STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225014	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spaulding Nursing and Therapy Center - Brighton	100 N Beacon Street Boston, MA 02134

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 15016 Based on observation, interview and policy review, the facility failed to ensure a resident was assessed for the ability to self-administer medications, failed to observe a resident take prescribed medication, and left the medication at the bedside, unsecured. Findings include: Review of the facility policy Medication Administration dated 5/28/24, indicated: - Observe the patient taking the medication and no medications are left at bedside. On 3/11/25 at 8:46 A.M., the surveyor observed a resident in his/her room sitting in a chair located in front of a breakfast tray. On the tray was a medicine cup which contained 8 pills of various sizes and colors. The Resident said that about five minutes ago a nurse left the medicine on his/her breakfast tray and then left the room. The Resident said that some nurses watch him/her take the medication while others leave the medication on the tray for him/her to take later. Review of the resident's medical record indicated he/she had not been screened for medication self-administration and did not have a physician's order to self-administer medications. During an interview with the Nursing Supervisor on 3/12/25 at 9:30 A.M., she said the resident did not have an order for medication self-administration. The Nursing Supervisor said nurses are not allowed to leave medications unsecured in resident bedrooms.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 36431 Based on observation, record review and interview the facility failed to implement a treatment order timely for an identified pressure injury for one Resident (#184), out of a total sample of 20 residents. Specifically, for Resident #184, a treatment order was not implemented until 72 hours after the facility first identified his/her pressure injury. Findings include: Review of the facility's Skin and Wound Care Policy, with a current revision date 3/4/2025 includes but is not limited to the following: Purpose: to outline how skin assessment and wound care is delivered safely and effectively within the facility. Policy Statement *Two nurses will provide a comprehensive skin assessment for all patients on admission ('four eyes skin check). *Comprehensive skin assessments will be completed a minimum once per day. Any undocumented or worsening pressure injuries, atypical, deteriorating or otherwise clinically concerning wounds warrant an order for IP Consult to Wound Nurse. *A validated tool to assess the risk of pressure ulcer development will be utilized to help determine treatment and preventative interventions. (Braden/Braden Q) *All pressure injuries will be categorized on admission by the wound care nurse or the designee using National Pressure Injury Advisory Panel staging system (NPIAP 2016) Review of the National Pressure Injury Advisory Panel (NPIAP) indicted the following definition for a Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Resident #184 was admitted to the facility in February 2025 and has diagnoses that include but not limited to failure to thrive in adult, rheumatoid arthritis, pneumonia, and breast cancer. Minimum Data Set Assessment information was not available at the time of survey for Resident #184. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Brief Interview for Mental Status Exam, dated 3/2/25 indicated Resident #184 had a score of 13 out of 15, indicating he/she has intact cognitive status. Further review of the medical record indicated Resident #184 requires partial to moderate assistance from staff for toileting hygiene and supervision/touching assistance with dressing, and receives enteral nutrition (tube feeding, a way of providing nutrition directly into the gastrointestinal tract through a tube). Review of the Braden Scale for Predicting Pressure Injury Risk dated 2/27/25 indicated Resident #184 had a score of 17, which indicates he/she as being mild risk for developing a pressure injury. During an observation and interview on 3/11/25 at 8:32 A.M., Resident #184 was sitting up in a chair. Resident #184's bed was equipped with an air mattress. Resident #184 said he/she has a wound on his/her buttock and that he/she did not come in with it. Review of the LDA (Lines/Drains/Airways - a field in the electronic health records) and wounds flowsheets indicated the following: Wound Pressure Injury date first assessed 2/28/25 primary wound stage 2 PI (pressure injury), present on admission, location left buttocks, Wound description Stage 2 PI. Review of the physician's orders indicated: Daily dressing to left buttocks PI, cleanse with normal saline and pat dry, cover with TRIAD hydrophilic wound dressing apply in a dime-thickness and cover with bordered dressing. Do not scrub old Triad off with force, just cleanse with gray bath wipes and if doesn't all have to be removed prior to reapplying, change daily, initiated 3/3/25. The physician's orders indicated a treatment was not implemented for Resident #184's pressure