Responsible Party must be notified, written request/permission must be obtained, roommate(s) needs to be notified, and the reason for the room change must be provided.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43963 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to report ensure they reported an allegation of abuse to the Department of Public Health (DPH) within two hours, as required. On 01/02/25, Resident #1 was observed with an injury of unknown origin and the Facility did not report the incident to DPH, until 02/02/25, a month after the injury had been identified. Findings include: Review of the Facility Policy titled Abuse Investigation and Reporting, dated as last reviewed 2/2024, indicated each resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of their property. The Policy defines Injury of Unknown Etiology as any resident injury where the source of injury was not observed, or the source of injury cannot be explained by the resident. The Policy further indicated that the Facility must report to DPH and local law enforcement any reasonable suspicion of a crime committed against an individual who is a resident of, or is receiving care from, the facility. If the events that cause reasonable suspicion result in serious bodily injury, the report must be made immediately (but no later than two. (2) hours) after forming the suspicion. Otherwise, the report will not be made later than 24 hours after forming the suspicion. Review of the Health Care Facility Reporting System (HCFRS) indicated the Facility submitted the Report regarding an incident, an injury of unknown origin involving Resident #1 on 02/02/25, 33 days after the incident occurred. The Report indicated that it had been reported as an allegation of Abuse and Other Injury including type of harm identified as a bruise/hematoma. Resident #1 was admitted to the Facility in December 2024, diagnoses include bilateral pulmonary embolisms (blood clots), left lower extremity deep vein thrombosis (blood clot), low back pain, and dementia. Review of Resident #1's Hospital Discharge Summary, dated 12/02/24, indicated he/she had a diagnosis of Encephalomalacia (a serious brain injury that involves the softening or loss of brain tissue) to his/her left posterior parietal/occipital (receives incoming somatosensory signals/processing sensory modalities) lobe of indeterminate age. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 12/08/24, indicated he/she had moderate cognitive impairment. Review of Resident #1's Physical Therapy Aide (PTA) Progress Note, dated 01/02/25, indicated that the PTA identified a small bump on his/her head, notified nursing and Resident #1 was sent out to the Hospital Emergency Department (ED) for evaluation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Nurse Progress Note, dated 01/02/25, indicated a small bump was identified to his/her left forehead and he/she was sent to the ED for evaluation. During an interview on 02/20/25 at 11:15 A.M., the former Director of Nurses (DON) said that the Administrator oversaw that incident (from 01/02/25) and investigation into the bump found on Resident #1's head. The former DON said she knew Resident #1 was sent to the Hospital Emergency Department for evaluation. The former DON said she had not submitted a report to DPH because she was unaware of the specifics of the injury, and that the Administrator was dealing with the issue. The former DON said the Administrator should have reported it to DPH as an injury of unknown origin within the 2-hour window. During an interview on 02/11/25 at 3:42 P.M., the Administrator said that he had instructed the (former) Director of Nurses (DON) to submit a 2-hour reportable incident to DPH and for her to inform the police. The Administrator said the former DON had not followed through with an appropriate investigation into the injury of unknown origin regarding Resident #1 and said the report had not been submitted to DPH, as required.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 43963 Based on records reviewed and interviews for one of three sampled residents (Resident #1), the Facility failed to ensure a thorough investigation was conducted related to an injury of unknown origin, when on 01/02/25 after staff found a bump on Resident #1's left forehead, the Facility was unable to provide documentation to support they conducted an investigation, into the injury. Findings include: Review of the Facility Policy titled Abuse Investigation and Reporting, dated as last reviewed 2/2024, indicated each resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of their property. The Policy defines Injury of Unknown Etiology as any resident injury where the source of injury was not observed, or the source of injury cannot be explained by the resident and the Nursing Supervisor will notify, the provider, Health Care Proxy, Responsible Party, Administrator, and Director of Nurses. The Policy indicates to do the following; -Interview appropriate individuals, any individual who may have knowledge of the event (alleged victim, employees working during the shift when the event was discovered/reported, as well as visitors or other residents); -Medical Record review to determine possible etiology and/or identify pertinent information relevant to the event; and -Review staffing schedule as warranted. Resident #1 was admitted to the Facility in December 2024, diagnoses include bilateral pulmonary embolisms (blood clots), left lower extremity deep vein thrombosis (blood clot), low back pain, and dementia. Review of Resident #1's Hospital Discharge Summary, dated 12/02/24, indicated he/she had a diagnosis of Encephalomalacia (a serious brain injury that involves the softening or loss of brain tissue) to his/her left posterior parietal/occipital (receives incoming somatosensory signals/processing sensory modalities) lobe of indeterminate age. Review of Resident #1's Physician's Orders, dated 12/02/24, indicated that his/her Health Care Agent (HCA) was responsible for his/her health care decisions. Review of Resident #1's Admission Minimum Data Set (MS) Assessment, dated 12/08/24, indicated he/she had moderate cognitive impairment. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Physical Therapy Progress Note, dated 01/02/25, indicated that the Physical Therapy Aide (PTA) identified a small bump on his/her head, notified nursing and Resident #1 was sent out to the Hospital Emergency Department for evaluation. Review of Resident #1's Nurse Progress Note, dated 01/02/25, indicated a small bump was identified to his/her left forehead and he/she was sent to the ED for evaluation. Review of the Health Care Facility Reporting System (HCFRS) report submitted by the Facility, dated 02/02/25, indicated Resident #1's investigation of the bump found on 01/02/25 had been classified by the Facility as Injury Other and Abuse Policies and Procedures. Further review of the HCFRS Report indicated there was no documentation to support that an investigation had been immediately initiated on 01/02/25 when the bump (injury of unknown origin) was first identified. Review of the facility's investigation indicated a witness statement was obtained on 01/09/25 from Nurse #1, and that Nurse #1 provided a second witness statement on 01/15/25, along with Certified Nurse Aide (CNA) #1 and #3 witness statements. Although the PTA was the staff member that found the 'bump on Resident #1's head, there was no witness statement obtained from the PTA or interview conducted with the PTA as part of their investigation. Review of Resident #1's Medical Record, including but not limited to progress notes, care plans, incident reports, indicated that there was no further investigation regarding the investigation of Resident #1's injury of unknown origin. During an interview on 02/20/25 at 11:15 A.M., the former Director of Nurses (DON) said that the Administrator oversaw the incident and investigation into Resident #1's injury of unknown origin (bump on head). The former DON said that she does not recall any staff reporting a bump on Resident #1's head to her. During an interview on 02/11/25 at 3:42 P.M., the Administrator said that he had instructed the former DON to submit a report to DPH about Resident #1's injury of unknown origin and to inform the police. The Administrator said the former DON had not followed through with an investigation.

