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	07/09/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, record review, interview and policy review, the facility failed to ensure residents were treated with dignity for five Residents (#8, #25, #52, #15 and #48) out of a total sample of 27 residents. Specifically: 1a. For Resident #8, the facility failed to provide assistance with removal of unwanted chin hair. 1b. For Resident #25, the facility failed to provide a dignified dining experience. 1c. For Resident #52, the facility failed to provide assistance with removal of unwanted chin hair. 2a. For Resident #15, the facility failed to provide assistance with removal of unwanted chin hair. 2b. For Resident #48, the facility failed to provide a dignified dining experience. Findings include: Review of the facility policy titled Assistance with Meals, undated, indicated the following: - Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. - Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: not standing over residents while assisting them with meals Review of the facility policy titled Dignity, undated, indicated the following: - Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem - Residents are treated with dignity and respect at all times - When assisting with care, residents are supported in exercising their rights. For example, residents are: (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Groomed as they wish to be groomed (hair styles, nails, facial hair, etc.) - Provided with a dignified dining experience 1a. Resident #8 was admitted to the facility in October 2011 with diagnoses including schizophrenia, bipolar disorder and anxiety. Review of the Minimum Data Set (MDS) dated [DATE], indicated that Resident #8 scored a 12 out of 15 on the Brief Interview for Mental Status exam, indicating moderately impaired cognition. Further review indicated that Resident #8 requires substantial/maximal assistance with personal hygiene. On 7/2/24 at 7:14 A.M., and on 7/3/24, at 2:00 P.M. the surveyor observed Resident #8 lying in bed with significant chin hair. During an interview on 7/2/24, at 7:14 A.M., and on 7/3/24, at 2:00 P.M., Resident #8 said that he/she did not like the hair and wanted help to remove it. On 7/8/24, at 7:48 A.M., the surveyor observed Resident #8 lying in bed with significant chin hair. Review of the care plan dated reviewed 4/17/24, indicated Resident #8 requires total assist for personal hygiene. Further review failed to indicate a care plan for refusal of care. Review of the facility documents titled Documentation Survey Report v2 dated June 2024 and July 2024, failed to indicate that Resident #8 refused personal hygiene care. During an interview on 7/08/24, at 12:13 P.M., CNA #3 said that it was his responsibility to remove unwanted facial hair for Resident #8 today. CNA #3 said he was not aware that Resident #8 wanted the facial hair removed. 1b. Resident #25 was admitted to the facility in May 2020 with diagnoses including dysphagia and dementia with psychosis. Review of the Minimum Data Set (MDS) dated [DATE] indicated that Resident #25 was not able to complete the Brief Interview for Mental Status exam. Further review indicated Resident #25 is severely cognitively impaired. Further review indicated that Resident #25 requires continuous supervision/assistance for eating. Review of the care plan indicated that Resident #25 requires continual supervision/assist with meals when fatigued or behavioral. On 7/3/24, at 12:02 P.M., the surveyor observed a Certified Nurse's Aide (CNA) standing while feeding Resident #25 in bed. On 7/08/24 at 8:10 A.M., the surveyor observed CNA #3 standing while feeding Resident #25. During an interview on 7/08/24 at 8:10 A.M., CNA #3 said that he was supposed to be sitting while feeding a resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c. Resident #52 was admitted to the facility in May 2022 with diagnoses including dementia, schizophrenia and dysphagia. Review of the Minimum Data Set (MDS) dated [DATE] indicated that Resident #52 was unable to complete the Brief Interview for Mental Status. Further review indicated that Resident #52 is severely cognitively impaired and is totally dependent for personal hygiene. On 7/2/24, at 7:46 A.M., the surveyor observed Resident #52 lying in bed with significant chin hair. During an interview on 7/02/24, at 11:49 A.M., Resident #52 said he/she would like help to remove it. On 7/03/24, at 7:45 A.M. the surveyor observed Resident #52 in bed with significant chin hair. On 7/8/24, at 7:49 A.M., the surveyor observed Resident #52 lying in bed with significant chin hair. Review of the care plan failed to indicate that Resident #52 refuses care. Further review indicated that he/she is totally dependent for personal hygiene. Review of the facility documents titled Documentation Survey Report v2 dated June 2024 and July 2024, failed to indicate that Resident #52 refused personal hygiene care. During an interview on 7/08/24, at 12:24 P.M., Certified Nurse's Aide (CNA) #4 said that it is the responsibility of the CNA's to provide facial hair removal if the resident wants it. During an interview on 7/08/24, at 12:27 P.M., CNA #3 said that it was his responsibility to remove facial hair for Resident #52 as Resident #52 is on his assignment today. CNA #3 said he did not remove Resident #52's facial hair during morning care. 36431 2a. For Resident #15 the facility failed to provide dignity by failing to remove chin hair. Resident #15 was admitted to the facility in August of 2023 with diagnoses that include but are not limited to Alzheimer's disease, lupus anticoagulant syndrome, muscle weakness, and unsteadiness on feet. Review of Resident #15's MDS dated [DATE] indicated staff assessed Resident #15 as having severely impaired cognition and required supervision/or touching assistance as resident completes the activity for personal hygiene and had one to three days of rejecting care. Review of Resident #15's care plans failed to indicate he/she resisted care or resisted having assistance with removing his/her chin hair. