STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225133	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blueberry Hill Rehabilitation and Healthcare Ctr	75 Brimbal Avenue Beverly, MA 01915

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to help prevent the development and potential transmission of communicable diseases and infections. Specifically, 1. For Resident #134 who was diagnosed with Influenza Type A, the facility failed to ensure staff implemented precautions after entering and exiting a room identified as being on contact precautions.2. Failed to, ensure nursing staff disinfected a blood glucose monitor after use.3. Failed to, ensure nursing staff performed hand hygiene appropriately during the medication administration task.Findings include:Review of the facility policy titled Influenza, Prevention and Control of Seasonal, dated March 2022, indicated the following: This facility follows current guidelines and recommendations for the prevention and control of seasonal influenza.-The prevention of seasonal flu outbreaks is a coordinated effort which is organized by the infection preventionist and overseen by the medical director.Infection Precautions-Visual alerts (e.g., signs, posters) are posted at the entrance to and in common areas of the facility to provide residents, visitors and staff with instructions about respiratory hygiene and cough etiquette. Instructions include:a. how to use facemask or tissues to cover nose and mouth when coughing or sneezing and to dispose of contaminated items in waste receptacles; andb. how and when to perform hand hygiene.-Contact and droplet precautions are implemented for residents with suspected or confirmed influenza for seven (7) days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer. Precautions may be applied for longer periods based on clinical judgement. Review of the facility policy titled Enhanced Barrier Precautions, dated as revised April 2025, indicate the following:-Enhanced Barrier Precautions (EBP) are utilized to prevent the spread of multi-drug resistant organisms (MDRO's) to residents.-Example of high contact resident care activities requiring he use of gown and gloves for EBP's include:h. prolonged, high-contact with items in the residents' room, with resident equipment, or with resident's clothing or skin.-Signs are posted at the door or wall outside the residents room which communicate the type of precautions and PPE required. Review of the facility policy titled Personal Protective Equipment', dated as revised July 2009, indicated the following:-Gloves must be worn when handling blood, body fluids, secretions, excretions, mucous membranes and/or non-intact skin.-Gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed.-The use of gloves will vary according to the procedure involved. The use of disposable gloves in indicated:a. when it is likely that the employee's hand will come in contact with blood, body fluids, secretions, excretions, mucous membranes, and/or non-intact skin while performing the procedure;d. when handling soiled linen or items that may be contaminated;g. during invasive procedures;-Wash your hands after removing gloves.1. Resident #134 was admitted to the facility in December 2025 has diagnosis including Influenza due to identified novel influenza A, a virus with other respiratory manifestations (a contagious respiratory illness), acute respiratory failure with hypoxia, congestive heart failure, and type two diabetes mellitus.Review of the medical record indicated Minimum Data Set assessment had not been completed as of the date of this survey as the Resident was a new admission.Review of the hospital Discharge summary dated [DATE] indicated Resident #134 tested (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	positive for Influenza Type A on 12/5/25.Review of Resident #134's medical record indicated physician's orders indicated the following:-Droplet Precautions for flu every shift, dated 12/10/25.-Contact Precautions for flu, dated 12/11/25.On 12/10/25 at 11:10 A.M., the surveyor observed Resident #134 sitting up in bed, the Resident could be heard coughing, the Resident's door was open, there was a sign on the door indicating droplet precautions, and a cart containing Personal Protective Equipment (PPE) was located outside the door.On 12/10/25 at 11:27 A.M., the surveyor observed the Admissions Director enter Resident #134's room without wearing gloves and was wearing a regular facemask. The Admissions Director was observed touching Resident #134's personal items located on his/her overbed table and picked up a pile of soiled linens off the bed with her bare hands and placed them on the floor. The admissions director then obtained gloves from a box inside of the room and was observed donning (apply) gloves, without performing hand hygiene. The Admissions Director was observed picking up a folder with her contaminated gloved hands and placing it on the empty bed located in the room and then picked up the soiled linen off the floor and placed the linen into a trash bag and proceeded to touch the outside of the bag with her contaminated gloves. The Admissions Director was observed removing her contaminated gloves by touching the inside of the gloves with her contaminated hands and did not perform hand hygiene after removing her gloves. The surveyor then observed the Admissions Director touch Resident #134's overbed table and call light with her bare contaminated hands. The Admissions Director then picked up a folder with her bare hands and walked out of Resident #134's room wearing a gown and regular face mask and was observed removing her gown and facemask as she walked down the hall. Pieces of the plastic blue gown had fallen to the ground as she tore off the waist ties.On 12/10/25 at 11:27 A.M., the surveyor observed the Admissions Director walking back into Resident #134's room