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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 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. 43963 Based on records reviewed and interviews, for two of three sampled residents (Resident #1 and #2), who upon admission were each identified as at risk for falls, the Facility failed to ensure after they experienced a witnessed and/or unwitnessed fall, that their plans of care were reviewed and revised for new interventions goals, and outcomes, as needed. Findings include: Review of the Facility Policy titled Fall Prevention and Management, dated as last revised 11/2024, indicated to prevent or minimize resident fall risk through identification of fall risk factors and implementation of interventions to prevent falls. The Policy further indicated the following; -If a resident falls, the nurse will conduct a physical assessment of the resident and notify the Provider and Responsible Party; -If a fall is unwitnessed or the resident hits his/her head during the fall, Neurological Assessment should be conducted. -Statements should be obtained from staff on the unit at the time of the fall; and -A new intervention will be added to the resident's care plan. Review of the Facility Policy titled Care Plans, Comprehensive Person Centered, dated as last revised 01/2024, indicted that care plan will identify problem areas and their caused as warranted and develop interventions that are targeted and meaningful to the resident. The Policy also indicated; -Evaluation of residents is ongoing and care plans are revised as information about the resident and the residents condition changes; and -The Interdisciplinary Team (IDT) will review and update the care plans when there has been a significant change in the residents' condition. 1) Resident #1 was admitted to the Facility in December 2024, diagnoses include bilateral pulmonary embolisms (blood clots), left lower extremity deep vein thrombosis (blood clot), low back pain, and dementia. Review of Resident #1's Admission Minimum Data Set (MS) Assessment, dated 12/08/24, indicated he/she had moderate cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Physician's Orders, dated 12/02/24, indicated that his/her Health Care Agent (HCA) had been responsible for his/her health care decisions. Review of Resident #1's Care Plan titled, Risk for Falls, dated 12/03/24, indicated that he/she would remain free from falls through his/her next review and interventions indicated the following; -Educate the resident/family about safety reminders and what to do if a fall occurs; -Ensure that he/she is wearing proper footwear when ambulating; -Rehabilitation evaluation and treat as ordered and as needed; -Call light within reach and encourage him/her to use it; -Provide safe environment with floors free from spills and/or clutter, adequate light, a working are reachable call light; and -Follow facility fall protocol. Review of Resident #1's Nurse Progress Note, dated 12/29/24, indicated that he/she had been found on the floor in the hallway, said he/she was tired and decided to sit on the floor. Review of Resident #1's care plan related to falls, indicated that there were no documentation to support that his/her fall care plan interventions had been reviewed, revised, or that new interventions were added to his/her care plan with the goal to minimize his/her risk for additional falls. Resident #1's unwitnessed fall and new behavior of putting self on floor when tired were not identified in the plan of care. During an interview on 02/11/25 at 3:14 P.M., Nurse #2 said that she does not know who is responsible for updating the care plans and said she does not do anything with care plans. Nurse # 2 said she did not make any changes to Resident #1's Care Plan after the 12/29/24 incident. 2) Resident 2 was admitted to the Facility in November 2024, diagnoses include anxiety, deep vein thrombosis (blood clot), hypertension, and dementia. Review of Resident #2's Admission Minimum Data Set (MS) Assessment, dated 11/29/24, indicated he/she had significant cognitive impairment. Review of Resident #2's Care Plan titled, Risk for Falls, dated as initiated 11/23/24 indicated he/she would be free from falls through his/her next review and interventions indicated the following; -Educate the resident/family about safety reminders and what to do if a fall occurs; -Ensure that he/she is wearing proper footwear when ambulating; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Rehabilitation evaluation and treat as ordered and as needed; -Call light within reach and encourage him/her to use it; -Provide safe environment with floors free from spills and/or clutter, adequate light, a working are reachable call light; and -Follow facility fall protocol. Review of Resident #2's Facility Incident Report, dated 11/27/24, indicated that he/she was observed lying on the floor in another resident's room. Review of Resident #2's care plan related to Fall Risk, indicated that there were no new interventions added to his/her care plan that addressed his/her unwitnessed fall on 11/27/24. During an interview on 02/11/25 at 2:07 P.M., the MDS Coordinator said that she was responsible for the initial comprehensive care plans for each resident and said once they are completed, the floor nurses or supervisors are responsible for updating the care plans. During an interview on 02/11/25 at 4:26 P.M., the ADON (acting DON) said that he was not aware that the care plans for Resident #1 and #2 had not been updated and/or reviewed after each of their fall related incidents. The ADON said that it is the Facility's expectation that any resident involved with a witnessed or unwitnessed fall will be reviewed and new or revised interventions be added to their care plan, as needed.