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/2/24 at 7:15 A.M., Resident #15 was observed, dressed in clothes resting on his/her bed. Resident #15 was observed to have thick hair approximately over one-half inch on his/her chin. Resident #15 said he/she was interested in having it removed, then said someone would need to get me a razor. On 7/2/24 at 3:48 P.M., Resident #15 was observed with thick chin hair, approximately one-half inch long, on his/her chin. On 7/03/24 at 4:26 P.M., Resident #15 was observed with thick chin hair approximately one-half inch or more long. On 7/8/24 at 7:33 A.M., five days since the last observation, Resident #15 was observed on his/her bed. Resident #15 had thick chin hair approximately one-half inch or more. During an interview on 7/8/24 at 7:35 A.M., CNA #6 said Resident #15 will tell you what he/she needs and may need a few approaches to accomplish care but will allow care when he/she is ready. CNA #6 said removing facial hair is part of the care provided and said she observed that Resident #15 had facial hair. During a subsequent interview on 7/9/24 at 11:00 A.M., CNA #6 said she recognizes Resident #15 as someone who wants to be independent but requires help. CNA #6 said she worked with Resident #15 and was able to assist him/her with removing Resident #15's chin hair. 45984 2b. Resident #48 was admitted to the facility in December 2021 with diagnoses including muscle wasting and atrophy, dysphagia and anxiety disorder. Review of Resident #48's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 8 out of a possible 15 indicating that he/she has moderate cognitive impairment. Further review of the MDS indicated that Resident #48 requires substantial/maximum assistance with eating and is dependent on staff for all other activities of daily living (ADLs). The surveyor made the following observations: - On 7/2/24 at 8:31 A.M., Resident #48 was lying in his/her bed behind a closed curtain. The surveyor walked into the room and observed a staff member feeding Resident #48 while standing over him/her, not at eye level. - On 7/2/24 at 12:24 P.M., Resident #48 was lying in his/her bed behind a closed curtain. The surveyor walked into the room and observed a staff member feeding Resident #48 while standing over him/her, not at eye level. The staff member was holding the entire plate of food in his left hand while feeding the resident with his right hand. The tray of food was on a table out of reach for the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 7/3/24 at 12:25 P.M., Resident #48 was lying in his/her bed behind a closed curtain. The surveyor walked into the room and observed a staff member feeding Resident #48 while standing over him/her, not at eye level. The staff member was holding the entire plate of food in his left hand while feeding the resident with his right hand. The tray of food was on a table out of reach for the resident. Review of Resident #48's Kardex (a nursing care card) indicated the following under the Eating/Nutrition section: - Assistance with meals as needed - Provide finger foods when the resident has difficulty using utensils. Needs to be cued, assisted and fed at times Review of Resident #48's ADL self-care performance deficit care plan dated 12/23/22 indicated the following intervention: - EATING: Provide finger foods when the resident has difficulty using utensils. Needs to be cued, assisted and fed at times. Review of Resident #48's Nutritional Risk care plan dated 3/22/23 indicated the following: - Assistance with meals as needed During an interview on 7/8/24 at 8:52 A.M., Nurse #1 said she was not sure if staff should be sitting or standing while feeding residents. She continued to say whatever is most comfortable for the staff member feeding the resident. During an interview on 7/8/24 at 10:20 A.M., Certified Nursing Assistant #2 said staff should be at eye level when assisting residents with feeding.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 36797 Based on observations, record review, policy review, and interviews, the facility failed to ensure one Resident (#13), out of 27 total sampled residents, was assessed for the ability to self-administer medications. Specifically, for Resident #13 the facility failed to ensure he/she was assessed to self-administer Centrum vitamins and Nystatin powder (used to treat fungal infections of the skin). Findings include: Review of the facility policy titled Safety and Supervision of Residents, dated 4/2018 indicated the following: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Further review indicated that as part of their overall evaluation, the staff and/or practitioner will assess each resident's mental and physical abilities to determine whither self-administering medications is clinically appropriate for the resident. Resident #13 was admitted to the facility in September 2019 with diagnoses including bipolar disorder, psychosis and psychoactive substance abuse. During medication pass on 7/3/24, at 9:23 A.M., the surveyor observed a bottle of Centrum vitamins and a bottle of Nystatin powder (used to treat a fungal infection) on top of the over the bed table. The surveyor also observed Nurse #3 observe the medications and not remove them or secure them. On 7/09/24, at 7:27 A.M., the surveyor observed a bottle of Centrum vitamins and a bottle of Nystatin powder on top of the over the bed table. During an interview on 7/09/24, at 7:28 A.M., Resident #13 said that he/she takes on of the vitamins every morning. Review of the medical record failed to indicate an assessment for the self administration of medication had been completed. Review of the doctor's orders dated July 2024 failed to indicate an order for the self administration of medication. Review of the care plan failed to indicate a plan of care for the self administration of medication. During an interview on 7/09/24, at 7:28 A.M., Nurse #4 said that the Resident should not have medications at bedside unless they have been assessed to self administer and have a doctor's order to do so.