without donning PPE and was observed obtaining a folder from the second bed located in the Resident's room. The Admissions Director walked out of the room and did not perform hand hygiene.During an interview on 12/10/25 at 11:31 Certified Nursing Assistant (CNA) #3 and said Resident #134 is a new admission who just came in and is positive for Influenza and is on isolation precautions.During an interview on 12/10/25 at 11:38 A.M., the Infection Preventionist (IP) said she doesn't know much about Resident #134 because he/she is a new admission and said the admission Director should have worn PPE as the Resident is on precautions because he/she is positive for influenza and is on isolation precautions. The IP said staff can wear a regular face mask and do not need an N95 mask (fitted filtered mask that reduces the spread of viruses). During an interview on 12/11/25 at 8:32 A.M. the Admissions Director said she knew Resident #134 was positive for the flu and should have followed the sign for precautions when entering the room and put on gloves and removed PPE before leaving the room. The Admissions Director said she should have performed hand hygiene before putting on and after removing her gloves.During an interview on 12/11/25 at 9:15 A.M., the Director of Nurses said we would want Resident #134 on droplet precautions as he/she is symptomatic and requires additional doses Tamiflu (medication to treat influenza), and staff must always follow infection control guidelines for hand hygiene and PPE precautions. The DON said staff can keep the door open and said staff can wear a regular face mask and do not need to wear an N95 mask when caring for Residents who are positive for Influenza.1b. On 12/12/25 at 6:41 A.M., the surveyor observed Resident #134 in bed, the Resident could be heard coughing, the door to the Resident room was open and a new sign was hanging on the outside door and was changed to Isolation Precautions indicating N95 mask must be worn.On 12/12/25 at 8:43 A.M. the surveyor observed Resident #134's door open. Certified Nursing Assistant (CNA) #2 was observed entering Resident #134's room wearing a gown, face shield, and a regular facemask that was covering her chin leaving her mouth exposed and entered Resident #134's room touching the overbed table with her ungloved bare hand. CNA #2 was not wearing gloves. CNA #2 could be seen talking with Resident #134 and Resident #134 could be heard coughing from the hallway and the Resident was not wearing a facemask. CNA #2 was observed walking out of the resident's room wearing PPE and used her ungloved potentially contaminated hand, to open the PPE cart located (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	outside of the room in the hall and obtained an N95 facemask. CNA #2 was observed removing the potentially contaminated face shield with her bare hand, and donned the N95 mask, placing it over the regular facemask that was still applied to her face covering her chin. The N95 mask was applied directly over the regular facemask and did not contain a tight seal. CNA #2 then picked up the potentially contaminated face shield with her bare hands and placed it over her head. Without performing hand hygiene CNA #2 then donned gloves and re-entered Resident #134's room and was observed touching items on Resident #134's bed and overbed table. CNA #2 was then observed removing her gown, gloves, face shield and N95 mask in the doorway and exited the room still wearing the regular facemask that was applied to her chin exposing her mouth and proceeded to walk down the hall.During an interview on 12/12/25 at 9:04 A.M., CNA #2 said the resident was on precautions and the sign said to use an N95 mask. CNA #2 said she was not sure why the resident was on precautions, but she put on an N95 mask to follow the instructions.During an interview on 12/12/25 at 10:31 A.M., the Director of Nurses (DON) said staff must follow the guidelines for infection control and said the CNA should not have worn the N95 mask over the regular mask. During an interview on 12/17/25 at 2:13 P.M., Physician #2 said infection control guidelines are to be followed to reduce the spread of infection and said staff must follow enhanced barrier precautions and contact precautions when providing care. Physician #2 said he expects all staff to wear appropriate PPE including an N95 mask appropriately when caring for a resident with influenza. 2. The facility failed to ensure nursing staff disinfected a blood glucose monitor after use.-On 12/17/25 at 7:52 A.M., the surveyor observed Nurse #4 remove a black bag from a drawer located in the medication cart, containing a glucometer, several lancets, and alcohol prep pads. Nurse #4 placed the black bag on top of a cart containing Personal Protective Equipment (PPE) located in the hall outside the Resident's door. There was a sign located outside the door indicating the Resident was on Enhanced Barrier Precautions. Nurse #4 put on a gown, facemask and gloves, picked up the black bag and entered the Resident's room and placed the black bag directly on top of his/her uncleaned overbed table. Nurse #4 obtained the Resident's blood sugar and immediately put the glucometer back into the black bag without cleaning it and potentially contaminating the contents of the bag. Nurse #4 used her contaminated gloved hand to zip up the black bag and then proceeded to use her contaminated gloved hand to remove her personal cell phone from her pocket to check the time on her phone and place the phone back into her pocket. Nurse #4 then removed her gloves, did not perform hand hygiene, and picked up the black bag with her ungloved potentially contaminated hands and proceeded to walk toward the Resident's door. Nurse #4 used one hand to remove gown and mask while holding on to the black bag and proceeded to exit the room without performing hand hygiene. Nurse #4 walked