STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225145	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhill Healthcare	76 North Street Middleboro, MA 02346

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 43935 Based on interview and document review, the facility failed to ensure residents had the right to voice and formulate grievances, have those grievances responded to promptly, and be provided a resolution to their grievance. Specifically, the facility failed to: 1. Have voiced grievances investigated and addressed, for two Residents (#86 and #68), out of a sample of 18 residents; and 2. Ensure residents had access to grievance/concern forms so they could formulate grievances anonymously, should they choose not to alert a staff member to their concern. Findings include: Review of the facility's policy titled Grievances, dated as revised 12/2018, indicated but was not limited to the following: - it is the policy of this facility to make information on how to file a grievance available to residents and/or resident representatives - the facility will support the right of each resident to voice grievances and to ensure that after a grievance has been received, the grievance official (administrator or designee) will work collaboratively with team members to resolve the issue and provide written decision to the resident and/or family - grievances and complaints may be submitted orally or in writing - if a grievance is submitted orally, the facility employee taking the grievance must write it up on the grievance form - if a person filling out the grievance is anonymous or wishes to remain anonymous, confidentiality will be maintained to the extent possible 1A. Resident #86 was admitted to the facility in June 2024 with diagnoses including: Chronic respiratory failure with hypercapnia (buildup of carbon dioxide in the bloodstream) and chronic obstructive pulmonary disease (lung disease causing restricted air flow). (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
	225145	A. Building B. Wing	11/06/2024

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Brief Interview for Mental Status (BIMS) score for Resident #86, dated 6/25/24, indicated the Resident was cognitively intact with a score of 15 out of 15. During an interview on 11/3/24 at 8:33 A.M., Resident #86 said he/she does not believe he/she is listened to when voicing grievances or concerns and there are times when no one gets back to him/her or the situation goes completely unaddressed. The Resident said at the time of admission he/she voiced a concern about the room temperature and the air conditioner in the room not working well, resulting in the room being very warm throughout the summer. The Resident said he/she told the Administrator about this concern and he/she is still in the same room now without a functioning air conditioner and no resolution to his/her concern. Review of the facility's Grievance Book failed to indicate a grievance was completed for Resident #86. During an interview on 11/4/24 at 3:36 P.M., the Social Worker said she was aware Resident #86 voiced a grievance about a hot room back in June or July of 2024, but that a grievance form was not completed as it should have been. She said the process is for staff to complete a grievance form or provide the Resident with a grievance form and assist them with completing one, but that process was not followed in this circumstance. During an interview on 11/4/24 at 4:00 P.M., the Administrator said he was aware of Resident #86's voiced concern regarding a hot room and he was actively involved in attempting to resolve the concern, but no grievance form was ever completed and there is no documentation about the issue, investigation or resolution. He said the facility does not always complete grievance forms if the issue is something they think they can resolve internally quickly but can see that the process was not followed and now the concern appears unresolved and there is no documentation to indicate otherwise. B. Resident #68 was admitted to the facility in August 2024 with diagnoses including: chronic kidney disease and hypertension. Review of the BIMS score for Resident #68, dated 8/15/24, indicated the Resident was cognitively intact with a score of 14 out of 15. During an interview on 11/3/24 at 1:02 P.M., Resident #68 said he/she had complained to the Administrator about a few certified nurse aides on several occasions but has never received any follow up or feedback. During an interview on 11/4/24 at 2:14 P.M., Resident #68 said he/she had spoken with both the Director of Nurses and the Administrator about poor customer service he/she received from two different nurse aides, most recently a few weeks ago. The Resident said all he/she ever hears is I'll talk to them but then never hears back and the situation is never resolved. Resident #68 said he/she feels that the facility is not listening to his/her concerns and is just trying to appease the staff at the expense of the resident. Review of the facility's Grievance Book failed to indicate a grievance was completed for Resident #68. (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/4/24 at 2:54 P.M., the Social Worker said when a resident voices a grievance of concern the staff are supposed to either complete a form or help the resident complete a grievance form. She said from there the form goes to the Administrator, who is the grievance official, and a plan is put in place within 48 hours and communicated to the team for investigation and follow up. During an interview on 11/4/24 at 4:01 P.M., the Administrator said he was aware Resident #68 voiced concerns about receiving poor customer service and there should be grievances and are not. He reviewed the grievance book with the surveyor and there was no documentation available to indicate Resident #68 had voiced concerns about two separate aides on two separate occasions. He said the process for grievances was not being consistently followed by the facility. 2. During a tour of the facility on 11/4/24 at 7:34 A.M., the surveyors did not observe the availability of grievance or concern forms on any of the three nursing units. In the lobby area, the surveyors observed that there was a wall pocket labeled grievances/concerns, but it was empty. During an interview on 11/4/24 at 10:22 A.M., the Director of Nurses said grievance forms are typically available in the activity area, business office, social worker's office and on each nursing unit. During an interview on 11/4/24 at 10:32 A.M., Nurse #3 said she did not know where any grievance forms were kept, but if a resident were to voice a grievance, she would attempt to resolve it and then pass the issue on in nursing report. During an interview on 11/4/24 at 10:57 A.M., Nurse #10 said he was unaware of what to do if a grievance was voiced or received and said he would get the unit manager involved. He said he does not know where any grievance or concern forms are kept. During an interview on 11/4/24 at 11:10 A.M., Certified Nurse Aide #8 said if a resident wants to complete a grievance, then she notifies a nurse and doesn't know what happens after that. She said there may be forms behind the nurses' station in the drawers or filing cabinets but she isn't sure. During an interview on 11/4/24 at 11:12 A.M., Nurse #16 said the unit doesn't have any grievance forms, but she believes forms are kept in a wall pocket outside of the unit in the lobby area. During a group meeting on 11/4/24 at 1:03 P.M., seven out of nine residents in attendance said they do not know where to locate a grievance form to complete a grievance anonymously and that they would need to request a form from staff if they wanted to put in a concern. Three of nine residents in attendance said the facility does not always follow up on grievances and make the residents aware of any resolution. On 11/4/24, the survey team made the following observations: 7:34 A.M., wall pocket in the lobby labeled grievances/concerns did not contain any forms for the residents/their family members 11:13 A.M., a wall pocket in the lobby marked grievances was empty of any available forms (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1:32 P.M., the lobby wall pocket marked grievances remained empty of any available forms 2:13 P.M., wall pocket in the lobby marked grievances was empty of any available forms During an interview on 11/4/24 at 3:00 P.M., the Social Worker said each nursing unit and the front lobby all have wall pockets with grievance/concern forms available for residents or their family members to be able to complete a grievance form anonymously or just obtain a form. During a tour on 11/4/24 at 3:01 P.M., the Social Worker and the surveyor toured all three nursing units and the Social Worker said she was unaware that the units did not have grievance forms available for the residents/families to obtain them independently. Further she said the wall pocket in the lobby was empty and the forms needed to be kept in a location in which residents and their families could obtain the forms independently to voice concerns anonymously if they wanted to and for the facility to meet the guidelines. During an interview on 11/4/24 at 4:03 P.M., the Administrator said the process for grievances is for staff to obtain a form for the resident and if necessary assist the resident in completing the form. He said from there the form is discussed with the interdisciplinary team and a plan is put in place to investigate the situation and a resolution is determined. He said the facility will communicate a resolution to a voiced or written grievance within approximately five days. He said he was unaware that residents and their families needed the availability of forms for completing a grievance anonymously and/or independently and there is currently no process in the facility for that to be done. He reviewed the facility policy on grievances and said the process has not been fully implemented as it should be. During an interview on 11/4/24 at 4:39 P.M., Regional Clinical Nurse #1 said there should have been grievance forms completed for both Resident #86 and #68 and forms needed to be available for residents and/or their families to report grievances anonymously if they should wish to do so.

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	225145	A. Building B. Wing	11/06/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 43935 Based on document review and interview the facility failed to ensure Section C (Cognitive patterns) of the Minimum Data Set (MDS) assessment was complete and accurate to reflect the status of seven Residents (#86, #250, #60, #17, #9, #55, #40), out of a sample of 18 current residents and one discharged Resident (#97), who also had an incomplete pain section (Section J), out of a sample of three discharged records reviewed. Findings include: -Resident #86 was admitted to the facility in June 2024 with diagnoses including chronic respiratory failure with hypercapnia (buildup of carbon dioxide in the bloodstream). Review of the MDS assessment, dated 9/20/24, Section C indicated but was not limited to the following: C 0100: Should Brief Interview for Mental Status (BIMS) be conducted: Yes Further review indicated questions C 0200 through C 0400 were not assessed, and there was no BIMS score to determine the Resident's level of cognition. -Resident #250 was admitted to the facility in October 2024 with diagnoses including diabetes mellitus. Review of the MDS assessment, dated 10/28/24, Section C indicated but was not limited to the following: C 0100: Should BIMS be conducted: Yes Further review indicated questions C 0200 through C 0400 were not assessed, and there was no BIMS score to determine the Resident's level of cognition. -Resident #60 was admitted to the facility in October 2024 with diagnoses including unspecified dementia. Review of the MDS assessment, dated 10/14/24, Section C indicated but was not limited to the following: C 0100: Should BIMS be conducted: Yes Further review indicated questions C 0200 through C 0400 were not assessed, and there was no BIMS score to determine the Resident's level of cognition. -Resident #17 was admitted to the facility in August 2018 with diagnoses including quadriplegia. (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment, dated 10/18/24, Section C indicated but was not limited to the following: C 0100: Should BIMS be conducted: Yes Further review indicated questions C 0200 through C 0400 were not assessed, and there was no BIMS score to determine the Resident's level of cognition. -Resident #9 was admitted to the facility in September 2024 with diagnoses including dementia. Review of the MDS assessment, dated 9/10/24, Section C indicated but was not limited to the following: C 0100: Should BIMS be conducted: Yes Further review indicated questions C 0200 through C 0400 were not assessed, and there was no BIMS score to determine the Resident's level of cognition. -Resident #55 was admitted to the facility in January 2024 with diagnoses including: Acute respiratory failure with hypoxia (deficiency of oxygen to the body). Review of the MDS assessment, dated 10/11/24, Section C indicated but was not limited to the following: C 0100: Should BIMS be conducted: Yes Further review indicated questions C 0200 through C 0400 were not assessed, and there was no BIMS score to determine the Resident's level of cognition. -Resident #40 was admitted to the facility in December 2019 with diagnoses including dementia. Review of the MDS assessment, dated 9/6/24, Section C indicated but was not limited to the following: C 0100: Should BIMS be conducted: Yes Further review indicated questions C 0200 through C 0400 were not assessed, and there was no BIMS score to determine the Resident's level of cognition. -Resident #97 was admitted to the facility in September 2024 with diagnoses including spinal stenosis. Review of the MDS assessment, dated 9/25/24, Section C indicated but was not limited to the following: C 0100: Should BIMS be conducted: Yes (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review indicated questions C 0200 through C 0400 were not assessed, and there was no BIMS score to determine the Resident's level of cognition. Review of section J indicated but was not limited to the following: J 0200: Should pain assessment interview be conducted: Yes Further review indicated questions J 0300 through J 0600 were blank. During an interview on 11/4/24 at 3:28 P.M., the Social Worker said there is not a time she can think of in which Section C of the MDS should not be assessed for a resident. She said the MDSs were incomplete and they should not be and that is not her practice. During an interview on 11/6/24 at 12:01 P.M., the MDS Nurse said the expectation is that all residents have evaluations completed quarterly by the social worker who in turn completes Section C of the MDS. She said Section C is the BIMS assessment for the residents and should not be dashed or marked as not assessed; either the resident interview or staff interview for resident cognition should be completed for that section of the MDS each quarter. She reviewed Section C of the MDS for Residents #86, #250, #60, #17, #9, #55, and #40 as indicated above and said the MDS was incomplete and inaccurate since Section C for all of the reviewed Residents was dashed or marked as not assessed. During an interview on 11/6/24 at 3:00 P.M., the MDS Nurse reviewed Resident #97's (discharged Resident) MDS with the surveyor and said Section C of the MDS was dashed out and therefore incomplete for the Resident. She reviewed section J for pain and said the nursing evaluation was not complete and did not include a pain score. Therefore, she could not use it and that section is incomplete. During an interview on 11/6/24 at 12:58 P.M., Corporate Nurse #2 said the MDS should be complete and accurate including Section C. 48695 34145