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	225147	A. Building B. Wing	07/09/2024

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on record review and interview for one Resident (#32), out of a total sample of 27 residents, the facility failed to ensure advanced directives were implemented consistently in the medical record in accordance with the resident's/health care agent wishes. Findings include: Review of the facility's policy titled, 'Advanced Directives', not dated indicated Advanced directives will be respected in accordance with state law and facility policy. Policy Interpretation and Implementation included but not limited to the following: Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical, or surgical treatment and to formulate an advance directive if he or she chooses to do so. Prior to or upon admission of a resident, the social services director or designee will inquire of the resident his/her family members and/or his or her legal representative, about the existence of any written advanced directives. Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. The Director of nursing services or designee will notify the attending physician of advanced directives so that appropriate orders can be documented in the resident's medical record and plan of care. Resident #32 was admitted to the facility in [DATE] with diagnoses that include but not limited to hyperlipidemia, intracerebral hemorrhage, and unspecified dementia. Review of Resident #32's Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #32 scored a 7 out of 15 on the Brief Interview for Mental Status exam indicating Resident #32 had severe cognitive impairment and required partial to moderate assistance with personal hygiene, toileting and bathing. Review of Resident #32's medical record indicated the following: -A 'Physician's Progress Note to Activate Health Care Proxy/Durable Power of Attorney for Health Care, dated [DATE] indicating Resident #32 lacks the capacity to make, or to communicate decisions relative to his/her medical care. The document indicated the name of the designated decision maker/agent. -A Massachusetts Medical Orders for Life Sustaining Treatment (MOLST), signed by the Health Care Proxy Agent and dated by the Nurse Practitioner on [DATE] indicating the following orders: *Do Not Resuscitate (DNR) *Do not Intubate or Ventilate (DNI) *Do Not Transfer to Hospital (unless needed for comfort) (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current physician's orders in the electronic medical record indicated Resident #32 as a full code CPR (cardiopulmonary resuscitation), dated [DATE]. During an interview on [DATE] at 8:47 A.M., Nurse #6 reviewed the electronic medical record and said the orders for Resident #32 indicated full code/CPR. Nurse #6 said the nursing staff also check the medical record for advanced directives. Nurse #6 reviewed the Resident #32's medical record and said the Resident has a MOLST for DNR, DNI and Do not transfer to the hospital. Nurse #6 said staff should go by the MOLST, and that the physician's orders should match the MOLST and the physician's orders were not updated.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview for two Residents (#20 and #32) out of a sample of 27 Residents, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect the resident's status. Specifically,1. The MDS failed to indicate Resident #20 was at risk for developing a pressure ulcer/injury, and 2. The MDS failed to indicate Resident #32 had a significant weight gain, resulting in no further assessment of the accuracy of the weight gain and care planning process. Findings include: 1. Resident #20 was admitted to the facility in November of 2020 with diagnoses that include but are not limited to post traumatic seizures, atherosclerotic heart disease, muscle weakness, Crohn's disease of small intestine, cognitive communication deficit, cerebral infarction, and anxiety disorder. Review of Resident #20's most recent Minimum Data Set assessment (MDS) dated [DATE] indicated staff assessed Resident #20 with a severely impaired cognition and he/she was dependent on staff for all care and is incontinent of bladder and bowel and was not at risk of developing pressure ulcers. Further review of MDS assessments dated 1/31/24, 11/1/23 indicated the determination of developing pressure ulcers was a clinical assessment and that Resident #20 was not at risk for developing pressure ulcers. On 7/2/24 at 7:34 A.M., and 7/3/24 at 8:28 A.M., Resident #20 was observed resting in his/her bed. Resident #20 was uncovered, talking to him/herself, and was slight in stature and frail. Review of Resident #20's medical record indicated the following: -A care plan dated 11/30/22 and revised 5/8/24 indicated Resident #20 has a potential for pressure injury development r/t (related to) HX (history) of ulcers, immobility, incontinence with an intervention: Follow facility policies/protocols for the prevention/treatment of skin breakdown. - A Norton risk Assessment for developing pressure ulcers dated 7/1/23 indicated a score of 6 indicating Resident #20 as high risk for developing pressure ulcers. Review of Resident #20's medical record did not indicate any further Norton risk Assessments for developing pressure ulcers that indicated Resident #20 was no longer a risk for developing pressure ulcers. During an interview on 7/3/24 at 9:22 A.M., Certified Nursing Assistant (CNA) #4 said Resident #20 is dependent on staff for all care, does not like to get out of bed and had open skin area months ago that is healed. During an interview on 7/03/24 at 9:34 A.M., Nurse #6 said Resident #20 is at risk for developing skin injuries. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/03/24 at 3:31 P.M., The Assistant Director of Nursing (ADON) reviewed Resident #20's medical record and said the last Norton risk assessment dated [DATE] indicated Resident #20 as high risk for developing pressure ulcers. During an interview on 7/8/24 at 9:28 A.M., the Minimum Data Nurse said she recently started working at the facility. The MDS nurse said she reviewed Resident #20's care plans, medical record, and diagnoses which support Resident #20 as being a high risk for developing pressure ulcers. The MDS nurse said there was no indication in Resident #20's medical record that his/her risk for developing pressure ulcers was no longer high and the MDS needed to be modified to reflect the Resident's risk. 2. Resident #32 was admitted to the facility in March 2024 with diagnoses that include but not limited to hyperlipidemia, intracerebral hemorrhage, and unspecified dementia. Review of Resident #32's Minimum Data Set assessment (MDS) dated [DATE] indicated Resident #32 scored a 7 out of 15 on the Brief Interview for Mental Status exam indicating Resident #32 had severe cognitive impairment. Further review of the MDS indicated Resident #32's weight as 196.0 and was not checked off as having a weight gain of 5% or more in the last month or a gain of 10% or more in the last 6 months. Review of the Resident #15's weight recorded in the medical record indicated the following: -3/18/24 112.0 -4/1/24 112.0 -5/8/24 115.0 -6/5/24 196 .0 During an interview on 7/3/24 at 8:09 A.M., Nurse #6 said the Certified Nursing Assistants obtain resident weights and the nurses put in the PCC (the electronic medical record). During an interview on 7/3/24 at 10:14 A.M., The Assistant Director of Nursing said she believes firmly that the weight on 6/5/24 at 196.0 was a data entry error and that it still needed to be verified and that she struck it out today and asked for a reweigh of the Resident. During an interview on 7/08/24 at 9:25 A.M., the Minimum Data Set Nurse said the weight recorded on the MDS was populated from the Resident's medical record and that the significant weight gain was not picked up as a significant weight gain and not checked off on the MDS as a gain. The MDS nurse said the MDS should be accurate.