out of the room and returned to the medication cart. Using her potentially contaminated hands Nurse #4 touched the keys to the medication cart and used her bare hands to open the drawer to the cart and placed the black bag back into the drawer of the medication cart.3. The facility failed to ensure nursing staff performed hand hygiene appropriately during the medication administration task.On 12/17/25 8:03 A.M., Nurse #4 placed an insulin pen on top of a cart containing (PPE) located in the hall outside the Resident's door. There was a sign located outside the door indicating the Resident was on Enhanced Barrier Precautions. Nurse #4 was observed donning (applying) a pair of gloves only and entered the Resident's room without wearing a gown or mask. Nurse #4 then touched the Residents' blankets, clothing and skin area to expose the injection site, cleansed the area with alcohol and administered the insulin injection. Nurse #4 then touched the Resident's clothing covering up the injection area and removed her gloves by touching the contaminated glove with her bare hand, and without performing hand hygiene after discarding the contaminated gloves. Nurse #4 then carried the insulin pen into the hallway with her bare hand. Nurse #4 placed the insulin pen on top of the medication cart. Nurse #4 did not perform hand hygiene during this observation.On 12/17/25 at 8:09 A.M., Nurse #4 was observed donning (applying) a pair of gloves and administered an insulin injection. Nurse #4 then touched the Resident's clothing covering up the injection area and removed her gloves by touching the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contaminated glove with her bare hand, and without performing hand hygiene after discarding the contaminated gloves. Nurse #4 then carried the insulin pen into the hallway with her bare hand. Nurse #4 placed the insulin pen on top of the medication cart. Nurse #4 did not perform hand hygiene during this observation.During a medication observation on 12/17/25 at 8:39 A.M., the surveyor observed Nurse #4 administer insulin to a Resident then doffing (removing) her gloves, touching the contaminated glove with her bare hand, and without performing hand hygiene after discarding the contaminated gloves. Nurse #4 then used her ungloved hands to touch the Resident's clothing and personal items on the over bed table and exited the Resident's room carrying the insulin syringe with her bare hands. Nurse #4 was observed placing the insulin syringe directly on top of the medication cart, performed hand hygiene, then picked up the contaminated insulin syringe and needle with her bare hands and discarded them in the sharp's container located on the side of the medication cart. Nurse #4 then touched her computer and keyboard and did not perform hand hygiene.During an interview on 12/17/25 at 8:54 A.M., Nurse #4 said she cleans the glucometer after she is finished obtaining blood sugars and administering insulin to residents. Nurse #4 said she should have cleaned the glucometer with the bleach wipes and said she should have performed hand hygiene before and after removing her gloves and should not have touched items with her bare hands.During an interview on 12/17/25 at 8:59 A.M., Unit Manager #1 said staff must ensure the glucometer is cleaned before and after each use with bleach wipes and said staff must perform hand hygiene before and after glove removal and not touch items with their contaminated hands.During an interview on 12/17/25 at 11:18 A.M., the Infection Preventionist (IP) said she expects staff to follow all infection control guidelines when administering insulin and performing proper hand hygiene and when putting on or taking off gloves. The IP said staff must clean the glucometer between each use with the proper bleach wipes to reduce the risk of cross contamination.During an interview on 12/17/25 at 10:45 A.M., the Director of Nurses (DON) said staff must follow infection control guidelines and clean the glucometer before and after use and said hand hygiene must be performed before and after glove use. The DON said staff should not be placing items on residents' overbed tables and should not be touching items with contaminated gloves.During an interview on 12/17/25 at 10:49 A.M., the Regional Clinical Director said the glucometer bag should not have been brought into the room and placed on the Resident's overbed table and said staff must use approved bleach wipes to clean and disinfect shared equipment. She expects all staff to follow infection control guidelines for proper cleaning and disinfection and said not following recommendations could increase the risk of blood borne pathogens between residents if equipment is not properly cleaned in between use.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure it reported an allegation of abuse to the state agency for one Resident (#18) of 36 sampled residents. Findings include:Review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, dated April 2021, indicated, but was not limited to:Investigate and report any allegations within timeframes required by federal requirements.Resident #18 was admitted to the facility in October 2022 and has active diagnoses which include schizoaffective disorder, major depressive disorder, recurrent, severe with psychotic features, anxiety disorder, and urinary incontinence.Review of Resident #18's Minimum Data Set (MDS) assessment dated [DATE] indicated he/she was incontinent of bowel and bladder, exhibited behavioral disturbances, and a Brief Interview for Mental Status exam score of 10, signifying moderate cognitive impairment.Review of Resident #18's care plan dated 3/11/24 indicated he/she exhibits paranoia, makes accusatory statements and reports false information. The care plan (dated 10/29/22) indicated the Resident has bowel and urinary incontinence and he/she obsesses over wipes and