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 43935 Based on document review and interview, the facility failed to ensure two Residents (#250 and #60) were offered or provided a summary of their baseline care plans, out of a total sample of 18 residents. Findings include: Review of the facility's policy titled Care Plans - Baseline, dated as revised 11/2017, indicated but was not limited to the following: - the resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to the initial goals of the resident, a summary of medications and dietary instructions, any services or treatments to be administered by the facility and personnel acting on behalf of the facility. 1. Resident #60 was admitted to the facility in October of 2024 with diagnoses including unspecified dementia, diabetes mellitus and hypertension. Review of the Brief Interview for Mental Status (BIMS), dated 10/23/24, indicated the Resident suffered from severe cognitive impairment with a score of 3 out of 15. Further review of the medical record indicated the Resident's healthcare proxy (HCP) was activated to make all medical decisions on behalf of the Resident. During an interview on 11/3/24 at 8:00 A.M., the Resident said he/she does not recall anyone discussing goals with him/her for their stay or what the plan is for him/her to go home and to check with their daughter. Review of the medical record for Resident #60 failed to indicate the baseline care plan was reviewed with the Resident and/or their responsible party or that they were offered a summary of the care plan. During an interview on 11/4/24 at 11:06 A.M., Nurse #3 reviewed Resident #60's medical record and said she could not find any information in the record that indicated a baseline care plan meeting was completed or that the Resident or HCP was offered a copy of the baseline care plan summary. During an interview on 11/4/24 at 11:37 A.M., Resident #60's HCP said no one has met with her to discuss how the Resident is doing in rehab, whether or not they are improving towards the goals of discharge or ascertained information from her on what those goals must entail. She said she has never received any summary of his/her care plans or what treatments and services are being provided and was not offered one. (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/4/24 at 3:08 P.M., the Social Worker said the process for new admissions is for care plans to be initiated within the first 48 hours and a meeting held within 72 hours to get input from the resident and/or family and ensure they are all on the same page with a plan for the resident's treatment and that information is documented on a form under the evaluations section of the medical record and contains a box to check that the resident and/or their family was offered a summary of the meeting and they agree with the plan. She said she was not part of the baseline care plan meeting for Resident #60. She reviewed the medical record for the Resident and said it does not appear that the facility followed the process or completed a 72-hour meeting for Resident #60 and there is no documentation to demonstrate they were offered a copy or summary of the Resident's care plans or treatment plans. 2. Resident #250 was admitted to the facility in October 2024 with diagnoses including vertigo, diabetes mellitus, and repeated falls. Review of the Nursing evaluation, dated 10/22/24, indicated the Resident was alert and oriented to person, place and time. During an interview on 11/3/24 at 10:44 A.M., Resident #250 said he/she had not yet met with anyone to review the treatment plan and is not aware what care plans are, but would like to meet with the facility and his/her family to discuss his/her likes, preferences, goals and overall plan of care; there has been no meeting with the interdisciplinary team to discuss any of these things. Resident #250 said no one has offered him/her any summary or copy of care plans and he/she has never heard of those and is unaware of what those are. During a follow up interview on 11/4/24 at 9:55 A.M., the Resident said he/she still had not had a meeting to discuss the goals of their stay or care and no one had offered them any care plans or a summary of what to expect while they are in the facility. During an interview on 11/4/24 at 10:02 A.M., Nurse #3 said the process for baseline care plans is for nursing to trigger the care plans during the nursing evaluation and then she believes social services has a meeting with the resident and their family to review the care plans and offer them a copy. She said that is then documented in the computer under evaluations by the social service team. She reviewed the medical record of Resident #250 and said she could not find any evidence that the 72-hour meeting ever took place or that the Resident was ever offered a copy or summary of his/her care plans. During an interview on 11/4/24 at 3:21 P.M., the Social Worker reviewed the medical record of Resident #250 and said she did not attend a baseline care plan meeting for the Resident and there is no evidence that the Resident ever had a baseline care plan meeting or was ever offered a copy or summary of his/her baseline care plans and it appears the process is not being followed.

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	225145	A. Building B. Wing	11/06/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48695 Based on observation, interview, and document review, the facility failed to review and revise the care plan for one Resident (#22), out of a total sample of 18 residents. Specifically, the facility failed to ensure the care plan was updated with current Health Care Proxy (HCP) status. Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, last revised 1/2024, indicated but was not limited to: - Policy: a comprehensive, person-centered care plan will be developed for each resident. The care plan will include objectives that meet the resident's physical, psychosocial, and functional needs is developed for each resident. - the resident comprehensive care plan will identify problem areas and their causes as warranted and developing interventions that are targeted and meaningful to the resident. Review of the facility's policy titled Advanced Directives, last revised 1/2024, indicated but was not limited to: - Policy: Advanced Directives will be respected in accordance with state law and facility policy - Guidelines: The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directives. Resident #22 was admitted to the facility in April 2022 with diagnoses including chronic obstructive pulmonary disease (lung diseases that make it hard to breathe) and respiratory failure with hypoxia (a condition that occurs when the body doesn't have enough oxygen). Review of Resident #22's Significant Change Minimum Data Set (MDS) assessment, dated 10/6/24, indicated Resident #29 was cogitatively intact as evidenced by a Brief Interview for Mental Status score of 13 out of 15. Further review of Resident #22's MDS indicated section S which addresses advanced directives had not been completed. Review of Resident #22's medical record indicated his/her HCP was activated on 6/26/24 with Probable duration of Resident's Incapacity of 30 days. Review of Resident #22's Advanced Directives Care Plan indicated but was not limited to: - Focus: Advanced Directives, last revised 4/24/24 - Goal: Resident Advanced Directives are in effect, an (sic) their wishes and directions will be carried out in accordance to their advanced directives & MOLST, last revised 10/25/24 (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Interventions: - Allow resident, if able, to discuss feelings regarding their Advanced Directives, date initiated 4/16/24 - An Advanced directive can be revoked or changed, the advanced directive can be revoked or changed if the resident and/or appointed health care representative changes their mind about medical care, date initiated 4/16/24 - Discuss Advanced Directives with the resident and/or appointed HCP, date initiated 4/16/24 - Follow MOLST form as ordered, date initiated 4/16/24 - Notify physician to assess capacity of the resident and certify capacity or incapacity, date initiated 4/16/24 Further review of Resident #22's Medical Record indicated but was not limited to: - A change to his/her wishes as indicated on the Resident's Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) form, dated 9/30/24, signed by the HCP, and - A consent to admit Resident #22 to Hospice, dated 9/30/24, signed by the HCP. During an interview on 11/6/24 at 12:29 P.M., the Physician and surveyor reviewed Resident #22's Health Care Proxy activation form, dated 6/26/24. The Physician said he had originally only wanted to activate Resident #22's for 30 days to see if Resident #22 would cognitively improve. The Physician said he meant to go back and update Resident #22's plan of care to reflect that his/her HCP should have been activated indefinitely but forgot. During an interview on 11/6/24 at 2:40 P.M., the Social Worker said the Physician should have updated Resident #22's plan of care to reflect that his/her HCP should have been activated indefinitely. She said Resident #22's HCP should not have been able to sign him/her on to Hospice or change his/her advanced directives because their plan of care did not reflect that his/her HCP was activated at the time those decisions were made and those documents were completed. During an interview on 11/6/24 at 3:38 P.M., Regional Clinical Nurse#2 said Resident #22's care plan should reflect an extended HCP activation but does not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225145	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhill Healthcare	76 North Street Middleboro, MA 02346