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	225147	A. Building B. Wing	07/09/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, record review, interview and policy review, the facility failed to implement and develop the plan of care for four Residents (#25, #52, #21 and #221) out of a total sample of 27 residents. Specifically: 1. For Resident #25 the facility failed to provide supervision with eating. 2. For Resident #52 the facility failed to provide supervision with eating. 3. For Resident #21 the facility failed to implement the plan of care to have two staff for Activities of Daily Living Care. 4. For Resident #221 the facility failed to develop a personalized history of alcohol abuse, marijuana and opoid dependence care plan. Findings include: Review of the facility policy titled Activities of Daily Living, not dated, indicated the following: Appropriate care and services will be provided for residents who are unable to carry out activities of daily living (ADLs) independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with dining. A review of the facility policy titled 'Care Plans-Comprehensive' with a revision date of July 2023 indicated the following: -An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, emotional and psychological needs is developed for each resident. A review of the facility policy titled 'Substance Use Disorder Policy' with a revision date of November 2017 indicated the following: -The purpose of this policy is to identify residents prior to admission as they relate to substance use disorder. To identify all appropriate diagnoses or specific services needed as they relate to substance abuse/use on addiction and to determine risk for relapse and the level of supervision needed. - Social Service will assess the resident to identify risk and to put a plan of care in place. 1. Resident #25 was admitted to the facility in May 2020 with diagnoses including dysphagia and dementia with psychosis. (continued on next page)

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	07/09/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) dated [DATE] indicated that Resident #25 was not able to complete the Brief Interview for Mental Status exam. Further review indicated Resident #25 is severely cognitively impaired. Further review indicated that Resident #25 requires continuous supervision/assistance for eating. Review of the care plan indicated that Resident #25 requires continual supervision/assist with meals when fatigued or behavioral. On 7/02/24, at 8:03 A.M. the surveyor observed a Certified Nurse's Aide (CNA) set up the breakfast tray, place it on the over the bed table and then left the room. Resident #25 was observed to be lying in bed attempting to feed him/herself and spilling food down the front of him/her. Resident #25 was also observed to spill the glass of orange juice on the tray when attempting to drink it. On 7/08/24, at 11:58 A.M. the surveyor observed Resident #25 lying in bed with a meal tray in front of him/her without supervision. Resident #25 was not eating. Resident #25 was then observed to attempt to drink from a straw. Resident #25 was not able to bring the straw to his/her mouth and repeatedly stuck the straw in his/her cheek before giving up and putting the drink down. On 7/08/24, at 12:13 P.M., the surveyor observed CNA #3 at bedside, assisting Resident #25 to eat. During an interview on 7/08/24, at 12:13 P.M., CNA #3 said that Resident #25 needs to be supervised while eating. CNA #3 then said that Resident #25 has to be fed most of the meal now and should not have been left alone with the meal tray. 2. Resident #52 was admitted to the facility in May 2022 with diagnoses including dysphagia, dementia and schizophrenia. Review of the Minimum Data Set (MDS) dated [DATE] indicated that Resident #52 is severely cognitively impaired. Further review indicated that Resident #52 requires supervision with meals. Review of the care plan dated as revised 4/23/24 indicated that Resident #52 requires continual supervision with eating related to dysphagia. Review of the facility documents titled Documentation Survey Report v2 dated June 2024 and July 2024, indicated that Resident #52 required continual supervision daily with meals. On 7/02/24 11:46 A.M. the surveyor observed Resident #52 sitting on the edge of the bed eating without staff supervision. On 7/02/24 12:03 PM The surveyor observed Resident #52 lying in bed. The surveyor also observed that Resident #52 had eaten only about 25% of his/her meal. On 7/02/24 12:06 P.M. the surveyor observed a staff member remove Resident #52's meal tray. The surveyor observed that Resident #52 had still eaten only about 25% of his/her meal. On 7/8/24 7:49 A.M. the surveyor observed Resident #52 sitting on the edge of the bed eating without staff supervision. (continued on next page)

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	07/09/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/8/24 12:00 P.M. the surveyor observed Resident #52 sitting on the edge of the bed eating without staff supervision. During an interview on 07/08/24 12:17 PM CNA #3 said that he checks on Resident #52 before picking up his/her tray and provides encouragement to finish the meal if he notices that Resident #52 has not eaten. CNA #3 said that he didn't know that Resident #52 required continuous supervision with meals related to dysphagia. 36431 3. Resident 21 was admitted to the facility in January of 2016 and with diagnoses that include but are not limited to type 2 diabetes mellitus, chronic obstructive pulmonary disease, dementia, and anxiety. Review of Resident #21's Minimum Data Set (MDS) dated [DATE] indicated Resident #21 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) exam, indicating severely impaired cognition, is dependent on staff for toileting, bathing, dressing and hygiene and receives hospice services. Review of Resident #21's medical record indicated the following: -A physician's order to admit to hospice for care and comfort on 2/4/22. Review of Resident #21's care plans indicated the following: -Resident requires assistance with ADL (activities of daily living) care in bathing, grooming, personal hygiene, dressing, toileting r/t (related to) cognitive loss, dated 6/16/2018 with an intervention dated 6/16/2018, Resident is dependent on 2 staff for toileting and incontinence care. -In the aftermath of the rape abuse allegation by resident on august 2023, it was decided that two aids will attend to the resident at all times during provision of care dated 8/17/23 and entered by the facility Social Worker. - Resident is on hospice services for care and comfort, dated initiated 3/10/2022. Interventions included HHA (home health aide) 3-5 times a week. On 7/8/24 at 8:52 A.M., Hospice HHA #1 was observed in Resident #21's room by himself/ herself. Resident #21 was sitting up in bed eating his/her breakfast. During an interview at this time HHA #1 said she provided ADL care to Resident #21 Monday through Friday and does the care by herself and gets staff to help with transfers out of bed only. During an interview on 7/8/24 at 11:12 A.M., Certified Nursing Assistant (CNA) #6 said Resident #21 requires total care and requires two staff for ADL care for his/her safety after an allegation of abuse. CNA #6 said the hospice aid (HHA) provides care to the Resident by herself and will ask staff for help with transfers only. CNA #6 said she was not told to discontinue having two aids and she did not know if the hospice aid knew the plan to have two staff for Resident #21's care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/8/24 at 11:28 A.M. the Social Worker said the intervention to have two caregivers during care should be implemented even by the hospice HHA. 43807 4. Resident #221 was admitted to the facility in June 2024 with diagnoses including opoid dependence and alcohol use unspecified with alcohol induced mood disorder. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 indicating intact cognition. During an interview on 7/2/24 at 12:54 P.M., Resident #221 said he/she has a history of ingesting drugs and alcohol. He/she said he/she relapsed on 5/24/24, he/she said he/she used cocaine and heroin. A review of the hospital discharge summary dated 5/27/24-6/17/24 indicated the following: -Patient endorses drug and alcohol use but does not report on time of last use. Does report a history of complicated withdrawals from alcohol including seizures. Urine drug screen on admission positive for cocaine, fentanyl, buprenorphine and benzodiazepines. Further review of the hospital discharge summary dated 5/28/24 indicated the following: -Social history: He/she reports current drug use. Drugs: Heroin, Fentanyl, Marijuana, and Crack cocaine A review of Resident #221's substance abuse care plan initiated on 6/18/24 indicated the following: -Focus-Resident has a substance abuse disorder related to opiate dependence with intoxication. -Goal-Resident will have minimal or no symptoms of withdrawal during stay at the facility. -Interventions-offer substance abuse counseling and AA (Alcoholic Anonymous) services. During an interview and chart review on 7/3/24 at 11:46 A.M., the Social Worker reviewed the substance abuse care plan with the surveyor. She said she is responsible for completing all substance abuse care plans. The Social Worker said she did not initiate the substance abuse care plan. The Social Worker said the care plan was incomplete because it did not include the Resident's history of alcohol abuse and marijuana in the focus. The Social Worker also said the only intervention listed was the one initiated on 6/18/24 that indicated, offer substance abuse services and AA services. The Social Worker said the substance abuse care plan required more interventions. During a telephone interview on 7/10/24 at 2:13 P.M., the Social Worker said Resident #221's substance abuse care plan was not individualized. She said the intervention to offer AA services was not correct because the focus only identified opiate dependence. The Social Worker said the care plan should also identify the Resident's drugs and alcohol of choice and the Resident's most recent relapse date and risk of relapse. She said Resident #221's substance abuse care plan should be personalized. (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/8/24 at 2:29 P.M., , the Assistant Director of Nurses said Resident #221 should have individualized care plans with individualized interventions for histories of alcohol, marijuana and opoid dependence.