stays on the toilet for long periods of time.During an interview on 12/10/25 at 9:23 A.M., Resident #18 said that yesterday and this morning, during the 11:00 P.M. to 7:00 A.M. shift, an unidentified member of the nursing staff turned the bathroom lights on and off while she was using the toilet and tried to rush him/her. Resident #18 said the staff member entered the bathroom and pushed him/her off the toilet. Resident #18 said the staff member wanted him/her to stop using the wipes and physically struggled with him/her over the wipes.Following the interview, on 12/10/25 at approximately 9:30 A.M., the surveyor told Nurse #3 (nurse assigned to the Resident) that Resident #18 alleged that yesterday and this morning a staff member pushed him/her off the toilet and they struggled over toilet wipes. Nurse #3 said he would immediately interview Resident #18 and inform management of the alleged incident.During an interview on 12/10/25 at 12:15 P.M., Nurse #3 said Resident #18 told him that for the past couple of days during the 11:00 P.M. to 7:00 A.M. shift, an aide was rough with him/her while in the bathroom. Nurse #3 said Resident #18 told him that the aide was fighting over placing used wipes in a bag. Nurse #3 said Resident #18 told him the aide pushed him/her while still sitting on the toilet and that the aide grabbed the bag from him/her. Nurse #3 said he told management about the alleged incident. Review of the Facility's grievance binder and the state agency's Health Care Reporting System on 12/15/25 at 10:01 A.M. indicated there was no report of the alleged incident. During an interview on 12/15/25 at 10:39 A.M., Resident #18 said he/she did not recall the alleged incident, or reporting to staff of an incident.On 12/15/25 at 10:45 A.M., the Director of Nurses and Administrator said no one reported that Resident #18 alleged a staff person pushed him/her off the toilet. The DON said that pushing a resident off the toilet rose to the level of an allegation of abuse. The DON and Administrator said they would begin an abuse investigation immediately and report the incident to the state agency. The DON said it was the facility's policy for all allegations of abuse to be immediately reported to administration and the state agency.

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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 record reviews, observations and interviews, the facility failed to ensure resident centered care plans were developed and/or implemented for one Resident (#9) out of a total sample of 36 residents. Specifically, for Resident #9, the facility failed to develop a psychotropic medication care plan. Findings include:Review of the facility policy titled Care Plans, Comprehensive Person-Centered', indicated but was not limited to the following:-A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.-The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care play for each resident.-The comprehensive, person-centered care plan is developed withing seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.-The comprehensive, person-centered care plan:a. includes measurable objectives and timeframes.e. reflects currently recognized standards of practice for problem areas and conditions.9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.11. Assessments of residents are ongoing, and care plans are revised as information about the residents and residents' condition change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition b. when the desired outcome is not met c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. Resident #9 was admitted to the facility in January 2024 with diagnoses including type two diabetes mellitus, hypertension, and depression. Review of Resident #9's most recent Minimum Data Set (MDS) assessment, dated 11/11/25, indicated Resident #9 had no cognitive impairment as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Further review of the MDS indicated the use of antipsychotic medications daily.Review of Resident #9's physician orders indicated the following:*Aripiprazole (an antipsychotic medication) 7.5 MG (milligrams) at bedtime for anxiety and depression. Start Date 10/16/25.Review of October 2025 through December 2025 Medication Administration Records (MAR) indicated Aripiprazole was administered as ordered by the physician.Review of Resident #9's comprehensive care plans failed to indicate a care plan had been developed for the use of Aripiprazole that identified resident-specific symptoms or targeted behaviors, resident-specific interventions, including non-pharmacological approaches, and measurable goals of treatment to meet the Resident's needs.During an interview on 12/16/25 at 8:39 A.M., the Director of Nursing said the care plans should include the use of antipsychotic medications and should be personalized and individualized to meet the residents' needs and keep them safe.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and records reviewed, the facility failed to meet professional standards of practice for three Residents (#7, #8, and #34) out of a total sample of 36 residents. Specifically: the facility failed to implement physician orders for insulin administration prior to the breakfast meal. Findings include:Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following:- Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error.Review of the facility policy titled Administering Medications, dated as revised March 2025, indicated the following:-Medications are administered in a safe and timely manner, and as prescribed.-Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions.-Medications are administered in accordance with prescriber orders, including any required time frame.-Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).