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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 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** 34145 Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards of practice for three Residents (#95, #33, and #22), out of a total sample of 18 residents and three closed records. Specifically, the facility failed to ensure: 1. For Resident #95, that the Registered Nurse (RN), who made a pronouncement of death, documented the assessment in the medical record as required; 2. For Resident #33, that all components of wound care recommendations were implemented timely and air mattress settings were in accordance with physician's orders; and 3. For Resident #22, that a physician's order was in place to transfer the Resident to the hospital. Findings include: 1. Review of the facility's policy titled RN Pronouncement, last revised ,d+[DATE], indicated but was not limited to: -Documentation in Nurses Notes by the Registered Nurse (RN) making the pronouncement should include: -Absence of respirations, apical pulse, and blood pressure -Time of pronouncement -Notification to Funeral Home Review of the Massachusetts 244 CMR Board of Registration in Nursing, Section 3, dated [DATE], indicated but was not limited to the following: -A registered nurse shall act, within his or her generic and continuing education and experience to systematically assess health status of individuals and groups and record the related health data. Review of the Massachusetts 244 CMR Board of Registration in Nursing, Advisory Ruling on the Initiation and Withholding of Cardiopulmonary Resuscitation in Massachusetts Long-term Care Facilities with 24-hour Skilled Nursing Staff on Duty chapter 30A, section 8, and chapter 112, section 80B, dated [DATE], indicated but was not limited to: -The nurse licensed by the Massachusetts Board of Registration in Nursing (Board) is expected to engage in the practice of nursing in accordance with accepted standards of practice (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nursing Assessment: the nurse must make complete, accurate and legible entries in all appropriate patient or resident records required by federal and state laws and regulations, and accepted standards of practice. To demonstrate that the nurse has adhered to the accepted standard of nursing practice in the initiation or withholding of CPR, such documentation entries must include: *Patient or resident DNR status (or absence of); *Findings from the nurse's sequential assessment of the patient or resident including responsiveness; respiratory status; cardiac status; pupillary responsiveness; and the presence of dependent lividity and/or rigor mortis that substantiates the nurse's determination of irreversible death; *Judgments and interventions made by the nurse based on his or her sequential assessment of the patient or resident including, the decision to initiate or withhold CPR; *Collaboration and communication with other health care providers to ensure quality and continuity of care including dates and times of notifications of primary care providers; *Collaboration and communication with the patient or resident's family or significant others including dates and times of notification. Resident #95 was admitted to the facility in [DATE] and had diagnoses including metastatic lung cancer. Review of a Nursing Note, dated [DATE] and written by a Licensed Practical Nurse (LPN), indicated during rounds at 4:05 A.M., Resident #95 was noted to be unresponsive with no pulse or respirations detected. The on-call clinician was notified and the Director of Nursing (DON) was notified to pronounce as ordered. Review of a RN/PA/NP Pronouncement of Death form, dated [DATE] and signed by the DON (who is a RN), indicated Resident #95 was pronounced deceased by the DON on [DATE] at 6:32 A.M. A Nursing Note, dated [DATE] and written by a LPN, indicated an RN pronouncement of death was made at 6:32 A.M., the health care proxy was notified at 6:40 A.M., and the funeral home removed the body at 7:50 A. M. Further review of the medical record failed to indicate the DON who assessed and pronounced Resident #95 deceased wrote a note that substantiates the nurse's determination of irreversible death in the medical record according to professional standards of practice. During an interview on [DATE] at 10:14 A.M., the DON reviewed Resident #95's medical record and said he thought he wrote a Nurse's Note, but he did not. He said he should have written a note documenting his assessment of the Resident, family notification, notification of the funeral home and when the funeral home removed the body from the facility. 48362 2. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised [DATE], indicated but was not limited to: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of Registered Nurse and Practical Nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered Nurse and Practical Nurse respectively. The regulations stipulate that both the Registered Nurse and Practical Nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the Registered Nurse and Practical Nurse incorporate into the plan of care and implement prescribed medical regimens. The Rules and Regulations 9.03 define Standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. Review of the facility's policy titled Support Surface Guidelines, dated ,d+[DATE], indicated but was not limited to the following: - Redistributing support surfaces are to promote comfort for all bed-or chair bound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. - Support surfaces are modifiable. Individual resident needs differ. - Selecting a mattress for the resident based on pressure ulcer risk is clinically appropriate. Resident #33 was admitted to the facility in [DATE] with diagnoses including chronic kidney disease, muscle weakness, and muscle wasting/atrophy. Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #33 was cognitively intact as evidenced by a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS). Further review indicated Resident #33 had a stage four unhealed pressure injury and was utilizing a pressure reducing device for their bed. On [DATE] at 8:25 A.M., the surveyor made the following observations: - Resident #33 was resting in bed, lying on their back. - Air mattress was set to 150 pounds (lbs.) at an alternating pressure. On [DATE] at 7:31 A.M. and 2:06 P.M., the surveyor made the following observations: - Resident #33 was resting in bed, lying on their back. - Air mattress was set to 150 lbs. at an alternating pressure. On [DATE] at 7:21 A.M., the surveyor made the following observations: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #33 was resting in bed, lying on their back. - Air mattress was set to 150 lbs. at an alternating pressure. Review of Resident #33's Physician's Orders included but were not limited to: - [DATE]: Air mattress settings at 100 lbs., check every shift. - [DATE]: Wound Doctor (MD) Consult as indicated. Review of the Wound MD's progress note, dated [DATE], indicated Resident #33 had a stage four pressure area to their sacrum and recommended a low air loss mattress. Review of the Wound MD's progress notes, dated [DATE], indicated Resident #33 had a stage four pressure area to their sacrum that was at goal and recommended a low air loss mattress. Review of the Wound MD's progress notes, dated [DATE], indicated Resident #33 had a stage four pressure area to their sacrum that was at goal and recommended a low air loss mattress. Review of the Wound MD's progress notes, dated [DATE], indicated Resident #33 had a stage four pressure area to their sacrum that was improved as evidenced by decreased surface area and recommended a low air loss mattress. Review of Resident #33's Treatment Administration Record (TAR) indicated the air mattress was assessed each shift on [DATE], [DATE] and the day shift on [DATE] and was in accordance with physician's orders for settings at 100 lbs. Further review of Resident #33's medical record failed to indicate orders for the air mattress were implemented prior to [DATE], 16 days after the initial recommendation by the Wound MD. During an interview on [DATE] at 10:38 A.M., Nurse #8 said residents who utilize air mattresses are checked every shift to make sure the mattress is inflated and in accordance with physician's orders. Nurse #8 reviewed Resident #33's medical record and said his/her air mattress settings should be set to 100 lbs. Nurse #8 and the surveyor observed Resident #33's air mattress. Nurse #8 said the current settings on the air mattress were to 150 lbs. and did not match the physician's orders. During an interview on [DATE] at 10:46 A.M., the Infection Control Nurse, who also participates in wound rounds, said residents with open areas are followed by the Wound MD on a weekly basis. She said she follows the Wound MD on rounds and after receiving their reports, updates orders, progress notes and/or evaluations for each resident as needed. The Infection Control Nurse and the surveyor reviewed the observations made of Resident #33's air mattress. The Infection Control Nurse also reviewed Resident #33's medical record. The Infection Control Nurse said the setting on Resident #33's air mattress did not follow the physician's orders and the orders for the air mattress should have been implemented on [DATE] when the recommendations were made by the Wound MD. 48695 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #22 was admitted to the facility in [DATE] with diagnoses including chronic obstructive pulmonary disease (lung diseases that make it hard to breathe) and respiratory failure with hypoxia (a condition that occurs when the body doesn't have enough oxygen). Review of Resident #22's MDS assessments, dated [DATE] and [DATE], indicated he/she was discharged to the hospital with return anticipated. Review of Resident #22 Nursing Progress Note, dated [DATE], indicated he/she was transferred to the hospital. Review of Resident #22 Nursing Progress Note, dated [DATE], indicated he/she was transferred to the hospital. Review of Resident #22's Order Listing Report for [DATE] through [DATE] failed to indicate an order to transfer him/her to the hospital on [DATE] and [DATE]. During an interview on [DATE] at 2:18 P.M., Nurse #6 said prior to sending a resident to the hospital a nurse would need to obtain an order. Nurse #6 and the surveyor reviewed Resident #22's physician's orders. Nurse #6 said she did not see an order to send Resident #22 to the hospital on [DATE] or [DATE]. During an interview on [DATE] at 3:38 P.M., the DON said there was not an order to transfer Resident #22 to the hospital on [DATE] or [DATE] but there should have been.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48362 Based on observation, interview, and record review, the facility failed to ensure the environment was free from accident hazards for one Resident (#85), out of a total sample of 18 residents. Specifically, the facility failed to implement interventions on the comprehensive care plan to ensure safety precautions were taken for resident safety as related to smoking and complete an accurate initial and quarterly smoking evaluation. Findings include: Review of the facility's policy titled Smoking Policy - Residents, dated last revised 3/2024, indicated but was not limited to the following: - This facility shall establish and maintain safe resident smoking practices. - Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas and smoking times. - A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by staff. - The resident will be evaluated upon admission and/or when a resident chooses to smoke, to determine the resident's ability to smoke safely. - Any smoking related concerns will be noted in the resident care plan. - Residents who are supervised for smoking will be monitored by a staff member or designee during the allowed smoking times. Resident #85 was admitted to the facility in June 2024 with diagnoses including cerebral infarction, depression, and hypertension. Review of the Minimum Data Set (MDS) assessment indicated Resident #85 was cognitively intact as evidenced by a score of 14 out of 15 on the Brief Interview for Mental Status (BIMS). Further review of the MDS assessment failed to indicate Resident #85 used tobacco. On 11/3/24 at 1:50 P.M., the surveyor made the following observations: - Resident #85 was in the courtyard in a reclining chair with a visitor. - A lit cigarette was noted in Resident #85's right hand. - No staff were observed outside in the courtyard area with Resident #85. - No smoking protection, such as an apron, was on the Resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/3/24 at 1:55 P.M., Resident #85 and their visitor said he/she only smokes occasionally when family is visiting. Resident #85 and their visitor said family brings his/her cigarettes into the facility for them and he/she does not smoke during the allotted facility times. During an interview on 11/3/24 at 2:00 P.M., the Activities Director said she is in charge of supervising smoking on the days she is in the facility. The Activities Director said residents who are smokers are allowed to smoke at 11:00 A.M. daily. The Activities Director said Resident #85 does not smoke daily. The Activities Director said Resident #85 only smokes when his/her family visits. The Activities Director said she does not have any smoking equipment for Resident #85 as their family brings it in with them when they are visiting. Review of Resident #85's initial Smoking Evaluation, dated 6/27/24, indicated the following: - Does the Resident Smoke: Not Applicable (N/A) - No other portion of the assessment was completed. Review of Resident #85's quarterly Smoking Evaluation, dated 9/24/24, indicated the following: - Does the Resident Smoke: Not Applicable (N/A) - No other portion of the assessment was completed. Review of Resident #85's physician's orders indicated the following: - 10/24/24: Nicotine Transdermal Patch 24 Hour 21 milligrams (MG) per 24 hours; apply one patch transdermally one time a day for smoking cessation; on at 8:00 A.M. and off at 7:59 A.M. Review of Resident #85's nursing progress notes, dated 10/28/24, indicated that nicotine patches will start tomorrow and will address with nurse practitioner (NP) a stop date or titration schedule. Review of Resident #85's Medication Administration Record (MAR) for November 2024 indicated he/she received a nicotine patch transdermally on 11/3/24 and 11/4/24. Review of Resident #85's smoking care plan, initiated 6/27/24 and revised 11/3/24, indicated he/she smokes occasionally. The smoking care plan failed to indicate individualized interventions specific to Resident #85. During an interview on 11/5/24 at 2:46 P.M., Nurse #7 said smoking evaluations are completed on admission and quarterly thereafter. Nurse #7 said a staff member will take a resident who wants to smoke out for an assessment to determine their needs including supervision status. During an interview on 11/5/24 at 2:48 P.M., Nurse #8 said Resident #85 used to smoke occasionally with family. Nurse #8 said Resident #85 wears a nicotine patch transdermally. Nurse #8 said a resident who is wearing a nicotine patch should not also be smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/5/24 at 2:55 P.M., Nurse #6 said she will sometimes complete the smoking assessments for residents in the facility. Nurse #6 said when a resident comes into the facility and is identified as a smoker, the facility will discuss options with the resident including smoking or smoking cessation. Nurse #6 said if a resident or a representative chooses to smoke, an assessment is performed to assess their needs during smoking times. Nurse #6 said Resident #85 only smokes with family per their request and the facility does not keep any smoking equipment on-site for the resident. Nurse #6 said all smoking assessments should be completed for Resident #85 per facility policy. During an interview on 11/5/24 at 3:00 P.M., the Director of Nursing (DON) said the facility offers smoking for those residents who choose to smoke. The DON said residents are assessed by staff and smoking evaluations are completed. The DON said everyone in the facility is supervised for smoking. The DON and the surveyor reviewed the observations made regarding Resident #85 and smoking. The DON reviewed Resident #85's medical record. The DON said Resident #85's smoking evaluations are incomplete and not accurate. The DON said Resident #85's smoking care plan should be individualized to indicate they smoke only with family members. The DON said Resident #85 should not have a nicotine patch if they are smoking and it would need to be addressed with the physician.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on observation, interview, and record review, the facility failed to provide the necessary respiratory care and services for one Resident (#22), out of a total sample of 18 residents. Specifically, the facility failed to ensure oxygen (O2) equipment was maintained in a sanitary manner to help decrease the risk of potential contamination and infection. Findings include: Review of the User's Technical Manual, dated January 2019, for Resident #22's oxygen concentrator indicated but was not limited to: - Description of operations: - Air is drawn into the Oxygen Concentrator through an external air intake gross particulate filter. -Routine Maintenance - To ensure accurate output and efficient operation of the unit, the user must perform simple routine maintenance tasks: -Clean the air intake gross particle filter Review of the World Health Organization: Care, Cleaning and Disinfection of Oxygen Concentrators Checklist (2022) indicated: -Inspect and clean air intake filter (1-2 times per week) 1. Pull the filter gently out and replace with spare one. 2. Put the filter in cool, soapy water and swirl gently to remove debris. 3. Remove from soapy water and place it in [NAME] area until completely dry. 4. Store the spare filter until next cleaning is needed. Review of the National Library of Medicine (NLM), dated 1/19/22, indicated but was not limited to: -One of the main issues affecting the oxygen concentrators, is that related to the filters, which are designed to filter out dust, particles, bacteria. https://pmc.ncbi.nlm.nih.gov/articles/PMC8768026/ (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #22 was admitted to the facility in April 2022 with diagnoses including chronic obstructive pulmonary disease (lung diseases that make it hard to breathe) and respiratory failure with hypoxia (a condition that occurs when the body doesn't have enough oxygen). Review of the Minimum Data Set (MDS) assessment, dated 10/6/24, indicated Resident #22 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15 and utilizes oxygen therapy. Review of Resident #22 Physician's Orders indicated but were not limited to: - Oxygen at 3 Liters (L)/Min (min) via nasal cannula continuous to maintain SpO2 (blood oxygen saturation) of 88-92%, 10/23/24 - Oxygen Saturation every shift, dated 10/23/24 - Change oxygen tubing every Sunday, dated 10/23/24 The surveyor observed Resident #22's oxygen concentrator running without a filter as follows: -11/3/24 at 8:47 A.M. -11/3/24 at 3:21 P.M. -11/4/24 at 7:07 A.M. -11/4/24 at 2:54 P.M. -11/5/24 at 9:33 A.M. -11/6/24 at 7:38 A.M. During an interview on 11/6/24 at 7:38 A.M., Nurse #14 said residents who utilized oxygen therapy had their tubing and filters changed weekly for their oxygen concentrator on the 11:00 P.M. to 7:00 A.M. shift. Nurse #14 and the surveyor inspected Resident #22's oxygen concentrator. Nurse #14 said Resident #22 did not have a filter on the back of his/her oxygen concentrator but should have one. During an interview on 11/6/24 at 7:48 A.M., the Director of Nursing (DON) and the surveyor inspected Resident #22's oxygen concentrator. The DON said he was not familiar with Resident #22's concentrator as it is not one that the facility usually uses. During an interview on 11/6/24 at 3:38 P.M., the DON said Resident #22 did not have a filter in the back of his/her oxygen concentrator but should have had one.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 48362 Based on interview and record review, the facility failed to develop a person-centered plan of care which included trauma informed approaches and identified triggers to avoid potential re-traumatization for two Residents (#39, #22) with a history of trauma, out of a total sample of 18 residents. Findings include: Review of the facility's policy titled Trauma Informed Care, dated last revised 10/2019, included but was not limited to: - Policy: to guide staff in appropriate and compassionate care specific to individuals who have experienced trauma. - Staff are provided in-service training about trauma, its impact on health, and post-traumatic stress disorder in the context of the healthcare setting. - Nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization. - Trauma informed care is culturally sensitive and person-centered. - As part of the comprehensive assessment, identify history of trauma or interpersonal violence when such information is provided to the facility. Identifying past trauma or adverse experiences may involve record review or use of screening tools. - Reduce or eliminate unnecessary stimuli (noise, lighting, unwanted or sudden physical contact, etc.) as able. 1. Resident #39 was admitted to the facility in July 2023 with diagnoses including depression, psychosis, delusional disorders, dementia and anxiety. Review of Resident #39's Minimum Data Set (MDS) assessment, dated 9/27/24, indicated he/she had a moderate cognitive impairment as evidenced by a score of 12 out of 15 on the Brief Interview for Mental Status (BIMS). Further review of the MDS assessment indicated Resident #39 had verbal and other behavioral symptoms. Review of the Social Service Admission Assessment, dated 7/11/23, indicated but was not limited to the following: - Resident #39 had an experience so upsetting it changed him/her emotionally, spiritually, physically, or behaviorally. - Resident #39 indicated some of these problems bother him/her now. - Resident #39 indicated he/she would be interested in discussing these problems. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No identification of triggers related to trauma. Review of the Social Service Quarterly Assessment, dated 4/9/24, indicated but was not limited to the following: - Resident #39 reported on admission several trauma related instances throughout his/her life. - On-going psych services have been in place to manage feelings and behaviors. - Trauma continues to be reflected on and continues to receive on-going trauma support counseling. - No identification of triggers related to trauma. Further review of Resident #39's medical record failed to indicate any further Social Service Assessments were completed. Review of the facility's Consultant Behavioral Health Services Notes dated 9/16/24, 10/4/24, 10/10/24, 10/17/24, 10/18/24, 10/24/24, 10/25/24, 10/31/24 and 11/1/24 indicated Resident #39 was receiving services, but failed to indicate specific triggers related to his/her history of trauma. Review of the medical record failed to indicate facility staff collaborated with the Resident representative, or any other health care professional that provided care to the Resident to gather information related to the Resident's trauma to develop a person-centered plan of care that identified potential triggers or trauma with interventions to prevent re-traumatization. Review of Resident #39's trauma informed care plan failed to indicate an individualized, person-centered approach to indicate his/her history of trauma and/or specific resident related interventions. During an interview on 11/5/24 at 11:45 A.M., the Social Worker (SW) said all residents are screened and assessed for history of trauma upon admission to the facility. She said residents are then assessed quarterly. The SW said triggers should be indicated on the assessment and/or care plan if a resident identifies them during an admission, annual, or quarterly assessment. The SW said if a resident does not identify triggers related to their trauma or does not wish to discuss their trauma further, it would also be identified on the assessment and care plan. The SW reviewed Resident #39's medical record including the assessment and care plan and said, no triggers were identified for Resident #39. The SW said no quarterly assessment had been completed since 4/9/24 and there should have been assessments completed on 7/2024 and 10/2024. The SW said Resident #39's trauma informed care plan was not particularly individualized to the Resident. During an interview on 11/6/24 at 1:07 P.M., Nurse #7 said Resident #39 is followed by behavioral health services at the facility since admission. Nurse #7 said she was not aware of Resident #39 having a history of trauma or any triggers related to trauma. During an interview on 11/6/24 at 1:45 P.M., Certified Nursing Assistant (CNA) #7 said she cares for Resident #39 often; he/she requires a lot of encouragement to perform activities of daily living, such as bathing and dressing. CNA #7 said she was unaware of Resident #39 having a history of trauma. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225145	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/6/24 at 2:56 P.M., the Regional Clinical Nurse said care plans for residents with a history of trauma should be individualized to their specific situation and needs. The Regional Clinical Nurse said triggers or the inability to identify triggers should be present on the care plan and updated as needed. The Regional Clinical Nurse said care plans should be updated at least quarterly to identify if any information has changed as related to trauma. 48695 2. Resident #22 was admitted to the facility in April 2022 with bipolar disorder, anxiety, and depression. Review of Resident #22's MDS assessment, dated 10/6/24, indicated Resident #22 was cognitively intact as evidenced by a BIMS score of 13 out of 15 and had verbal behavioral symptoms. Review of the Social Service Re-Admission Assessment, dated 4/15/24, indicated but was not limited to the following: - Resident #22 had an experience so upsetting it changed him/her emotionally, spiritually, physically, or behaviorally. - Resident #22 indicated some of these problems bother him/her now. - Resident #22 indicated he/she would be interested in discussing these problems. - No identification of triggers related to trauma. - Plan: A referral for psych services has been completed. Review of the Social Service Re-Admission Assessment, dated 8/28/24, indicated but was not limited to the following: - Resident #22 had an experience so upsetting it changed him/her emotionally, spiritually, physically, or behaviorally. - Resident #22 indicated some of these problems bother him/her now. - Resident #22 indicated he/she would be interested in discussing these problems. - No identification of triggers related to trauma. Review of the facility's Consultant Behavioral Health Services Notes, dated 9/5/24, 9/13/24, 9/26/24, 10/3/24, 10/17/24, 10/24/24, 10/25/24, and 10/31/24, indicated Resident #22 was receiving therapy and psychiatric services, but failed to indicate specific triggers related to his/her history of trauma. During an interview on 11/6/24 at 2:08 P.M., Nurse #10 said he was not aware of Resident #22 having a history of trauma or any triggers related to trauma. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/6/26 at 2:10 P.M., Nurse #6 said she knew Resident #22 had a history of trauma. Nurse #6 Resident #22 had two people for care, one on one counseling as well as being seen by the Psychiatric Nurse Practitioner. Nurse #6 said she was not aware of Resident #22's triggers to prevent a potential re-traumatization to the Resident. During an interview on 11/6/24 at 2:43 P.M., the SW said triggers should be identified on the assessment and/or care plan if a resident identifies them during an admission, annual, significant change, or quarterly assessment. She said if a resident does not identify triggers related to their trauma or does not wish to discuss their trauma further, it would also be identified on the assessment and care plan. The SW reviewed Resident #22's medical record including the assessment and care plan and said there were no triggers identified for Resident #22. The SW said Resident #22's care plan was not individualized for his/her needs. During an interview on 11/6/24 at 3:38 P.M., Regional Clinical Nurse #2 and the surveyor reviewed Resident #22's Social Service Assessments and care plan. She said Resident #22 had a generic care plan that was not specific to his/her trauma and his/her needs. Regional Clinical Nurse #2 said Resident #22's assessments and care plans should have been individualized to his/her care needs.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 48695 Based on records reviewed and interviews, for one Resident (#55), out of 18 sampled residents, the facility failed to ensure the Resident was seen by the physician at least every 30 days for the first 90 days after admission and at least every 60 days thereafter, with alternate visits by a nurse practitioner as indicated. Findings include: Review of the facility's policy titled Physician Services, last revised February 2020, indicated but was not limited to: - Policy: The medical care of each resident is under the supervision of a Licensed Physician. Policy Interpretation and Implementation: - The physician will perform pertinent, timely medical assessments; prescribe an appropriate medical regimen; provide adequate, timely information about the resident's condition and medical needs; visit the resident at appropriate intervals; and ensure adequate alternative coverage. - Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current regulations and facility policy. Resident #55 was admitted to the facility in January 2024 with diagnoses including cerebral infarct (stroke), diabetes mellitus, and hypertension. Review of Resident #55's medical record indicated he/she was seen by the Physician on 2/21/24, as evidenced by a Physician's Progress Note. Further review of Resident #55's medical record indicated there was a 210-day span from the last physician visit to the next one as evidenced by a Physician's Progress Note dated 9/18/24. During an interview on 11/6/24 at 12:35 P.M., Physician #1 said he and the Nurse Practitioner (NP) would alternate visits every 60 days for long term residents. Physician #1 said his office would keep track of visits and notify him when he would need to visit a Resident. Physician #1 and the surveyor reviewed Resident #55's medical record; Physician #1 then reviewed his resident visit history in his records. Physician #1 said he had seen Resident #55 on 8/7/24 (168 days later). Physician #1 said he was late with his visit and should have seen Resident #55 prior to or around 6/21/24. During an interview on 11/6/24 at 3:38 P.M., the Director of Nursing (DON) said the physician should have seen residents every 30 days for the first 90 days after admission then the resident should be seen at least every 60 days thereafter alternating visits with the NP. The DON said the expectation was for residents to be seen in a timely manner.