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	225147	A. Building B. Wing	07/09/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on observation, record review and interviews, the facility failed to meet professional standards of nursing practice for one Resident (#221) out of a sample of 27 Residents. Specifically, the facility failed to obtain a leave of absence physician's order for a resident with a history of drug dependence and recent relapse. Findings include: A review of the facility policy titled 'Substance Use Disorder Policy' with a revision date of November 2017 indicated the following: -The purpose of this policy is to identify residents prior to admission as they relate to substance use disorder. To identify all appropriate diagnoses or specific services needed as they relate to substance abuse/use on addiction and to determine risk for relapse and the level of supervision needed. Resident #221 was admitted to the facility in June 2024 with diagnoses including opioid dependence, alcohol use unspecified with alcohol induced mood disorder, and bacteremia. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 indicating intact cognition. Further review of the MDS indicated that the Resident was receiving medication through Intravenous (IV) therapy. A review of the hospital discharge summary dated 5/27/24-6/17/24 indicated the following: -Patient endorses drug and alcohol use but does not report on time of last use. Does report a history of complicated withdrawals from alcohol including seizures. Urine drug screen on admission positive for cocaine, fentanyl, buprenorphine, and benzodiazepines. Further review of the hospital discharge summary dated 5/28/24 indicated the following: -Social history: He/she reports current drug use. Drugs: Heroin, Fentanyl, Marijuana, and Crack cocaine. On 7/3/24 at approximately 9:39 A.M., the surveyor observed Resident #221 leaving the facility with a responsible party. A review of the sign out log indicated the Resident's responsible party signed out the Resident on 7/3/24 from 9:35 and signed him/her back in the facility at 10:00. [sic] A review of the July 2024 physician's orders failed to indicate a leave of absence order. (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview and chart review on 7/11/24 at 12:07 P.M., Nurse #6 reviewed Resident # 221's medical record and said he/she did not have any written telephone orders in the chart. She told the surveyor all the orders are acquired verbally from the Physician or Nurse Practitioner and added electronically into the medical record. Nurse #6 reviewed the electronic physician's orders and told the surveyor that Resident #221 did not have a leave of absence order. Nurse #6 said Resident #221 does leave the facility with a responsible party often, she said the responsible party signs him/her in and out. Nurse #6 said the Resident should have a physician's order before he/she is able to leave the facility with a responsible party. During a telephone interview on 7/11/24 at 10:50 A.M., the Physician said residents should have a leave of absence physicians orders prior to leaving the facility. He said Resident #221 is especially high risk because he/she has a history of substance abuse, he/she just had a recent relapse, and he/she has an intravenous (IV) port for medication. He said the Resident has the right to leave the facility with a responsible party but there has to be a physician's order in place.

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	225147	A. Building B. Wing	07/09/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observations, record reviews and interviews, the facility failed to adhere to quality standards of care for one Resident (#20), out of a total sample of 27 residents. Specifically, the facility failed to identify skin injuries on Resident #20. Findings include: Resident #20 was admitted to the facility in November of 2020 with diagnoses that include but are not limited to post traumatic seizures, atherosclerotic heart disease, muscle weakness, Crohn's disease of small intestine, cognitive communication deficit, cerebral infarction, and anxiety disorder. Review of Resident #20's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated staff assessed Resident #20 with severely impaired cognition and he/she was dependent on staff for all care and is incontinent of bladder and bowel. On 7/02/24 at 7:34 A.M., Resident #20 was observed resting on his/her bed. Resident #20 was uncovered and was observed to have a small dark, raised area on his/her left second toe. His/her third toe had a small area of raised skin. On 7/3/24 at 8:29 A.M., Resident #20 was resting on his/her bed. Resident #20 was observed to have a raised dark area on his/her left second toe and raised skin on his/her third toe. Review of the weekly skin assessment dated [DATE] indicated in the section describe and document any skin issues, was blank and skin condition was checked off as intact. During an interview on 7/3/24 at 9:22 A.M., Certified Nursing Assistant #4 said Resident #20 is dependent on staff for all daily care. CNA #4 observed Resident #20's left foot with the surveyor. CNA #4 said she did not know how to describe it, then said he/she has a dark small area of his/her second toe and a smaller area on the third toe which was white, peeled skin. CNA #4 said he/she has had that area, and she told the nurse about it before. CNA #4 said staff need to make sure they boost the Resident away from the bottom of the bed to protect his/her toes. During an interview on 7/3/24 at 9:34 A.M., Nurse #6 said if a skin injury is present on a resident, it should be documented on the skin check. Nurse #6 observed Resident #20, with the surveyor, and said the area on the left foot second toe is scabbing, dry not open and that she was not aware of it until now and will have to notify the doctor. Review of Resident #20's medical record progress notes from 5/27/24 through 7/2/24 did not indicate any entries regarding Resident #20's skin including areas on the left second and third toe. During an interview on 7/03/24 3:31 P.M., the Assistant Director of Nursing said she was not aware that Resident #20 had any skin injuries and that an incident report would need to be completed for any new skin injury.