-The individual administering the medication initials the resident's MAR (Medication Administration Record) on the appropriate line after giving each medication and before administering the next one. 1.Resident #7 was admitted to the facility in February 2025 with diagnoses including type two diabetes, chronic kidney disease stage three, heart failure, and vascular dementia. Review of the Minimum Data Set (MDS) assessment, dated 12/10/25, indicated Resident #7 had a Brief Interview for Mental Status (BIMS) score of 4 out of a possible 15 indicting severe cognitive impairment.On 12/11/25 at approximately 7:45 A.M., the surveyor reviewed physician orders for blood sugar checks and insulin administration on the [NAME] unit. On 12/11/25 the following observations were made on the [NAME] Unit:-At 7:45 A.M., the surveyor observed Unit Manager #1 on the [NAME] unit medication cart obtaining report from the overnight nurse. -At 8:12 A.M. the surveyor observed Unit Manager #1 assisting with the breakfast cart passing out trays.-At 8:49 A.M., breakfast carts had arrived, and all breakfast meal trays were delivered and set up was completed. Residents on the unit were observed eating breakfast in their rooms and in the dining room.-On 12/11/25 at 8:15 A.M., the surveyor observed Resident #7 sitting up in bed eating his/her breakfast meal while being assisted by a staff member. Review of the active physician orders for Resident #7 indicated the following:NovoLOG Injection Solution Inject as per sliding scale: if 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10 under 70 or over 400 CALL NP/MD (Nurse Practitioner/Medical Doctor), subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus with Diabetic Nephropathy. Start Date: 8/14/25. Scheduled for 8:00 A.M., 11:00 A.M., and 4:00 P.M.Review of Resident #7's Electronic Medical Record (EMAR) at 8:40 A.M., failed to indicate the blood sugar was completed and contained no documentation.Review of the administration history report indicated the medication was not documented as administered until 9:14 A.M., after the breakfast meal. 2.Resident #8 was admitted to the facility in May 2022 with diagnoses including type two diabetes, chronic kidney disease, asthma and major depressive disorder.Review of the Minimum Data Set (MDS) assessment, dated 10/6/25, indicated Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 indicating intact cognition.On 12/11/25 at 8:50A.M., Resident #8 was observed sitting up in bed eating his/her breakfast meal. Resident #8 said he/she has not received any morning medications including insulin.Review of the active physician orders for Resident #8 indicated the following:-NovoLOG FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart). Inject 5 units subcutaneously before meals related to Type 2 Diabetes Mellitus without complications. Hold Novolog insulin 5 units with meals if fasting blood sugar is less than 100 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and notify provider. Start Date: 6/6/25. Scheduled for 8:00 A.M., 11:00 A.M., and 4:00 P.M.Review of Resident #8's Electronic Medical Record (EMAR) at 10:04 A.M., failed to indicate the blood sugar was completed and contained no documentation.Review of the administration history report indicated the medication was not documented as administered until 11:08 A.M., after the breakfast meal.During an interview on 12/11/25 at 9:04 A.M., the Medical Director said nurses must ensure blood sugar checks and insulin orders are to be administered as ordered and said he expects residents to have blood sugars and insulin administered prior to meals as indicated per the physician orders. During an interview on 12/11/25 at 8:57 A.M., Unit Manager #1 who was assigned to work on the medication cart, said she had not administered any medications and had not obtained any blood sugar checks. Unit Manager #1 said she does not know which residents need to have blood sugars checked and has not reviewed the lab values in the electronic medical record yet as she obtained report from the overnight nurse around 7:45 A.M. During an interview on 12/12/25 at 10:35 A.M., Unit Manager #1 said she did not administer the insulins before the breakfast meals.During an interview on 12/12/25 at 10:37 A.M., the Director of Nurses said she expects orders to be followed and said she expects staff to obtain blood sugar levels when they are ordered and insulin to be administered prior to meals being served.3. Resident #34 was admitted to the facility in August 2024 with diagnoses including type two diabetes, chronic kidney disease stage three, hypertension and major depressive disorder.Review of the Minimum Data Set (MDS) assessment, dated 11/7/25, indicated Resident #34 had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 indicating intact cognition.On 12/17/25 at 8:28A.M., Resident #34 was observed sitting up in bed eating his/her breakfast meal. Resident #34 said he/she has not received any morning medications including insulin.Review of the active physician orders for Resident #34 indicated the following:-NovoLOG Injection Solution 100 UNIT/ML Inject 3 unit subcutaneously before meals for Type 2 Diabetes. Notify MD if glucose is over 200. Hold if no starch/carbs with meals. Start Date: 9/9/25. Scheduled for 8:00 A.M., 11:30 A.M., and 4:00 P.M.-NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML Inject as per sliding scale: if 0 - 150 = 0; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401+ Call NP/MD, subcutaneously before meals for DMII (Diabetes Mellitus type two) Notify MD of glucose greater than 400. Start Date: 3/11/25. Scheduled for 8:00 A.M., 12:00 P.M., and 4:00 P.M.During a medication pass observation on 12/17/25 at 8:58 A.M., Nurse #3 prepared to administer Insulin to Resident #34. Resident #34 was sitting up in bed eating the breakfast meal.During an interview on 12/17/25 at 9:00 A.M., Nurse #3 said she should have administered the insulin prior to the breakfast meal as ordered.During an interview on 12/17/25 at 11:45 A.M., the Director of Nurses said insulin must be administered prior to the breakfast meal and said she expects nurses to follow physician orders to ensure medications are given on time as ordered.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blueberry Hill Rehabilitation and Healthcare Ctr	75 Brimbal Avenue Beverly, MA 01915