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	225145	A. Building B. Wing	11/06/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 42742 Based on observation, record review, and interview, the facility failed to ensure sufficient staffing to assure residents attain or maintain the highest practicable physical, mental, and psychosocial well-being. Specifically, the facility failed to have sufficient staffing on the weekends as indicated on the payroll-based journal (PBJ) report submitted to Centers for Medicare and Medicaid Services (CMS) for Fiscal Year Quarter 3, 2024. Findings include: Review of the PBJ Staffing Data Report, CASPER Report 1705D FY Quarter 3, 2024 (April 1 - June 30) indicated the following: This Staffing Data Report identifies areas of concern that will be triggered (e.g., requires follow-up during the survey). -One Star Staffing Rating Triggered= Star Staffing Rating Equals 1 Excessively Low Weekend -Staffing Triggered = Submitted Weekend Staffing data is excessively low Review of the facility's healthcare Facility Assessment (FA), revised August 2024, indicated the following: Part 1: Resident Profile 1.1 Number of residents you are licensed to provide care for - 121 -Number of licensed beds on Unit A: 41 -Number of licensed beds on Unit B: 41 -Number of licensed beds on Unit C: 39 -Average daily census: 83 Staffing Plan 3.2 Total Number Needed or Average or Range of Staff: - Licensed nurses providing direct care: 13-16 Nurses daily based on shift and acuity - Nurse Aides: 18-21 daily based on shift and acuity (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The FA did not include a minimum standard of staffing for hours per patient day (HPPD- staffing hours per resident per day which is the total number of hours worked by each type of staff divided by the total number of residents) of direct nursing care provided to ensure the residents' health and safety. Review of the as worked weekend staffing schedules provided by the Scheduling Coordinator for licensed nurses and nurse aides during FY Quarter 3, 2024, indicated the total number of nurse aides was below the needed or average range, per the FA, for the following dates: 4/6/24 -Total census, 77, (A Unit-7, B Unit-37, C Unit-35) -15 total aides (three less than the minimum required) 4/12/24 -Total census, 82, (A Unit-10, B Unit- 36, C Unit-37) -17 total aides (one less than the minimum required) 4/19/24 -Total census, 82, (A Unit-11, B Unit-36, C Unit-36) -15 total aides (three less than the minimum required) 4/20/24 -Total census, 82, (A Unit-11, B Unit-36, C Unit-36) -14 total aides (four less than the minimum required) 4/21/24 -Total census, 83, (A Unit-12, B Unit-36, C Unit-35) -16 total aides (two less than the minimum required) 4/26/24 -Total census, 84, (A Unit-14, B Unit-35, C Unit-35) -17 total aides (one less than the minimum required) 4/27/24 -Total Census, 82, (A Unit-14, B Unit-35, C Unit-35) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-17 total aides (one less than the minimum required) 4/28/24 -Total census, 83, (A Unit-14, B Unit-35, C Unit-35) -15 total aides (three less than the minimum required) 6/16/24 -Total census, 79, (A Unit-15, B Unit-31, C Unit-35) -17 total aides (one less than the minimum required) During the Resident Group conducted on 11/04/24 at 1:03 P.M., nine out of nine residents said call lights are typically not answered timely and it can take, on average, 45 minutes. They said there doesn't seem to be any day or shift that's worse than others and there's no rhyme or reason, but the facility just doesn't consistently have enough staff to answer the lights. During an interview on 11/5/24 at 10:25 A.M., Nurse #12 and Nurse #13 said there are normally three aides on the B and C Wings for day shift, but there are call outs sometimes so then they only have two. They said there is a lot of agency staff that don't show up or call out, with the day shift on the weekends being the worst. They said it happens frequently. During an interview on 11/6/24 at 6:28 A.M., Nurse #14 on the B Wing said she mostly works nights and occasionally there are sick calls, and they have to give up one aide, but it was getting better. She said sometimes on the weekends when there's call outs, they have only one aide overnight, but it was rare. During an interview on 11/6/24 at 6:32 A.M., Nurse #15 on the C Wing said she was agency staff and there were three aides scheduled overnight, but there was a call out, so they lost one to another unit. During an interview on 11/6/24 at 8:15 A.M., the Scheduling Coordinator said she thought the low weekend staffing was triggered due to call outs. She said it was their biggest thing and she could overstaff, but they're still going to do it. She said she used six different agencies for staffing needs, approximately 300-400 hours/week all shifts for nursing and approximately 200 hours/week for aides, but it was down to 50-100 hours/week. She said the facility will be having a job fair and hadn't had one before. The Scheduling Coordinator said they get a lot of call outs the last minute mostly from aides that are facility staff, typically for the 11p-7a shift. She said normal staffing should be as follows, depending on the census: A Wing: -2-3 aides for 7a-3p shift -2 aides for 3p-11p shift, sometimes 2.5 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1-2 aides for 11p-7a shift B and C Wings: -3-4 aides for 7a-3p shift -typically, 3 aides for 3p-11p shift -2 aides for 11p-7a shift The Scheduling Coordinator said, in general, she goes by the census and there should be one aide for every 14 residents (1:14). She said if there's a full census on every unit then there should be 4 aides for each unit during the 7a-3p and 3p-11p shifts and 2 aides during the overnight shift (11p-7a). During an interview on 11/6/24 at 10:05 A.M., the Scheduling Coordinator said staffing requirements, per the FA, to meet the needs of the residents included 18-21 aides daily based on the daily census but did not include a minimum standard for HPPD. She said there wasn't a staffing policy or documentation of staffing needs she could provide to the surveyor other than the facility assessment. During an interview on 11/6/24 at 10:39 A.M., the surveyor reviewed the above staffing schedules (4/6/24, 4/12/24, 4/19/24, 4/20/24, 4/21/24, 4/26/24, 4/27/24, 4/28/24, and 6/16/24) and daily census reports with the Scheduling Coordinator who said the dates reviewed, including on 5/3/24 and 6/29/24, did not meet the standard for nurse aide staffing per the FA and actual schedules worked per census requirement. She said the staffing was insufficient and there should have been a ratio of 1:14, but the facility did not meet this requirement for the dates reviewed. She said the schedules provided to the surveyor by her were all updated and were as worked, and there were no other variations of the schedules. During an interview on 11/6/24 at 11:49 A.M. with the Director of Nursing (DON) and Consulting Staff #2, the DON said A Wing nurse aide staffing should be at a ratio of 1:10 for the day and evening shifts and typical staffing for night shift was 2 aides in general. He said they flex as needed based on admissions, discharges, and acuity level. The DON said the FA should reflect current staffing needs, not hours worked. Consulting Staff #2 said the A Wing required a 1:10 ratio because there was a higher level of acuity and the B and C Wings had a 1:12 ratio, not 1:14, per the Scheduling Coordinator, but the C Wing had more independent residents, so they didn't require as much care. The DON said the goal is to meet the staffing requirement and be as safe as possible.

