STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225147	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saugus Center	266 Lincoln Avenue Saugus, MA 01906

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37342 Based on records reviewed and interviews, for two of three sampled residents (Resident #1 and Resident #3), who were admitted to the Facility with pressure injuries (localized damage to the skin and underlying soft tissue usually over a bony prominence which can present as intact skin or an open ulcer and may be painful) the Facility failed to ensure that nursing adequately assessed and documented their wounds, including but not limited to measurements of each wound, as well as notification of and obtaining orders for wound care treatments from the provider. Findings include: The Facility Policy, titled, Pressure Injury Prevention and Management, dated ,d+[DATE], indicated: -Pressure injuries were defined as localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. -Licensed nurses would conduct a pressure injury assessment and full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. -Findings of assessments would be documented in the medical record. -After completing a thorough assessment, the interdisciplinary team would develop a relevant care plan that included measurable goals for prevention and management of pressure injuries with appropriate interventions. -Evidence based treatments in accordance with current standards of practice would be provided for all residents who had pressure injuries present. -The goals and preferences of the resident and/or authorized representative would be included in the plan of care. The Facility Policy, titled, Prevention of Pressure Injuries, dated ,d+[DATE], indicated nursing would conduct a comprehensive skin assessment within eight hours of admission, and would document findings from the assessment. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Hospital Discharge Summary, dated [DATE], indicated he/she had a Stage 3 pressure injury (Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer, and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location) on his/her coccygeal sacral area. Resident #1 was admitted to the Facility in February 2025, diagnoses included diabetes and stage three pressure injury of the sacral region. Review of Resident #1's Admission Evaluation, dated [DATE], completed by nursing, indicated he/she had a stage three pressure injury on his/her sacrum. The sections on the assessment designated for documenting measurements of length, width and depth of the pressure injury, were left blank. Further review of Resident #1's medical record indicated there was no documentation to support that nursing obtained measurements of his/her pressure injury, notified his/her medical provider of his/her pressure injury, obtained orders for or initiated treatment to his/her pressure injury. Review of Resident #1's Treatment Administration Record (TAR) for the month of February 2025, indicated there was no documentation to support any physician's orders were obtained for treatment of his/her pressure injury. Review of Resident #1's Nurse Progress Note, dated [DATE], indicated that at 07:40 A.M., nursing found him/her unresponsive, provided Cardiopulmonary Resuscitation (CPR), and Resident #1 died . During a telephone interview on [DATE] at 03:20 P.M., Nurse Practitioner (NP) #1 said that on [DATE], she assessed Resident #1, but was unable to assess his/her pressure injury because he/she was up in his/her wheelchair. NP #1 said she read Resident #1's Hospital paperwork, and thought he/she had an area of moisture associated dermatitis on his/her buttocks, but did not know he/she had a larger, stage 3 pressure injury. NP #1 said nursing should have notified her or the on-call provider of the extent of the wound and should have assessed and obtained orders for treatment to Resident #1's pressure injury upon admission. During an interview on [DATE] at 03:50 P.M., Nurse #3 said that he was Resident #1's assigned nurse on the 03:00 P.M. to 11:00 P.M., shift when he/she was admitted , and for the following 11:00 P.M. to 07:00 A.M. , shift. Nurse #3 said that Resident #1 said he/she preferred to have a female nurse complete his/her skin assessment, so Nurse #8 completed Resident #1's admission skin assessment, and he (Nurse #3) documented what she said. Nurse #3 said he did not obtain a physician's order for a treatment for Resident #1's pressure injury. During a telephone interview on [DATE] at 03:57 P.M., Nurse #8 said she helped Nurse #3 with Resident #1's admission by entering some of his/her medication orders, but said she did not assist with or conduct his/her skin assessment, that she never saw his/her pressure injury, and did not obtain a physician's order for a treatment for Resident #1's pressure injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 01:08 P.M., Nurse #4 said he was Resident #1's nurse on the 07:00 A.M. to 03:00 P.M., shift the day after he/she was admitted , and