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide behavioral health services for one Resident (#35) out of a total of 36 sampled Residents. Specifically, for Resident #35, the facility failed to a. ensure Resident #35 was seen by behavioral health services timely, and b. failed to implement medication change recommendations by the psychiatric Nurse Practitioner timely. Findings include:Review of the facility's Behavioral Health Services Policy dated as revised February 2019 indicated:Policy Statement: 1. The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial wellbeing in accordance with the comprehensive assessment and plan of care. Policy Interpretation and Implementation: 1. Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care. Resident #35 was admitted to the facility in July 2025 with diagnoses including unspecified dementia and major depressive disorder. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #35 scored 5 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS) indicating he/she is severely cognitively impaired. The MDS also indicated that Resident #35 experienced hallucinations and verbal behaviors. The MDS also indicated Resident #35 receives antipsychotic medications and antidepressant medications. a. Review of the Hospital Discharge paperwork dated 7/24/25 indicated: Discharging to [facility] where he/she will be followed psychiatrically DX: Major neurocognitive disorder with behavioral disturbance. Target symptoms: physical and verbal agitation, combativeness, anxiety, change in mental status and increased confusion. Review of the Nurse Practitioner's note dated 7/28/25 indicated: admitted to [facility] for long term care placement s/p (status post) lengthy geri-psychiatric hospitalization. Staff reporting appetite is poor. Not sleeping at night, sleeps during the day. Aggressive with redirection. Plan: Follow up with behavioral health. Review of Resident #35's physicians orders indicated: Consult psychiatric and/or psychology services as needed, 7/25/25.Review of Resident #35's care plan dated 7/28/25 indicated: Focus: I have mood problem r/t dementia. I scream, yell out, curse, I have delusions, I can get teary, anxious, continuously try to stand from wheelchair - staff have to provide continuous supervision because I am not aware of safety precautions. Interventions: Behavioral health consults as needed (psychiatry, psychology and/or Spiritual services). Review of the Consultant Pharmacist MRR (Monthly Record Review) Recommendation to Prescriber form dated 9/9/25 indicated: This resident receives Haloperidol, Sertraline and Trazodone. Please consider a psych consult for review of appropriateness of medications and/or possible decrease in dosage if you feel warranted at this time. Please indicate rationale if you feel not needed below.The 9/9/25 form failed to indicate the physician reviewed the recommendation and had handwritten note indicating: Conservator granted 5/2025. Conservator applied for MassHealth/Medicaid pending. Will sign consent for HD/psych (HCP) when approved. Review of the Consultant Pharmacist MRR (Monthly Record Review) Recommendation to Prescriber form dated 10/10/25 indicated: This resident receives Haloperidol, Sertraline and Trazodone. Please consider a psych consult for review of appropriateness of medications and/or possible decrease in dosage if you feel warranted at this time. Please indicate rationale if you feel not needed below.The 10/10/25 form indicated a psych referral was requested. Review of the clinical record indicated Resident #35 was not seen by Behavioral Health Services until 11/6/25; approximately 104 days after Resident #35's admission to the facility. During an interview on 12/15/2025 at 11:31 A.M., The Director of Nursing (DON) said she was unsure why there was a delay in behavioral health services seeing Resident #35, but it may have been related to Resident #35 being private pay at the time or obtaining consents from the Resident's conservator. During an interview on 12/15/2025 at 11:59 A.M., the Assistant Director of Nursing (ADON) said that Resident #35 could not be seen by behavioral (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	health services until he/she was covered by MassHealth and she called Resident #35's appointed health care proxy to obtain verbal consent for behavioral health services.During an interview on 12/15/2025 at 12:46 P.M., Physician #1 said that he would expect residents with a psych history and recent psychiatric hospitalization to be involved with behavioral health services upon admission to the facility. During an interview on 12/15/2025 at 1:38 P.M., Social Worker #1 said that residents with a psychiatric history are signed upon admission to be seen by behavioral health services. Social Worker #1 said that consent forms need to be signed and once the forms are signed, they are automatically added to the list to be seen by behavioral health services. Social Worker #1 said that Resident #35's daughter is his/her activated healthcare proxy visits the facility and is involved in his/her care. Social Worker #1 said she was not aware that Resident #35 was not seen by behavioral health services until November 2025 when he/she was admitted to the facility in July 2025. On 12/15/2025 at 2:13 P.M., Resident #35 was observed seated in the activity room away from the large group and fidgeting with items on the table in front of him/her. Resident #35 was unable to engage in the interview process. Certified nurse aide (CNA) #1 