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	225145	A. Building B. Wing	11/06/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 43935 Based on document review and interview, the facility failed to ensure the monthly medication regimen review (MRR) for two Residents (#10 and #40), out of a total sample of 18 residents, were included in the medical record or readily available for review to indicate the Physician's response to the recommendations made by the Pharmacist and that recommendations for Resident #40 were acted upon in a timely manner. Findings include: 1. Resident #10 was admitted to the facility in August 2024 with diagnoses including sepsis (a severe whole-body infection), diabetes mellitus, and depression. Review of the medical record for Resident #10 indicated the Pharmacist had completed a MRR and indicated but was not limited to the following: 8/11/24: see report for recommendations 9/5/24: see report for recommendations 10/6/24: see report for recommendations 11/5/24: no irregularities or recommendations at this time During an interview on 11/6/24 at 9:29 A.M., Nurse #4 reviewed the medical record and said she could not locate any of the MRR pharmacy recommendation forms or reports indicating what the pharmacy recommendations were for those time frames and she would have to check with the Director of Nurses (DON) and get back to the surveyor. During a follow up interview on 11/6/24 at 9:31 A.M., Nurse #4 said the MRR reports and follow up forms are kept in the DON office in a binder and not in the medical record or readily available for the staff or residents to review if necessary. During an interview on 11/6/24 at 10:54 A.M., the DON said the process for MRR is that they are completed by the Pharmacy consultant monthly and then sent to him by email. From there he completes the nursing recommendations and reviews the physician's recommendations with the physicians and has them complete the document and then files it as complete in a binder in his office. They are not available to the unit unless they request them from him. He said the pharmacy MRR and follow up are not part of the medical record or accessible to the staff or residents if necessary and he was not aware that they should be. 48362 2. Review of the facility's policy titled Medication Regimen Review, dated 8/2020, indicated but was not limited to the following: (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The consultant pharmacist reviews the medication regimen of each resident at least monthly. - Resident-specific irregularities and/or clinically significant risks resulting from or associated with medication are documented in the resident's active record and reported to the Director of Nursing, Medical Director, and/or prescriber as appropriate. - Recommendations are acted upon and documented by the facility staff and/or the prescriber. Resident #40 was admitted to the facility in December 2019 with diagnoses including dementia, depression and insomnia. Review of Resident #40's medical record showed an MRR completed by the Pharmacist indicated the following: - July 2024: see report for any noted irregularities and/or recommendations. - August 2024: see report for any noted irregularities and/or recommendations. - September 2024: see report for any noted irregularities and/or recommendations. Further review of Resident #40's complete medical record failed to include the MRR Pharmacy forms for July, August or September. Review of July Medication Regimen Review (MRR) provided by the Director of Nursing (DON) to the surveyor indicated the following: - Resident #40 had an order for 0.5 milligrams (mg) by mouth every four hours as needed (PRN) for anxiety/agitation. - Please review this PRN order and consider discharge if appropriate or document continued need for therapy and specify stop date. - Further review indicated the Physician agreed with the recommendation on 7/17/24. Review of the August MRR provided by the DON to the surveyor indicated the following: - Resident #40 had an order for 0.5 mg by mouth every four hours PRN for anxiety/agitation. - Per 7/24/24 Physician progress note indicates recommendation was reviewed and note states to continue for 14-days then re-evaluate. - Please review MD note and add stop/re-evaluation date. Review of the September MRR provided by the DON to the surveyor indicated the following: - Resident #40 had an order for 0.5 mg by mouth every four hours PRN for anxiety/agitation. - Medication has not been used since it was ordered 6/15/24, please consider discontinuing. (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- If the medication is to continue, please document continued need and specify the stop date. - The Physician responded on 9/11/24 indicating to discontinue the Lorazepam medication. Review of Resident #40's Physician Orders indicated the following: - 6/15/24 to 9/11/24: Give 0.5 milligrams (MG) Lorazepam Oral Tablet by mouth every four hours as needed for anxiety/agitation. Review of Resident #40's medical record failed to indicate a 14-day stop date and re-evaluation was added to the PRN Lorazepam order prior to it being discontinued on 9/11/24. During an interview on 11/5/24 at 3:30 P.M., the DON said pharmacy recommendations are sent to him via email after being completed by the pharmacist. The DON said he then reviews each recommendation with the physician to determine if they agree or disagree with the recommendations. The DON said if the physician agrees with the recommendations, those changes are made and reflected in the resident's medical record. The DON said the recommendations are then kept in a binder in his office. He said the MRR recommendations are not placed in the resident's medical record. During an interview on 11/6/24 at 10:54 A.M., the DON said he completes the nursing recommendations and reviews the physician recommendations with the physicians and has them complete the MRR document. The DON said he then files the completed form in a binder in his office. The DON said they are not available to the unit unless they request them from him. During an interview on 11/6/24 at 12:23 P.M., the Physician and the surveyor reviewed the MRR recommendations completed by the pharmacist. The Physician said he agreed with the Pharmacy recommendation on 7/17/24. The Physician said he agreed because all PRN psychotropic medications need to be re-evaluated every 14 days. The Physician said the order should have been updated to reflect the need for the medication to be re-evaluated after 14 days after he addressed the recommendation on 7/17/24. During an interview on 11/6/24 at 2:30 P.M., the Regional Clinical Nurse said PRN psychotropic medications should be re-evaluated every 14 days for continued use. The Regional Clinical Nurse said the pharmacy recommendations should be implemented timely.