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	225147	A. Building B. Wing	07/09/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview, the facility failed to ensure for one Resident (#20) out of a total sample of 27 residents that professional standards of practice were adhered to for the prevention of developing pressure ulcers/skin injuries. Specifically, the facility failed to implement physician's orders for weekly skin evaluations. Findings include: Review of the facility's policy, entitled Pressure Ulcers/Skin Breakdown-Clinical Protocol, not dated included but was not limited to the following: The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers, for example immobility, recent weight loss, and a history of pressure ulcer(s) Review of the facility's policy entitled 'Pressure Injury Risk Assessment, not dated included but was not limited to the following: The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents, as risk of developing pressure injuries or worsening of existing pressure (PIs). General Guidelines 2. Risk factor that increase a resident's susceptibility to develop or to not heal PIs include, but are not limited to: a. Under nutrition, malnutrition, and hydration deficits. b. Impaired/decreased mobility and decreased functional ability; c. The presence of previously healed PI; d. The presence of existing PI; e. Exposure of skin to urinary and fecal incontinence or other sources of moisture; f. Elevated body temperature g. Altered skin status over pressure points h. Impaired perfusion, oxygenation or circulation deficits for example, general atherosclerosis or lower extremity arterial insufficiency; i. Conditions, such as end stage renal disease thyroid disease or diabetes mellitus; j. Drugs such as steroids that may affect healing; k. Advanced age; l. Impaired sensory perception; (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	m. Cognitive impairment; and n. Resident refusal of some aspects of care and treatment. The risk assessment should be conducted as soon as possible after admission, but no later than eight hours after admission is completed. Once the assessment is conducted and risk factors are identified and characterized, a resident-centered care pan can be created to address the modifiable risks for pressure injuries. Repeat the risk assessment if there is a significant change in condition and as needed. Resident #20 was admitted to the facility in November of 2020 with diagnoses that include but are not limited to post traumatic seizures, atherosclerotic heart disease, muscle weakness, Crohn's disease of small intestine, cognitive communication deficit, cerebral infarction, and anxiety disorder. Review of Resident #20's most recent Minimum Data Set assessment dated [DATE] indicated staff assessed Resident #20 with a severely impaired cognition and he/she was dependent on staff for all care and is incontinent of bladder and bowel. On 7/2/24 at 7:34 A.M., Resident #20 was observed resting in his/her bed. Resident #20 was uncovered, talking to him/herself, and was slight in stature and frail. Review of Resident #20's medical record indicated the following: -A care plan dated 11/30/22 indicated Resident #20 has a potential for pressure injury development r/t (related to) HX (history) of ulcers, immobility, incontinence with an intervention: Follow facility policies/protocols for the prevention/treatment of skin breakdown. - A Norton risk Assessment for developing pressure ulcers dated 7/1/23 indicated a score of 6 indicating Resident #20 as high risk for developing pressure ulcers. Review of the current active physician's orders indicated the following: -Weekly skin checks 11-7 shift and document findings on PCC (electronic medical record) under the assessment tab, every night shift every Mon (Monday) for skin risk assessment, dated 12/16/22. Review of the assessment tab in Resident #20's medical record indicated a skin assessment dated [DATE]. There were no further skin assessments resulting in two weeks of skin assessments not conducted. During an interview on 07/03/24 at 9:34 A.M. Nurse #6 said the nursing staff perform weekly skin checks on all residents and document the skin check on the assessment in the medical record. Nurse #6 reviewed the weekly skin checks in the medical record for Resident #20 and said there were two weeks that the skin checks were not documented in PCC (the electronic medical record). Nurse #6 said Resident #20 was at risk for pressure areas. (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/3/24 at 3:31 P.M., the Assistant Director of Nursing (ADON) said weekly skin checks should be completed per the doctor's orders and documented on the skin assessment in PCC. The ADON said Resident #20 is behavioral and may have refused the weekly skin assessments and if that were the case the nurse would document the refusals in a progress note. Review of progress notes dated from 5/27/24 through 7/2/24 did not indicate any progress notes regarding Resident #20 refusing weekly skin assessments.