and Nurse #1 were present. CNA #1 said that Resident #35 is very behavioral and often panics or goes to stand up from his/her chair constantly. Nurse #1 said that Resident #35 was having a good day today and that he/she has been slightly better since behavioral health services became involved in his/her care. During an interview on 12/16/2025 at 4:15 P.M., Family Member #1 said that she is Resident #35's activated health care proxy and was not aware that Resident #35 had not been seen behavioral health services until November 2025. Family Member #1 said that when Resident #35 was hospitalized he/she had a lot of communication with the psychiatrist at the hospital but felt that she did not receive a lot of communication from the facility unless it was to change Resident #35's medications or if something like a fall occurred. During an interview on 12/16/2025 at 8:33 A.M., Social Worker #1 said that Resident #35 had a delay in behavioral health services because the facility was waiting on a consent form from the health care proxy. The Social Worker and Director of Nursing (DON) said that staff should be documenting attempts to reach families regarding signed consents, and she believed the ADON called and received verbal consent for behavioral health services from the health care proxy on 10/30/25. Review of the clinical record failed to indicate any attempts were made by staff to alert Family Member #1 of the need to obtain consent to receive behavioral health services.During an interview on 12/17/2025 at 8:19 A.M., Nurse Practitioner #1 said that she believed all residents, especially residents on antipsychotic medications are involved in Behavioral Health services upon admission to the facility. Nurse Practitioner #1 said she assumed Resident #35 was being seen by Behavioral Health Services upon admission and was not aware that he/she had not been seen until November 2025. b. Review of the Behavioral Health Service note dated 11/13/25 indicated: Problem: Requested to be seen by staff due to increased anxiety and agitation. [Resident] states his/her name, then says I don't know to all other questions regarding mood, anxiety, sleep. Staff endorse worsening restlessness. Plan/Recommendations: Trazadone Hydrochloride, add as needed trazodone 25 mg twice daily for 14 days for anxiety (continue standing order for trazodone). Sertraline Hydrochloride, increase sertraline to 100 mg daily for depression and anxiety. Review of the Behavioral Health Service Note dated 11/20/25 indicated: Problem: Requested to be seen by staff for increased anxiety, agitation, and combative behaviors, (combative behaviors were not documented on the previous behavioral health visit). [Resident] states I'm okay denies depression and anxiety at this time. Staff endorse worsening restlessness. Plans/recommendations: Sertraline Hydrochloride, increase sertraline to 100 mg daily for depression and anxiety. Trazodone Hydrocholoride, initiated as needed trazodone 50 mg twice daily for 14 days, (the same recommendations as the previous visit with an increase in the dosage of the trazodone.) Review of the physician orders failed to indicate the recommendations for a PRN dose of trazadone or the increase of the Sertraline per the behavioral health nurse practitioner until 11/20/25. Review of the clinical record indicated Family Member #1 had signed consent forms dated 7/25/25 indicated Resident #35's healthcare proxy agreed to the use of 25-200 MG of Sertraline and (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12.5-400 mg of Trazodone daily.During an interview on 12/16/2025 at 8:04 A.M., Nurse #1 said that when psych services make medication change recommendations, they write it in their notes, and the DON inputs it in the system. Nurse #1 said staff also have to alert the family and obtain a new consent form if needed. Nurse #1 said that the process is usually very quick and the orders for medication changes are usually ready by the next medication pass. During an interview on 12/16/2025 at 8:33 A.M., the Director of Nursing (DON) said that medication recommendations from behavioral health services are communicated to nursing staff, families are notified and orders are verified with the attending physician. The DON said after orders are verified a consent is obtained and the order is implemented. The DON said that the timing can be variable when the medication changes are fully implemented.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure drugs and biologicals were stored in accordance with acceptable professional standards of practice. Specifically, the facility failed to 1.ensure that all drugs and biologicals used in the facility are labeled in accordance with professional standards, when two insulin pens were observed unlabeled during the medication pass observation and 2. failed to ensure staff secured medications as evidenced by leaving a syringe with insulin unattended on top of a medication cart on the [NAME] unit. Findings include:Review of the facility policy titled Medication Labeling and Storage, dated as revised February 2023, indicated the following: -The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. -Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. -Medications are stored separately from food and are labeled accordingly. -Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. -The medication label includes, at a minimum: a. medication name (generic and/or brand b. prescribed dose; c. strength; d. expiration date; e. resident's name; f. route of administration; and g. appropriate instructions and precautions. -If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items. Review of the facility policy titled Administering Medications, dated as revised April 2019, indicated the following: -Insulin Pens are clearly labeled with the resident's name or other identifying information. Prior to (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administering insulin with an insulin pen, the nurse verified that the correct pen is used for that resident. 