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	225145	A. Building B. Wing	11/06/2024

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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. 42742 Based on observation and interview, the facility failed to ensure all medications used in the facility were stored in accordance with currently accepted professional principles. Specifically, the facility failed to: 1. Provide a permanently affixed compartment and separate from all other medications for the storage of one schedule IV (low potential for misuse and dependence) and one schedule III (moderate to low potential for physical and psychological dependence) controlled substance in one of three medication room refrigerators reviewed; and 2. Ensure medications were not left unsecured when not in direct supervision of the licensed nurse. Findings include: 1. Review of the facility's policy titled Storage of Controlled Substances, revised August 2020, indicated but was not limited to the following: -Schedule II through V medications subject to abuse or diversion are stored in either a permanently affixed, double locked compartment separate from all other medications or in accordance with state regulations. On 11/5/24 at 9:37 A.M., the surveyor reviewed the B Unit medication storage room with Nurse #13 and observed the following: -One clear controlled substance storage box on a shelf inside the medication refrigerator, refrigerator was locked, box was locked but not permanently affixed to the shelf, the surveyor was able to remove the shelf from the refrigerator with the box attached, one bottle of liquid Ativan (treats anxiety) 2 milligrams (mg)/milliliter (ml) was stored inside and labeled with a resident's name -Two cards (22 capsules remaining on one, 30 capsules total on the other) of Dronabinol (treats nausea and vomiting caused by cancer treatment) 5 mg capsules resting on top of a shelf, not stored in a permanently affixed locked box, not stored separately from other medications stored in the refrigerator, labeled with a resident's name During an interview on 11/5/24 at 9:37 A.M., Nurse #13 said controlled substances that require refrigeration should be stored in a locked box at all times. She said the Dronabinol didn't fit in the storage box that was in there but should have been in one. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225145	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhill Healthcare	76 North Street Middleboro, MA 02346

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/5/24 at 11:25 A.M. with the Director of Nurses (DON) and Consulting Staff #2, the DON said refrigerated controlled substances should be double locked and in a locked storage box. The DON and Consulting Staff #2 said the storage box should have been permanently affixed and the surveyor should not have been able to remove the entire shelf with the box attached. The DON said the Dronabinol should have been stored in a locked box and affixed but they didn't have one that it would fit it. He said maintenance would put one in that would fit to ensure the medication could be stored properly. 48695 2. Review of the facility's policy titled Storage of Medications, dated September 2018, indicated but was not limited to: - Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access. During the medication pass on 11/4/24 at 8:15 A.M., the surveyor observed Nurse #10 walk away from the medication cart to the medication room. Nurse #10 left three medication blister packs on top of the medication cart unattended containing the following medications: - Amlodipine (medication used to treat high blood pressure) 2.5 mg - Atorvastatin (medication used to treat high cholesterol) 80 mg tabs - Plavix (antiplatelet medication used to prevent blood clots) 75 mg tabs On 11/4/24 at 8:28 A.M., the surveyor observed a nurse sitting at the nursing station desk without a direct view of the medication cart and Nurse #10 did not communicate to the nurse that he had left medications on top of the cart. During an interview on 11/4/24 at 8:28 A.M., Nurse #10 said he should not have left the medication cards on top of the medication cart unattended without communicating with the other nurse to watch them. Nurse #10 said he should have put the medication blister packs into the medication cart and locked the medication cart. During an interview on 11/6/24 at 3:38 P.M., the DON said medications should be locked and secured in the medication cart when not in direct supervision of the nurse.