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	225147	A. Building B. Wing	07/09/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observation, record review, and interview, the facility failed to ensure that the resident environment remained free of accident hazards for one Resident (#34) out of a total sample of 27 residents. Specifically, the facility failed to ensure that the smoking policy was adhered to, resulting in Resident #34 having numerous smoking materials in his/her room and smoking in his/her room. Findings include: Review of the facility policy titled Smoking Policy - Residents, undated, indicated the following: -Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. - Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Smoking is not allowed inside the facility under any circumstances. - Any smoking -related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to those issues. - The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. - Residents without independent smoking privileges may not have or keep any smoking articles, including cigarettes, tobacco, etc. except when they are under direct supervision. Resident #34 was admitted to the facility in August 2023 with diagnoses including end stage renal disease and type 2 diabetes mellitus. Review of Resident #34's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident has a Brief Interview for Mental Status score of 15 out of a possible 15 indicating intact cognition. Further review of the MDS indicated that Resident #34 requires staff assistance with activities of daily living. The surveyor made the following observation and interview: - On 7/2/24 at 10:38 A.M., the surveyor opened Resident #34's bedroom door and a very strong odor of marijuana was present. A facility contracted phlebotomist also entered the room and she said it smelled very strongly of marijuana. Resident #34 was not in his/her room, Resident #34's roommate said the resident smokes marijuana with a vape pen in the room. Review of Resident #34's Smoking Assessment, dated 5/17/24 indicated that the Resident is a smoker, and the facility is to hold Resident #34's smoking materials for him/her. (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #34's smoking care plan dated 12/11/23 indicated the following intervention dated 9/19/23: Educate on smoking policy, monitor smoking. Review of Resident #34's nursing progress notes indicated the following: - Dated 11/15/23 at 9:06 P.M.: Non compliant with smoke schedule. Suspicious of smoking in room, no evidence to prove the smoking, but the smell was unbearable. - Dated 1/5/24 at 8:46 P.M.: Patient found smoking in his/her room at 8 am in the morning not following smoking facility protocol. - Dated 3/10/24 at 11:05 P.M.: Patient in room most part of the day, about 1, could smell smoke of cigarettes for the patient room. They continue to smoke in the room, unable to redirect due to avoid altercation. - Dated 6/7/24 at 10:21 A.M.: Resident #34 had a discussion with administrator regarding smoking inside the building. The surveyor made the following observations and interviews: - On 7/2/24 at 12:16 P.M., Resident #34 was lying in his/her bed, his/her bedroom had a very strong odor of marijuana. A marijuana vape pen was observed on his/her bedside table within reach of the resident. - On 7/3/24 at 8:21 A.M., Resident #34's bedroom door was slightly opened, a strong smell of cigarettes was coming from the room. - During an interview on 7/3/24 at 8:36 A.M., the Administrator approached the surveyor and said Resident #34 has a history of smoking in his/her room and said no smoking materials are allowed in Resident #34's room. The surveyor made the Administrator aware that Resident #34 had a marijuana vape pen in his/her room and showed him a photo of the vape pen. The Administrator proceeded to enter Resident #34's room and confiscate the marijuana vape pen. The Administrator showed the marijuana vape pen to the surveyor. - During an observation on 7/8/24 at 7:37 A.M., the surveyor observed Resident #34's bedroom smelling strongly of marijuana. - During an interview on 7/8/24 at 7:43 A.M., Certified Nursing Assistant (CNA) #1 said Resident #34 has always smoked in his/her room. CNA #1 continued to say we have found pieces of marijuana under his/her bed and a few months ago, Resident #34 set his/her bed sheet on fire from smoking. CNA #1 said the hallway always smells like marijuana or cigarettes and it is a safety concern. - During an interview on 7/8/24 at 8:08 A.M., the Administrator said Resident #34 having smoking materials in his/her room and smoking in the facility is a safety concern and he was not aware of the safety instances from months ago. The Administrator told the surveyor that he confiscated a pack of cigarettes from Resident #34's bedside table once he heard complaints of the hallway smelling like smoke. (continued on next page)

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	07/09/2024

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- During an interview on 7/8/24 at 8:35 A.M., the Assistant Director of Nursing said Residents should not be smoking in the facility. - During an observation on 7/8/24 at approximately 11:50 A.M., Resident #34 was observed in his wheelchair coming from his/her bedroom, he/she had a pack of cigarettes between his/her legs.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview, the facility failed to address the nutrition and hydration status of three Residents (#57, #32, #34) out of a total sample of 27 residents. Specifically, the facility failed to: 1. Ensure a physician's order for an altered diet was obtained and appropriate for Resident #57. 2. Ensure the physician's orders were implemented for weekly weights and a re-weigh was obtained for Resident #32 whose recorded weight had a gain of 5% more than the previous month weight. 3. Obtain weights for pre and post dialysis treatment for Resident #34. Findings include: Review of the policy entitled 'Interdepartmental Notification of Diet (Including Changes and Reports), not dated indicated the following: Nursing services shall notify the food and nutrition service department of a residence diet orders, including any changes in the residence diet, meal service, and food preferences. 1. When a new resident is admitted , or a diet has been changed, the nurse supervisor shall ensure that the food and nutrition services department receives a written notice of the diet order. Review of the facility policy with the title, Subject: Weight Measurement, dated revised 2/2022 indicated 1. Weight will be obtained on all residents on admission. 3. All residents will be weighed at a minimum monthly. Procedure: 3. Residents with a weight variance of 5% more or less than the previous month will be re-weighed. 