1.During the medication pass observation Nurse #3 was observed drawing up insulin to administer during the morning medication pass. Nurse #3 removed a clear bag from the medication cart, and the following medications were inside: -One Novalog Insulin Aspart Injection FlexPen. The medication was open, dated and unlabeled. There was no resident name identified. -One Lantus SoloStar (insulin glargine) Injection Pen. The medication was open, dated and unlabeled. There was no resident name identified. During an observation and interview on 12/17/25 at 8:29 A.M., the surveyor asked Nurse #3 how she identifies the two insulin pens belonging to Resident #34 and she said because his/her name is written on the plastic bag. Upon inspection of the plastic bag, the surveyor and Nurse #3 observed partial letters of Resident #9's last name handwritten in faded black ink. The bag did not contain the residents' full name or any other identifying information. Nurse #3 observed each insulin pen and said there should be resident labels on each pen, but they are missing. During an interview on 12/17/25 at 8:42 A.M., the Unit Manager said she would expect the medications to labeled appropriately with the Residents information. During an interview on 12/17/25 at 11:45 A.M., the Director of Nurses said medications must be dated and labeled appropriately to identify the correct medication for each Resident. 2. On 12/15/2025 at12:09 P.M., the surveyor observed a syringe filled with liquid on top of a medication cart on the [NAME] unit. There were multiple staff walking by and residents in the area as the lunch trays were being passed. The surveyor moved the syringe to read how full of fluid it was, (1.2 ml), and the orange cap rolled away exposing the sharp. The surveyor then called over Nurse #2 who was down at the end of the hallway. Nurse #2 said it was her medication cart, and she needed to waste the contents of the syringe. Nurse #2 said that syringe was filled with insulin and she should not have left the sharp on the top of the medication cart unattended. During an interview on 12/15/2025 at 12:20 P.M., the Director of Nursing (DON) said that nurses should not leave medications and sharps unattended.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, record review and interview, the facility failed to ensure follow-up dental services were provided for one Resident (#121) out of a total of 36 sampled residents. Specifically, the facility failed to ensure Resident #121 received dental exams every six months as recommended by the dentist. Findings include:Resident #121 was admitted to the facility in September 2023 with diagnoses including Alzheimer's Disease, anemia and asthma.Review of the Minimum Data Set (MDS) assessment, dated 9/15/25, indicated Resident #121 had moderate cognitive impairment as evidence by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. This MDS also indicated that Resident #121 required partial to moderate assistance with functional daily tasks and had not exhibited any behaviors related to rejection of care. On 12/10/25 at 9:48 A.M., the surveyor observed a moderate amount of white substance on Resident #121's bottom teeth. Resident #121 stated to the surveyor that he/she had seen the dentist since being admitted to the facility but had not seen the dentist in a long time and would like to see the dentist again. Review of Resident #121's oral health care plan dated 9/21/23, indicated the following interventions:-Coordinate arrangements for dental care as ordered and as needed.-Monitor/document/report to physician as needed signs/symptoms of oral/dental problems needing attention such as eroded, decayed and debris in mouth. Review of Resident #121's medical record indicated a consent dated 8/9/25 indicating the Resident wanted to receive contracted dental services. Review of Resident #121's medical record indicated the Resident was seen by the dentist on 12/22/23 indicating the following: -Poor condition of teeth.-Moderate soft plaque/food debris buildup.-light hard calculus deposits.-Recommended treatment: annual exam dated 12/22/24 and follow up exams every 6 months. Further review of the medical record failed to indicate the following:-Recommended exams every 6 months from initial exam on 12/22/23.-Scheduled annual exam dated 12/22/24.-Refusals of dental services by Resident #121. During an interview on 12/15/25 at 1:34 P.M., the Building Clerk said when a resident is admitted , consent for contracted services is signed and the resident is added on a list to be seen by the selected discipline. She stated that visits from all services provided are automatically uploaded to the medical record for the residents who have been seen. She said that an email is sent out 3 weeks to a month indicating the scheduled discipline and the residents scheduled to be seen. During a follow up interview on 12/16/25 at 1:43 P.M., the Building Clerk said the contracted service provider keeps track of how many visits the residents require. She stated the facility went paperless and she did not have consents to reference services selected for the residents who have been in the facility for a long time. She stated that the family for Resident #121 had requested him/her to be seen by the dentist in August 2025 and a new consent for the contracted services were signed at that time. The Building Clerk was unable to articulate her tracking methods for follow up recommendations by the dentist for the residents who have been in the facility long-term. During an interview on 12/16/25 at 2:43 P.M., the Director of Nurses (DON) said she expects the facility to keep track of services provided to the residents by the contractors and follow up with their recommendations.