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	225145	A. Building B. Wing	11/06/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48362 Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Handle ready to eat food (food which does not require cooking or further preparation prior to consumption) utilizing proper hand hygiene to prevent cross contamination (transfer of pathogens from one surface to another); and 2. Properly label and date food products, and maintain safe and clean equipment in two of three nourishment kitchenettes. Findings include: Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA), revised ,d+[DATE], indicated but was not limited to the following: - ,d+[DATE].11 Preventing Contamination from Hands. (A) FOOD EMPLOYEES shall wash their hands as specified under S ,d+[DATE].12. (B) Except when washing fruits and vegetables as specified under S, d+[DATE].15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT. - ,d+[DATE].15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. 1. On [DATE] at 11:04 A.M., the surveyor made the following observations during the lunch meal service: - Two dietary aides and one cook were preparing and working the lunch service line. - At 11:16 A.M., [NAME] #1 grabbed a dish rag from a bucket of water underneath the service line and tossed it into the sink next to the stove top. [NAME] #1 then returned to the pan on the stove top to cook grilled cheese sandwiches. [NAME] #1 was never observed to perform hand hygiene. - At 11:24 A.M., [NAME] #1 double gloved (put on gloves over her existing gloves) while working the service line. [NAME] #1 touched the broccoli she plated with her gloved hand. [NAME] #1 then continued to work the service line without switching her gloves or performing hand hygiene. - At 11:29 A.M., [NAME] #1 touched carrots she plated. [NAME] #1 then returned to the service line without changing gloves or performing hand hygiene. (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 11:35 A.M., [NAME] #1 reviewed a paper on a cart next to the service line that listed resident specific preferences for the lunch meal service. [NAME] #1 touched her gloved hand to the side of the paper and cart. [NAME] #1 returned to the service line and began plating food items. [NAME] #1 was not observed to change her gloves or perform hand hygiene. - At 11:40 A.M., [NAME] #1 plated spinach and then used her gloved hand to move the spinach on the plate in order to make room for other food items. [NAME] #1 then moved to plating the next food items. [NAME] #1 was not observed to change her gloves or perform hand hygiene. - At 11:44 A.M., [NAME] #1 touched the side of her face with her gloved hand and continued to serve food items on the service line. [NAME] #1 was not observed to change her gloves or perform hand hygiene. - At 11:48 A.M., [NAME] #1 removed plates from the plate warmer and put them on the service line. [NAME] #1 was then observed to lean over the plates, allowing her top to brush over the top and sides of the plates. - At 11:57 A.M., [NAME] #1 plated chicken and then touched the chicken with her gloved hand to make room for fortified mashed potatoes. [NAME] #1 then continued to serve food items on the service line. [NAME] #1 was not observed to change her gloves or perform hand hygiene. - At 12:05 P.M., [NAME] #1 used her gloved hand to grab a grilled cheese sandwich out of a pan on the stove top. [NAME] #1 brought the grilled cheese from the pan to the service line. [NAME] #1 cut the grilled cheese on the counter of the service line using her gloved hands and plated the food. [NAME] #1 was not observed to change her gloves or perform hand hygiene. During an interview on [DATE] at 8:11 A.M., [NAME] #1 said she wears gloves during each meal service. [NAME] #1 said she would change her gloves when leaving the service line and before returning. [NAME] #1 said she would not change her gloves if she touches food items during meal service. During an interview on [DATE] at 8:35 A.M., the Food Service Director (FSD) said gloves should be changed when leaving the service line and before returning to the food service line during mealtimes. The FSD said cooks should not be touching food items that are plated. The FSD said [NAME] #1 should have changed her gloves if she touched food items before continuing to serve lunch meal items. 2. Review of the facility's policy titled Food Brought into Facility, last revised ,d+[DATE], indicated but was not limited to: - It is the policy of the Company that visitors or family members are permitted to bring food to a resident and are encouraged to limit foods to those that meet patient's meal plan and safe food handling practices. - Perishable food must be stored and identified with resident's name, food item and use by date. - These can be stored in the nursing unit kitchen nourishment refrigerator. - The nursing staff is responsible for discarding perishable foods on or before the use by date. (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:11 A.M., the surveyor made the following observations of the B Wing Unit nourishment kitchenette: - In the freezer there was one hot pocket labeled [NAME] - emergency with no further resident identification or use by date. - Four Healthy Shot Peach Protein and Amino Acid Solution drinks were located on the door of the refrigerator. One drink product had a date of ,d+[DATE] and a second with the date of ,d+[DATE]. None of the drink product bottles were identified with a resident name or other form of identification. - A six-pack of Adirondack Lemon Water was on the shelf of the refrigerator with no resident identification. - One 12-ounce Diet Coke Bottle was located on the door of the refrigerator. The bottle of soda had no resident identification. On [DATE] at 8:34 A.M., the surveyor made the following observations on the A Wing Unit nourishment kitchenette: - A white Styrofoam cup with ice and a red liquid substance was located in the freezer. There was no resident identification or use by date on the cup. - A white paper bag with a takeout food container was labeled only with a use by date of ,d+[DATE]. - A white paper bag with a wrap sandwich with no resident identification and a use by date of ,d+[DATE]. - An open container of individual plain cream cheese with no date or resident identification. - A 16-ounce Diet Coke soda bottle with no resident identification or use by date. - A 7.5-ounce Diet Coke can with no resident identification or use by date. On [DATE] at 3:30 P.M., the surveyor made the following observations on the A Wing Unit nourishment kitchenette: - A white Styrofoam cup with ice and a red liquid substance was located in the freezer. There was no resident identification or use by date on the cup. - A white paper bag with a takeout food container was labeled only with a use by date of ,d+[DATE]. - A 16-ounce Diet Coke soda bottle with no resident identification or use by date. - A 7.5-ounce Diet Coke can with no resident identification or use by date. (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 7:22 A.M., the surveyor made the following observations of the B Wing Unit nourishment kitchenette: - In the freezer there was one hot pocket labeled [NAME] - emergency with no further resident identification or use by date. - Three Healthy Shot Peach Protein and Amino Acid Solution drinks were located on the door of the refrigerator. One drink product had a date of ,d+[DATE]. None of the drink product bottles were identified with a resident name or other form of identification. - A six-pack of Adirondack Lemon Water was on the shelf of the refrigerator with no resident identification. - One 12-ounce Diet Coke Bottle was located on the door of the refrigerator. The bottle of soda had no resident identification. On [DATE] at 7:13 A.M., the surveyor made the following observations on the A Wing Unit nourishment kitchenette: - A 16-ounce Diet Coke soda bottle with no resident identification or use by date. - A 7.5-ounce Diet Coke can with no resident identification or use by date. During an interview on [DATE] at 1:30 P.M., the FSD said kitchenettes are stocked twice daily by dietary aides. The FSD said dietary aides are educated to remove any expired food products when stocking the refrigerators. The FSD said nursing staff are also responsible for checking food products in the nourishment kitchenette refrigerators. During an interview on [DATE] at 7:35 A.M., Nurse #7 said items are stocked by dietary staff members daily, at least twice a day. Nurse #7 said typically food items brought in for residents are kept for three days. Nurse #7 said staff will label food items with the resident's name and a use by date. Nurse #7 said if nursing notices that something is expired they will dispose of it. During an interview on [DATE] at 8:35 A.M., the FSD said kitchenettes should be checked daily for expired food products. The FSD said items should be labeled with the resident's name and use by date. The FSD and the surveyor reviewed the observations made out the A Wing and B Wing Unit nourishment kitchenettes. The FSD said food products that are not labeled or expired should not be in the nourishment kitchenettes.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on observation, document review, and interview, the facility failed to maintain accurate medical records in accordance with professional standards and practices for five Residents (#9, #15, #17, #55, and #10), out of 18 sampled residents. Specifically, the facility failed: 1. For Resident #9, to obtain a matching Physician's order for advanced directives in the Resident's Electronic Medical Record (EMR) which accurately reflected his/her wishes as indicated on the Resident's Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) form; 2. For Resident #15, to obtain a matching Physician's order for advanced directives in the EMR which accurately reflected his/her wishes as indicated on the Resident's MOLST form; 3. For Resident #17, to ensure his/her medical records contained an active and current [NAME] Treatment Plan (court approved treatment plan for the administration of antipsychotic medications); 4. For Resident #55, to ensure that documentation of physician visits was part of the medical record in a timely manner; and 5. For Resident #10, to ensure his/her medical record contained the Level 2 Pre-admission Screening and Resident Review (PASARR) that had been completed on [DATE]. Findings Include: 1. Resident #9 was admitted to the facility in [DATE] with diagnoses including dementia and weakness. Review of Resident #9's MOLST, dated [DATE], in the paper medical record indicated but was not limited to: -Do Not Resuscitate -Do Not Intubate and Ventilate -Transfer to Hospital Review of Resident #9's current Physician's Orders in the EMR indicated but was not limited to: -Do Not Resuscitate, DNI (Do not intubate), Do Not Transfer to Hospital (unless needed for comfort), dated [DATE] During an interview on [DATE] at 1:28 P.M., Nurse #11 said when the Physician or their designee signed a new MOLST form the nurse would put the order for advanced directives into the Resident's EMR. Nurse #11 said in case of an emergency the nurses would follow the MOLST. Nurse #11 said a resident's MOLST and his/her Physician orders should match. (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:41 P.M., the Director of Nursing (DON) reviewed Resident #9's MOLST and physician's orders. The DON said the expectation was for the MOLST and physician's orders to match, but Resident #9's did not match as they should have. 2. Resident #15 was admitted to the facility in [DATE] with diagnoses including dementia. Review of Resident #15's MOLST, dated [DATE], in the paper medical record indicated but was not limited to: -Do Not Resuscitate -Do Not Intubate and Ventilate -Do Not Transfer to Hospital (unless needed for comfort) Review of Resident #15's current Physician's Orders in the EMR indicated but was not limited to: -Do Not Resuscitate, DNI (Do not intubate), Transfer to Hospital, dated [DATE] During an interview on [DATE] at 1:28 P.M., Nurse #11 said when the Physician or their designee signed a new MOLST form the nurse would put the order for advanced directives into the Resident's EMR. Nurse #11 said in case of emergency the nurses would follow the MOLST. Nurse #11 said a resident's MOLST and his/her Physician orders should match. During an interview on [DATE] at 1:41 P.M., the DON reviewed Resident #15's MOLST and physician's orders. The DON said the expectation was for the MOLST and physician's orders to match, but Resident #15's did not match as they should have. 3. Resident #17 was admitted to the facility in [DATE] with diagnoses including traumatic brain injury and cognitive impairment. Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #17 had a Guardian and received antipsychotic medications on a routine basis. Review of Resident #17's medical record indicated the court issued an expansion of the Guardianship on [DATE] and authorized administration of antipsychotic medication via a [NAME] Treatment Plan which expired on [DATE] at 4:00 P.M. Further review of Resident #17's medical record failed to indicate a current [NAME] Treatment Plan was obtained. During an interview with record review on [DATE] at 2:30 P.M., the Social Worker (SW) reviewed Resident #17's medical record and said she did not see a current copy of Resident #17's [NAME] Treatment Plan. During an interview on [DATE] at 3:30 P.M., the SW provided the surveyor with a current [NAME] Treatment Plan for Resident #17 dated [DATE] that the facility's lawyer had faxed over. (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:38 P.M., the DON said Resident #17's medical record should have contained a current [NAME] Treatment Plan. The DON said the expectation is for all residents to have a complete and accurate medical record. 4. Review of the facility's policy titled Physician Services, last revised February 2020, indicated but was not limited to: Policy Interpretation and Implementation: - Physician orders and progress notes shall be maintained in accordance with current regulations and facility policy. Resident #55 was admitted to the facility in [DATE] with diagnoses including cerebral infarct (stroke), diabetes mellitus, and hypertension. Review of Resident #55's medical record indicated he/she was seen by the Physician on [DATE], as evidenced by a Physician's Progress Note. Further review of Resident #55's medical record indicated there was a 210-day span from the last physician visit to the next one as evidenced by a Physician's Progress Note dated [DATE]. During an interview on [DATE] at 12:35 P.M., Physician #1 reviewed Resident #55's medical record and then reviewed his resident visit history in his records. Physician #1 said he had seen Resident #55 on [DATE]. Physician #1 said his note from [DATE] should have been in Resident #55's medical record. During an Interview on [DATE] at 3:38 P.M., the DON said the physician should have had all his notes in Resident #55's medical record. The DON said the expectation is for all residents to have a complete and accurate medical record. 43935 5. Resident #10 was admitted to the facility in [DATE] with diagnoses including anxiety, depression, and insomnia. Review of the Pre-admission Screening and Resident Review (PASARR) for mental illness, mental retardation, or developmental disability indicated but was not limited to the following: - Level one PASARR was completed prior to admission by the discharging facility in [DATE] and indicated Resident #10 had a positive screen for serious mental illness (SMI) - PASARR Level 2 was not indicated due to exempt hospital discharge (allowing the Resident to remain in the skilled nursing facility for up to a maximum of 30 days without further evaluation) - Review of the PASARR Level 1 under the 30 day exemption indicated: If the nursing facility determines that the resident's stay will exceed the 30-day exemption period, the nursing facility must complete Section G (requesting a level 2 PASARR) in this form and submit the Level 1 form to Department of mental health (DMH)/designee by no later than the 25th calendar day after admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225145	A. Building B. Wing	11/06/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:01 P.M., Regional Nurse #2 said the facility does not have a policy for medical records but the expectation is they are complete and accurate. Review of the medical record on [DATE] failed to indicate a Level 2 PASARR was completed as required. During an interview on [DATE] at 10:58 A.M., the Social Worker said she was unsure where the Level 2 PASARR for Resident #10 was and would look into the situation and get back to the survey team. During an interview on [DATE] at 1:15 P.M., the Social Worker said the Level 2 PASARR was complete and in the PASARR portal and not available for review in the medical record as it should have been. She said the PASARR should be in the medical record to ensure the record was complete and it was not.

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	225145	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 43935 Based on interview and document review, the facility failed to explain binding arbitration agreements and provide the Residents or their responsible party with the right to fully review the agreement for two of two Residents (#60 and #92) that had signed Arbitration agreements in the facility. Findings include: During an interview on 11/3/24 at 9:34 A.M., the Administrator said the facility offered arbitration agreements, he was responsible for overseeing the arbitration agreement process and there were no residents currently residing in the facility that had ever signed an arbitration agreement. Review of the medical records for Resident #60 and Resident #92 on 11/4/24 indicated both Residents had a signed arbitration agreement in their records. During a follow up interview on 11/5/24 at 9:38 A.M., the Administrator said he is responsible for having the residents or their responsible party review and potentially sign the arbitration agreements in the facility at this time. He said there are not currently any resident in the facility who have a signed arbitration. He was made aware the the surveyor found signed arbitration forms in the medical records and said he would have to look into things to see what was happening because he was not aware of that. On 11/5/24 at 10:30 A.M., the Administrator provided a list to the survey team that indicated two Residents had signed into arbitration that currently reside in the facility. Resident #60 was admitted to the facility in October 2024 with diagnoses including: unspecified dementia, diabetes mellitus and hypertension. Review of the Brief Interview for Mental Status (BIMS), dated 10/23/24, indicated the Resident suffered from severe cognitive impairment with a score of 3 out of 15. Further review of the medical record indicated the Resident's healthcare proxy (HCP) was activated to make all medical decisions on behalf of the Resident. Review of the Arbitration agreement, dated as completed 10/8/24, indicated the HCP for Resident #60 signed the agreement. During an interview on 11/5/24 at 10:05 A.M., Resident #60's HCP said she does not know what an arbitration agreement is. When the form was reviewed with her, she said she certainly would never have signed that form had anyone read it or explained it to her. She said the form was presented to her in a pile of multiple forms for consent and she signed all of them as directed by the nurse who presented them to her and she did not have any parts of this document explained to her nor did she review the form or have a copy for review. She said she would need to contact the facility to determine next steps in rescinding the form since it was signed under false pretenses. (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/5/24 at 10:22 A.M., Nurse #1 said there are many documents the nurses are required to review with the residents or their HCP during the admission process including forms about their rights and consents. She said they have the forms signed and place them in the records and offer the copy of resident's rights to the resident or their HCP. She said the arbitration form is not read to the resident or HCP or explained in great detail, but they are offered to read it if they want to. She said she does not review with them that they are signing away their right to seek legal justice and use a neutral arbitrator should an issue arise or that they can rescind the document if they sign it within thirty days. She said it is just one of the numerous forms that was signed during the admission process and she was not aware of the specifics. During an interview on 11/5/24 at 10:27 A.M., Nurse #4 said she was unsure what an arbitration agreement was, but then said it was familiar to her when the surveyor explained and presented the form. She said the nurses are going through large amounts of information with the residents and/or their families at the time of admission and this form is part of that process. She said she explains the form, that it is a right that they can exercise, and then tells them they can read it if they want and asks them to sign it and offers them copies of all documents they sign. She said she does not explain the document in any way or explain that it contains information on a neutral arbitrator to settle disputes, a neutral venue, a right to decline to sign, or that the document outlives the resident and can only be rescinded in writing in the first 30 days. She said she has never read the document and was unaware it said all that and has never explained any of that to a resident or responsible party. She said she just has them sign what is in the packet and places it in their medical record. She said she herself did not fully understand the agreement so she wouldn't be qualified to explain the legal information in the document to others. Resident #92 was admitted to the facility in October 2024 with diagnoses including: dementia and hypertension. Review of the BIMS, dated 10/24/24, indicated the Resident had moderately impaired cognition with a score of 12 out of 15. Further review of the medical record indicated the HCP for Resident #92 was activated for a short-term duration of 30 days on 10/30/24. Review of the Arbitration agreement, dated as completed 10/18/24, indicated Resident #92 had signed his/her own agreement. During an interview on 11/5/24 at 10:57 A.M., Resident #92 said the word arbitration is not familiar to him/her and upon being read the document said the information is unfamiliar to them. He/She said it appears they signed the document and would sign anything the nurses asked them too because he/she trusts they needed all the paperwork to provide him/her care. During a follow up interview on 11/5/24 at 11:07 A.M., Nurse #4 said she completed the arbitration form with Resident #92 whose cognition fluctuates between fully understanding and not understanding. She said the Resident was his/her own person at the time of the signature, but again she cannot say that she fully explained the form to the Resident prior to it being signed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225145	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/5/24 at 3:47 P.M., the Administrator said at this time the process for Arbitration agreements is that they are having the nurses complete the arbitration agreements with the residents or their responsible party. He said Arbitration agreements should be fully explained to the person agreeing to sign into arbitration with the key points of longevity of the document, it consisting of using a neutral arbitrator in a neutral venue for dispute resolution, foregoing the judicial system, and being binding unless rescinded in 30 days in writing. He agreed that there was no way the nurses would know what the document was they were asked to have the Resident's sign or explain and said he should be the one to review the legal document in full with an explanation to anyone who is interested in signing. He said he was unaware that the nurses had anyone sign the document and that is why a list could not be produced for the survey team upon entrance or until he was made aware that arbitration agreements were in the medical records. He said the process of having Arbitration agreements explained and signed needed improvement. On 11/5/24 at 4:44 P.M., the Administrator said the facility does not have a policy or document indicating what the procedure is for the completion of an arbitration form.