said Resident #1 had an order to be seen by the wound specialist, who was not scheduled to come in until [DATE]. Nurse #4 said there was no physician's order for treatment to Resident #1's pressure injury, that he asked Resident #1 in the morning if he could assess his/her pressure injury but he/she said no. Nurse #4 said he did not re-approach Resident #1 again to assess his/her pressure injury. Review of Resident #1's Medical Record indicated there was no documentation to support that he/she refused to have his/her pressure injury assessed by nursing on [DATE]. During a telephone interview on [DATE] at 10:47 A.M., Nurse #2 said that she was the nurse assigned to care for Resident #1 on [DATE] during the 03:00 P.M. to 11:00 P.M., shift. Nurse #2 said when she assisted with Resident #1's incontinent care, she saw his/her pressure injury, but did not obtain measurements or document a description of the wound. Nurse #2 said there was no dressing in place, she did not put a dressing on the wound, and said she did think the wound needed a dressing. Nurse #2 said she did not call to notify the on-call provider of Resident #1's pressure injury or to obtain orders for treatment. During a telephone interview on [DATE] at 11:04 A.M., the Assistant Director of Nurses (ADON) said that on [DATE], she and the Director of Nurses (DON) provided post-mortem (after death) care to Resident #1. The ADON she had never assessed or measured Resident #1's pressure injury at any time, said she had not known of his/her pressure injury before his/her death on [DATE]. During an interview on [DATE] at 04:49 P.M., the Director of Nurses (DON) said she was not aware that Resident #1 had a pressure injury until after his/her death on [DATE], when she and the ADON provided post-mortem care. The DON said Resident #1 had a stage 4 pressure injury on his/her sacral area, and she did not measure Resident #1's wound post-mortem. The DON said there was no dressing in place at that time. The DON said nursing should have completed an assessment, including obtaining measurements, and documenting a description of Resident #1's pressure injury in his/her medical record and should have obtained a physician's order for treatment at the time of his/her admission to the Facility. The DON said nursing had several opportunities to assess, measure, notify the physician, and obtain orders. Although review of Resident #1's Skin Integrity Care Plan indicated that a plan of care related to alteration in skin was created for Resident #1 that included measurements and descriptions of his/her pressure injury, the care plan was initiated after he/she died and there were no nursing assessments in the medical record to support where, when, how, or who obtained the pressure injury information. 2. Resident #3 was admitted to the Facility in [DATE], diagnoses included Sacral Osteomyelitis (bone destruction and infection), sepsis, schizophrenia, and pressure injury of the sacral area. Review of Resident #3's Hospital Discharge Summary, dated [DATE], indicated Resident #3 had two wounds and one skin area at risk for breakdown identified upon discharge: a) stage 4 pressure injury on his/her sacral area, and indicated that on [DATE] his/her wound measured 15 by 10. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) deep tissue pressure injury (DTPI) (intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration, or epidermal separation revealing a dark wound bed or blood-filled blister) on his/her left heel. The Discharge Summary indicated that on [DATE] Resident #3's left heel DTPI was assessed as having a foam dressing in place, and offloading boots were ordered as a preventative measure. c) an area of skin at risk to his/her right heel, was assessed as having blanchable erythema, and offloading boots were ordered as a preventative dressing. Review of Resident #3's Admission Evaluation, dated [DATE], indicated he/she had the following skin alterations upon admission to the Facility: a) Sacral/Coccyx area stage four pressure injury. b) Left heel Deep Tissue Pressure Injury (DTPI) c) Right heel stage one pressure injury. Further review of the assessment indicated that for all three pressure injuries listed, the sections on the assessment designated for documenting measurements of length, width and depth of the pressure injuries, were left blank. Further review of Resident #3's medical record indicated there was no documentation to support nursing had measured his/her pressure injuries/wounds at all upon his/her admission to the Facility until six days after his/her admission, on [DATE], (which was during this survey.) Review of Resident #3's Wound Evaluation And Management Summary, dated [DATE], indicated he/she had the following skin alterations: a) Stage 4 pressure wound of his/her sacrum full thickness, measurements were documented as 6 centimeters (cm) long by 5 cm wide by 4 cm deep, and bone was visible. b) Unstageable (due to the presence of necrotic tissue) pressure wound of his/her left heel, full thickness, measurements were documented as 1 cm long by 1 cm wide, and un-measurable depth, with thick adherent black necrotic tissue over 100 percent of the wound. c) Further review of Resident #3's Wound Evaluation And Management Summary indicated there was no documentation to support nursing assessed, evaluated, or obtained measurements of the wound on Resident #3's right heel. Review of Resident #3's TAR for the month of [DATE] indicated nursing documented the following: a) Signed off as having completed his/her treatment orders to his/her sacral pressure injury on [DATE], [DATE], and [DATE]. b) Signed off as having completed his/her left heel pressure injury treatment on [DATE], [DATE], and [DATE]. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) Signed off as having completed his/her right heel treatment order on [DATE] through [DATE]. However, review of Resident #3's Medical Record indicated there was no documentation to support that nursing had completed an assessment including descriptions and measurements of Resident #3's wounds before [DATE], and no documentation to support that nursing had assessed and measured his/her right heel pressure injury at all. During a telephone interview on [DATE] at 10:50 A.M., the DON said nursing should have assessed, measured, and documented a description of Resident #3's pressure injuries upon his/her admission on [DATE], and said nursing had several opportunities to assess, measure, and document on his/her pressure injuries when completing treatments between [DATE] and [DATE], but did not.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 37342 Based on record reviews and interviews for one of three sampled residents (Resident #1), whose Hospital Discharge Summary included orders for insulin administration and blood glucose monitoring, the Facility failed to ensure he/she was free from significant medication errors, when the physician's orders were not accurately reconciled by nursing, he/she was not administered insulin and his/her blood glucose levels were not monitored for three days. Findings include: The Facility Procedure, titled, Reconciliation of Medications on Admission, dated 07/2017, indicated: -Nursing would ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission to the Facility. -Medication reconciliation was the process of comparing pre-discharge medications to post-discharge medications. -Nursing would obtain a medication history from the residents or their family. -Nursing would use an approved medication reconciliation form or other record to list all medications, their doses, routes, and frequencies from the medication history, the discharge summary, and the admitting orders. -Nursing would address any discrepancies with appropriate actions, including contacting the resident's referring facility, their physician in the community, their family, and their attending physician. The Facility Procedure, titled, Admission Assessment and Follow Up: Role of the Nurse, dated 09/2012, indicated nursing would reconcile the list of medications from the resident's medication history, admitting orders, and the discharge summary from the previous institution, according to established procedures. The Facility Policy, titled Administering Medications, dated 04/2019, indicated medications would be administered in accordance with prescriber orders, including any required time frame. Resident #1 was admitted to the Facility in February 2025, diagnoses included diabetes and a pressure injury to his/her sacral region. Review of Resident #1's Hospital Discharge Summary, dated 02/26/25, indicated his/her discharge medication orders included the following: - Glargine (Lantus, a long-acting insulin) subcutaneous solution, 100 Units/milliliter (ml) inject 15 units subcutaneously (under the skin) at bedtime. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Blood Glucose Sensor Device for monitoring glucose, change sensor every 10 days, however, the order did not indicate the frequency. Further review of Resident #1's Hospital Discharge Summary indicated to refer to his/her medication list in the Hospital After Visit Summary for complete details and dose instructions. Review of Resident #1's Hospital After Visit Summary, dated 02/26/25, indicated current medications orders included: - Lispro (Humalog, a rapid acting insulin), 0-5 units, to be administered subcutaneously following a sliding scale (dose is calculated depending on the blood glucose) three times daily with meals. - Lispro, three units subcutaneously, three times daily with meals. Review of Resident #1's Hospital Medication Administration Record (MAR) dated 02/26/25 indicated his/her Glargine and Lispro insulin orders were active orders upon discharge and indicated he/she was last administered Lispro on 02/26/25 at 05:05 P.M., before discharge from the Hospital. Further review of Resident #1's Hospital MAR indicated he/she was not administered Glargine (Lantus) at the Hospital on 02/26/25, (as it was scheduled for bedtime administration). Review of Resident #1's