injury until 3/3/25; three days after it was first identified. Review of the facility's incident report, titled Event: Skin/Tissue, dated 3/3/25 indicated the event occurred on 2/28/25. Event type Pressure Ulcer. Objectively describe the event: On 3/3/25 I was asked to review a 2nd day skin check photo of patient has a pressure injury (sic) small stage 2 PI noted on left buttocks. Actual Ulcer Stage, Stage 2, Ulcer Location: Left buttocks. Where was ulcer acquired? Noted on admission. During an interview on 3/12/25 at 9:22 A.M., Nurse #3 said the order for Resident #184's pressure injury was put in place on 3/3/25 and that there was no other treatment to the pressure injury prior to 3/3/25. During an interview on 3/12/25 at 9:28 A.M., Charge Nurse #1 said Resident #184 is at risk for developing pressure ulcers due to poor appetite and is on enteral feeding. Charge Nurse #1 reviewed Resident #184's medical record and said Resident #184 has a left buttock pressure injury. Charge Nurse #1 reviewed the record and said the Pressure injury on Resident #184's left buttock was identified on 2/28/25. Charge Nurse said there was no measurement of the wound, but it was noted as a Stage 2 Pressure injury. Charge Nurse #1 said when a pressure injury is identified the wound nurse is made aware, the MD (medical doctor) is notified, and a treatment is obtained. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Charge Nurse #1 said a treatment for Resident #184's wound did not get placed until 3/3/24, three days after the pressure area was identified. During an interview on 3/12/25 at 9:53 A.M., Unit Manager #1 said a treatment for a pressure injury should be in place when it is identified. During an interview on 3/12/25 at 10:05 A.M., the Wound Nurse, said she did not see the resident's pressure injury and that if the area was identified on 2/28/25 that the provider should have been notified, and a treatment order should be obtained, and should not have waited until 3/3/25. During an interview on 3/12/25 at 10:17 A.M., the Director of Nursing said a treatment order should have been obtained for the pressure injury when it was identified.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 36797 Based on observations, interviews and policy review, the facility failed to ensure staff stored drugs and biological's in accordance with State and Federal requirements. Specifically, the facility failed to ensure medication carts were locked while a nurse was not present. Findings include: Review of the facility policy titled Medication Storage, dated revised 8/2/24, indicated that carts, cabinets and other areas containing medications must be kept locked at all times when not in use. Further review indicated that all medications on the nursing units are stored securely in the med (medication) carts. On 3/11/25 at 7:42 A.M., the surveyor observed a medication cart unlocked and unattended in the hallway of the 2nd floor nursing unit. At 7:44 A.M., Nurse #1 arrived at the medication cart and said she was not aware the cart was unlocked and then locked it. On 3/11/25, at 8:33 A.M. the surveyor observed a medication cart open on the second floor. The surveyor was able to access the medication cart and open the drawers. The surveyor also observed several nurses and other staff members down the hall, not paying attention to the medication cart with the drawer wide open. The surveyor observed 2 staff members walk towards the medication cart, look at the open drawer, and then enter resident's rooms to deliver food trays. During an interview on 3/11/25, at 8:38 A.M., Unit Manager #1 said the medication cart was not supposed to be unlocked. During an interview on 3/11/25 at 8:42 A.M., Nurse #2 said she should not have left the medication cart open and should have locked it when she left. On 3/12/24 at 12:19 P.M. the surveyor observed a medication cart unlocked on the 2nd floor and unattended and accessible to others in the area. The nurse exited a resident room, walked down the hallway, passed the cart and went behind the nurse's station. The medication cart was equipped with an automatic locking mechanism which engaged at approximately 12:21 P.M. During an interview on 3/12/25, at 1:30 P.M. the Director of Nursing said that some of the medication carts are equipped with a timer that automatically lock the cart after 4 minutes of being idle.

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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. 46339 Based on observation and interviews, the facility failed to ensure infection control practices were maintained to prevent spread of infection during medication pass. Findings include: During medication pass observation on 3/12/25 at 8:40 A.M., on the 3rd floor unit. Nurse #2 was observed touching pills with her bare hands as she poured the medications from the blister pack and the bottles. During an interview on 3/12/25 at 8:56 A.M., Nurse #2 said she was touching the pills with her bare hands because she had sanitized her hands. During an interview 3/12/25 at 9:44 A.M., the Infection Control Nurse said nurses should not touch medications with bare hands during medication administration.