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	225145	A. Building B. Wing	11/06/2024

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 43935 Based on interview and document review, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) Committee which included the required members at their meetings. Specifically, the facility Medical Director failed to attend the last two quarterly QAPI meetings and the laboratory and pharmacy providers had not attended any of the four quarterly QAPI meetings throughout the year 2024. Findings include: Review of the facility provided QAPI Program Resource Guide, dated as revised 6/2019, indicated but was not limited to the following: - facility develops QAPI plans that are comprehensive, including all departments and all services offered by the facility - Leadership is accountable for fully engaging all members Review of the facility's QAPI calendar, last revised 6/2019, indicated the following people were expected to be in attendance quarterly: Medical Director, Administrator, Director of Nurses, Lab provider, MDS Nurse, Business office manager, Pharmacy provider, Medical records, Unit managers (if applicable) Review of the facility's QAPI Attendee sign-in sheets for 2024 indicated the following: -Neither the Lab provider nor pharmacy provider had attended the quarterly QAPI meetings on 1/25/24, 4/29/24, 7/26/24, or 10/23/24 -The Medical Director had not attended the quarterly QAPI meetings on 7/26/24 and 10/23/24 During an interview on 11/6/24 at 2:04 P.M., the Administrator said the QAPI committee meets on a quarterly basis. He said the Medical Director, laboratory provider and pharmacy provider were invited to each meeting but did not always attend. He said the Medical Director had not attended a QAPI meeting since at least late May that he is aware of. He reviewed the attendance sign-in sheets and said that although the Medical Director, pharmacy provider and laboratory provider are invited to each meeting, they do not attend and just send in their reports for review. He said he was unaware that attendance at QAPI meetings was required by certain members quarterly.

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	225145	A. Building B. Wing	11/06/2024

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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** 48695 Based on document review and interview, the facility failed to maintain an infection prevention and control program to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed: 1. For Residents #17 and #52, to ensure staff used appropriate personal protective equipment (PPE) for enhanced barrier precautions (EBP) when providing care; and 2. To have a written water management plan and documentation to ensure a facility risk assessment was conducted to identify where Legionella (bacteria that can cause Legionnaires' disease, a serious type of pneumonia) and other opportunistic waterborne pathogens could grow and spread in the facility's water system. Findings include: 1. Review of the Centers for Medicare and Medicaid Services (CMS) guidance titled Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, indicated but was not limited to: -Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. - EBP are used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing - EBP are indicated for residents with any of the following: a. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO - EBP should be used for any residents who meet the above criteria, wherever they reside in the Facility. Review of the facility's policy titled Infection Control Guidelines for Nursing Procedures, last revised 7/2024, indicated but was not limited to: - EBP are an infection control intervention designed to reduce transmission of MDROs. (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- EBP is indicated for nursing home residents with any of the following: 1. Infection or colonization with an MDRO when Contact Precautions don't otherwise apply; 2. Chronic wounds; 3. Indwelling medical devices, including but not limited to IV, feeding tubes, tracheostomy, drains/pleurex, urinary catheters. - PPE: use of gown and gloves during high-contact resident care activities that may provide opportunities for transmission of MDROs via staff hands and clothing examples of high contact resident activities are: dressing, bathing, shower, transferring, changing linen, personal hygiene, toileting/brief change, device care. - Signs - the facility will implement a system to alert staff and visitors to the type of precaution the resident requires. A. Resident #17 was admitted to the facility in August 2018 with diagnoses including Methicillin Resistant Staphylococcus Aureus (MRSA), gastrostomy, and quadriplegia. Review of Resident #17's Minimum Data Set (MDS) assessment, dated 10/8/24, indicated he/she had a gastrostomy tube. Review of Resident #17's current Physician's Orders indicated but was not limited to: - Enteral Feed Order- every shift for Nutrition Osmolite 1.5 at 55 milliliters (ml)/hour 6 P.M.-2 P.M. or total volume of 1100 ml with feeding pump - Gastrostomy Tube placed on 1/31/24 size 18 French/5 milliliters Resident #17 had an EBP sign, undated, from the CDC on the door to his/her room, which indicated but was not limited to the following: - Stop Enhanced Barrier Precautions Everyone Must: - Clean their hands, including before entering and when leaving the room. Providers and staff must also: - Wear gloves and a gown for the following High-Contact Resident Care Activities: Dressing; Bathing/Showering; Transferring; Changing Linens; Providing Hygiene; Changing briefs or assisting with toileting; Device care or use: central line, urinary catheter, feeding tube, tracheostomy; Wound Care: any skin opening requiring a dressing On 11/4/24 at 2:04 P.M., the surveyor observed Nurse #9, perform hand hygiene, don gloves, and perform gastrostomy tube care on Resident #17. Nurse #9 failed to don a gown. (continued on next page)

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	225145	A. Building B. Wing	11/06/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/6/24 at 7:38 A.M., the surveyor observed Nurse #14 perform hand hygiene and moved Resident #17's sheet and check his/her mattress, moving her hands across the mattress and over the bed and bed linens and examined the mattress. During an interview on 11/6/24 at 7:38 A.M., Nurse #14 said she was not aware that touching Resident #17 was considered high contact care. Nurse #14 and the surveyor reviewed Resident #17's EBP sign. Nurse #14 said she should have donned gloves and a gown but did not. During an interview on 11/6/24 at 3:38 P.M., the Director of Nursing (DON) said Nurse #9 and Nurse #14 should have worn the appropriate PPE while providing high contact care. B. Resident #52 was admitted to the facility in March 2019 with diagnoses including dementia and MRSA. Review of Resident #52's special instruction indicated but was not limited to: - Enhanced Barrier Precautions, undated Resident #52 had an EBP sign, undated, from the CDC on the door to his/her room, which indicated but was not limited to the following: - Stop Enhanced Barrier Precautions Everyone Must: - Clean their hands, including before entering and when leaving the room. Providers and staff must also: - Wear gloves and a gown for the following High-Contact Resident Care Activities: Dressing; Bathing/Showering; Transferring; Changing Linens; Providing Hygiene; Changing briefs or assisting with toileting; Device care or use: central line, urinary catheter, feeding tube, tracheostomy; Wound Care: any skin opening requiring a dressing The surveyor observed Hospice Certified Nursing Assistant (CNA) #1 perform high contact care on Resident #52 as follows: -On 11/5/24 at 8:48 A.M., Hospice CNA #1 performed hand hygiene and assisted Resident #52 out of bed. Hospice CNA #1 failed to don gown and gloves. -On 11/6/24 at 8:19 A.M., Hospice CNA #1 provided morning care (dressing and bathing) to Resident #52. Hospice CNA #1 was wearing gloves but failed to don a gown. During an interview on 11/6/24 at 8:33 A.M., Hospice CNA #1 said she was not aware Resident #52 was on EBP. Hospice CNA #1 and the surveyor reviewed Resident #52's EBP sign. Hospice CNA #1 said she should have donned gloves and gown while providing high contact care for Resident #52. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/6/24 at 8:35 A.M., CNA #4 said Resident #52 was on EBP and gloves and gown should be worn for all high contact care. During an interview on 11/6/24 at 3:38 P.M., the DON said Hospice CNA #1 should have worn the appropriate PPE while providing high contact care to Resident #52. 2. Review of Centers for Medicare & Medicaid Services (CMS) Memorandum titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease, revised July 2018, indicated but was not limited to the following: - In manmade water systems, Legionella can grow and spread to susceptible hosts, such as persons who are at least [AGE] years old, smokers, and those with underlying medical conditions such as chronic lung disease or immunosuppression. Legionella can grow in parts of building water systems that are continually wet, and certain devices can spread contaminated water droplets via aerosolization. Examples of these system components and devices include: - Hot and cold-water storage tanks - Water heaters - Water-hammer arrestors - Pipes, valves, and fittings - Expansion tanks - Water filters - Electronic and manual faucets - Aerators - Faucet flow restrictors - Showerheads and hoses - Centrally-installed misters, atomizers, air washers, and humidifiers - Non-steam aerosol-generating humidifiers - Eyewash stations - Ice machines - Hot tubs/saunas - Decorative fountains (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cooling towers - Medical devices (such as CPAP machines, hydrotherapy equipment, bronchoscopes, heater-cooler units) CMS expects Medicare and Medicare/Medicaid certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. Facilities must have water management plans and documentation that, at a minimum, ensure each facility: - Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, non-tuberculous mycobacteria, and fungi) could grow and spread in the facility water system. Review of the facility's policy titled Legionella Water Management Program, last revised 8/2018, indicated but was not limited to: -Policy: Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. -Guideline: - As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. -The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionella Disease. -The water management program used by our facility is based on applicable federal and state regulations. The water management program may include the following elements: a. An interdisciplinary water management team; b. A description and diagram of the water system in the facility is available upon request; c. The Identification of area in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria; d. The identification of situations that can lead to legionella growth; e. Specific measures used to control the introduction and/or spread of legionella; f. The control limits or parameters that are acceptable and that are monitored; g. A diagram of where control measures are applied; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. A system to monitor control limits and the effectiveness of control measures; i. A plan for when control limits are not met and/or control measures are not effective; and j. Documentation of the program. -The water Management Program will be reviewed at least once a year, or sooner. Review of the facility's Healthcare Water Management Plan on 11/5/24 at 9:00 A.M. failed to indicate a facility specific risk assessment had been completed to identify where Legionella and other waterborne pathogens could grow and spread in the facility water system or a water management plan specific to the facility. Further review of the Healthcare Water Management Plan indicated but was not limited to: - A schematic drawing which included a Cooling Tower - Another Facility's Name under Water Management Plan activities During an interview on 11/5/24 at 10:04 A.M., the Director of Maintenance (DOM) said the facility does not have a water management committee. The DOM said the facility did not have a facility specific water management risk assessment or plan. During an interview on 11/5/24 at 10:24 A.M., the Administrator said the Healthcare Water Management Plan was not specific to the facility and did not include a facility specific risk assessment or schematic.