Physician's Order, dated 02/26/25, indicated nursing to administer Glargine (Lantus) subcutaneous solution, 100 Units/ml inject 15 units subcutaneously at bedtime. Review of Resident #1's Facility Medication Review Report indicated there was no documentation to support that he/she ever had a physician's order for Lispro during his/her inpatient stay at the Facility. During an interview on 03/31/25 at 03:50 P.M., Nurse #3 said he was Resident #1's nurse on the 03:00 P.M. to 11:00 P.M., shift, the day he/she was admitted . Nurse #3 said he entered his/her admission orders according to Resident #1's Hospital Discharge Summary, but said he did not review his/her Hospital After Visit Summary. Nurse #3 said when he called to confirm Resident #1's admission orders, he spoke with Nurse Practitioner (NP) #1, and said NP #1 told him to go by what the Hospital Discharge Summary indicated. Nurse #3 said he did not review each medication order one by one with the Nurse Practitioner. Nurse #3 said he retrieved a vial of Lantus insulin from the Facility's Emergency Medication Kit on 02/26/25 and administered Resident #1's dose of 15 units that night. Review of the Facility's contracted Pharmacy's Transactions By Patient Medication Record, dated 02/26/25 through 02/27/25, indicated there were no medications, including Lantus, having been signed off as removed from the Facility's Emergency Medication Kit for Resident #1 during that time frame. Review of Resident #1's Medication Administration Record (MAR) for the month of February 2025 indicated that the start date for his/her Lantus was documented as 02/27/25, and the section for nursing to administer Lantus on 02/26/25 was blocked out with an X (indicating not administered). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #1's February 2025 MAR indicated that Lantus had not been administered to Resident #1 at all during his/her admission. Review of Resident #1's Pharmacy Requisition Report indicated that on 02/27/25 Nurse Practitioner (NP) #1 gave a telephone order to Nurse #2 to discontinue Resident #1's Lantus. During an interview on 04/01/25 at 10:47 A.M., Nurse #2 said she was Resident #1's assigned nurse on 02/27/25 for the 03:00 P.M. to 11:00 P.M., shift. Nurse #2 said she did not remember obtaining or entering an order to discontinue Resident #1's Lantus, and said she did not call NP #1 or any other provider about Resident #1 at all that shift. Review of Resident #1's Nurse Progress Notes dated 02/26/25 through 02/28/25, indicated there was no documentation to support his/her Lantus order was discontinued or any documentation that indicated nursing discussed his/her Lantus dose with a provider. Review of Resident #1's Medical Record indicated there was no documentation to support that nursing completed a Medication Reconciliation of his/her home, hospital discharge, and Facility medication orders, per Facility policy. During a telephone interview on 03/31/25 at 03:20 P.M., Nurse Practitioner (NP) #1 said she was not on-call when Resident #1 was admitted to the Facility, and said the Facility used an on-call service provider that had multiple Nurse Practitioners available for Facilities to call for resident orders. NP #1 said when providers are not on-site they rely on what the nurses tell them over the phone, because they do not have access to the medical record offsite. NP #1 said that on 02/27/25 she was at the Facility, and reviewed Resident #1's admission orders, which included Lantus. NP #1 said she reviewed Resident #1's Hospital Discharge Paperwork, but said she did not see his/her orders for Lispro. NP #1 said the physician's order for Blood Glucose Sensor Device for monitoring glucose indicated in Resident #1's Hospital Discharge Summary should have prompted nursing to obtain an order for blood glucose monitoring via fingerstick three or four times daily. NP #1 said she expected that nursing would complete a thorough record review to ensure admission medication orders were accurate and complete, and said nursing should have included Resident #1's Lispro and blood glucose monitoring when obtaining his/her admission orders. NP #1 said she did not provide or authorize an order to discontinue Resident #1's Lantus on 02/27/25, and said she did not receive any calls from the Facility regarding Resident #1 after she left the Facility that day. During an interview on 03/31/25 at 04:49 P.M., the Director of Nurses (DON) said nursing should have reviewed all of Resident #1's Hospital Discharge Summary and instructions upon his/her admission to the Facility and should have obtained orders from the provider on call that aligned with his/her Hospital discharge orders, but did not. The DON said nursing should have completed a Medication Reconciliation for Resident #1's medication orders, but did not. The DON said Nurse #3 should have administered Resident #1's scheduled Lantus at bedtime on 02/26/25, but did not. The DON said Nurse #2 should not have discontinued Resident #1's Lantus without a provider's order, but did.