1. For Resident #57 the facility failed to ensure a diet order was obtained and was an appropriate diet upon admission to the facility. Resident #57 was admitted to the facility in April of 2024 with diagnoses that include but not limited to Huntington's disease (a neurodegenerative disease that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotions), ataxic gait, unspecified severe protein-calorie malnutrition, adult failure to thrive and hearing impairment. Review of Resident #57's Minimum Data Set assessment (MDS) dated [DATE] indicated Resident #57 had a Brief Interview of Mental Status exam score of 6 out of 15 which indicates a severe cognitive impairment, absence of useful hearing, requires supervision for eating, and complains of difficulty or pain with swallowing. On 7/02/24 at 12:01 P.M., Resident #57 was observed eating lunch in his/her room, consisting of puree food on a plate. (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician discharge summary indicated the following: #frailty, #failure to thrive, #Severe protein calorie nutrition, # Hypophosphatemia. Has been (Resident #57) drinking exclusively liquids. Drinks plenty of ensure, milk, juice. Still not eating solid foods, even after change to mechanically soft consistency. Ultimately changed to a full liquid diet. Further review of the discharge summary indicated: -Diet: full liquid with ensure plus high protein 3 times daily. Review of Resident #57's medical record indicated the following: -The physician's orders failed to indicate an admission diet order. -A diet requisition form signed and dated by Nurse #1 on 4/19/24, indicated: new admission, nutrient content: regular, texture: regular. -NSG (nursing): Admission/Readmission evaluation V2, indicated Diet and consistency: regular dated 4/23/24 and no swallowing problem. During an interview on 7/2/24 at 12:48 P.M., Nurse #1 said when a resident is admitted a nursing assessment is completed, the discharge summary is reviewed and the doctor, nurse practitioner or on call medical service is called to verify the medication orders. When asked about other orders, Nurse #1 said treatment orders and diet orders would be reported to the doctor, nurse practitioner or covering medical service to verify and obtain orders. Nurse #1 said when Resident #57 was admitted she helped the nurse doing the admission and was told to fill out the diet requisition form for a regular diet, regular texture. Nurse #1 said they will follow the diet order from the discharge summary, write a physician's order and send the diet requisition to the kitchen. During an interview on 7/02/24 at 2:37 P.M., Nurse #9 said she was the nurse who did Resident #57's admission. Nurse #9 said the nursing staff call the Doctor or Nurse Practitioner to verify medication orders or make changes as ordered. Nurse #9 said the diet order from the discharge summary is used to determine the diet order unless indicated otherwise by verbal report from the hospital. Nurse #9 said she did not recall if a verbal report indicating a regular diet was obtained. Review of the medical record did not indicate any verbal report was obtained for Resident #57 to have a regular diet, nor were any diet orders in the physician's orders. Review of the Speech Therapy Evaluation dated 4/23/24 indicated Resident #57 had the diagnoses of dysphagia (a swallowing disorder) Further the evaluation indicated Pt (patient) was referred for a comprehensive evaluation due to new onset of difficulty with swallowing. During an interview on 7/3/24 at 12:37 P.M., The Speech Language Pathologist (SLP) said Resident #57 would have a swallowing risk related to the Huntington's disease diagnosis. The SLP said she did not know that Resident #57 was discharged from the hospital with an order for a full liquid diet. The SLP said the admission nurse would obtain the diet order. The SLP said she screens residents who require altered diets. The SLP said Resident #57 should not have gone from a full liquid diet to a regular diet without an clinical assessment. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/8/24 at 1:21 P.M., the facility Medical Director who is Resident #57's physician said if a resident was on a liquid diet in the hospital and it was on the discharge summary, he would continue that diet unit further assessment was completed. 2. Resident #32 was admitted to the facility in March 2024 with diagnoses that include but not limited to hyperlipidemia, intracerebral hemorrhage, and unspecified dementia. Review of Resident #32's Minimum Data Set assessment (MDS) dated [DATE] indicated Resident #32 scored a 7 out of 15 on the Brief Interview for Mental Status exam indicating Resident #32 had severe cognitive impairment and required partial to moderate assistance with personal hygiene, toileting and bathing. Review of the current physician's orders indicated the following: Weekly weight for 4 weeks every evening shift every Monday, dated 3/18/24. Review of the Resident #32's weight recorded in the medical record indicated the following: -3/18/24 112.0 -4/1/24 112.0 -5/8/24 115.0 -6/5/24 196 .0 Review of the recorded weights failed to indicate the physician's order for weekly weight was implemented with two weekly weights not recorded. Further, the increase between Resident #15's weight between 5/8/24 and 6/5/24 exceeded a 5% gain and the medical record failed to have a re-weigh to verify the weight. During an interview on 7/3/24 at 8:09 A.M., Nurse #6 said the Certified Nursing Assistants obtain resident weights and the nurses put it in the PCC (the electronic medical record). During an interview on 7/3/24 at 10:14 A.M., The Assistant Director of Nursing said she believes firmly that the weight on 6/5/24 at 196.0 was a data entry error and that it still needed to be verified and that she struck it out and asked for a reweigh of the Resident. During an interview on 7/8/24 at 1:29 P.M., The Registered Dietician said if a significant weight change is recorded then a re-weigh would be done to determine if the weight change is true. 45984 3. Resident #34 was admitted to the facility in August 2023 with diagnoses including end stage renal disease and type 2 diabetes mellitus. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #34's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident has a Brief Interview for Mental Status score of 15 out of a possible 15 indicating intact cognition. Further review of the MDS indicated that Resident #34 requires staff assistance with activities of daily living. Review of Resident #34's physician's order dated 8/23/23 indicated the following: - Patient goes to dialysis every Tuesday, Thursday and Saturday, pick up at 5am Review of Resident #34's dialysis care plan revised and dated 9/19/23 indicated the following intervention: - Weight Resident #34 before and after dialysis Review of Resident #34's Dialysis book located at the first floor nursing station indicated that the entire book was blank and no information was written in it. Review of Resident #34's paper medical chart indicated the following days where communication forms were completed containing pre and post weights for dialysis treatment: - 8/31/23, 9/12/23, 9/23/23, 9/28/23, 10/5/23, 10/7/23, 10/19/23, 11/2/23, 11/30/23, 12/2/23, 12/16/23, 12/21/23, 12/30/23, 1/2/24, 1/4/24, 1/9/24, 1/18/24, 1/25/24, 1/29/24, 2/6/24 and 2/24/24. Review of Resident #34's weight log in the electronic medical record indicated the following weights: - 8/23/23: 191.4 lbs. (pounds) - 9/7/23: 200.0 lbs. - 9/22/23: 198.3 lbs. - 10/5/23: 213.9 lbs. - 11/1/23: 207.0 lbs. - 11/2/23: 204.7 lbs. - 11/24/23: 204.6 lbs. - 12/5/23: 202.4 lbs. - 1/19/24: 207.0 lbs. - 1/26/24: 207.4 lbs. - 2/1/24: 208.6 lbs. (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/23/24: 208.0 lbs. - 3/6/24: 210.2 lbs. - 4/3/24: 214.6 lbs. - 5/3/24: 214.6 lbs. - 5/21/24: 217.0 lbs. - 7/5/24: 215.1 lbs. During an interview on 7/8/24 at 11:06 A.M., Nurse #1 said when a resident goes to dialysis they should be taking their dialysis communication book with them and someone from the facility reviews it when they return for any relevant information including the resident's weight. Nurse #1 and the surveyor looked through Resident #34's dialysis book and Nurse #1 was not sure why it was empty. During an interview on 7/8/24 at 12:38 P.M., the Assistant Director of Nursing (ADON) said each resident who receives dialysis has their own communication book they take to and from dialysis treatment. The ADON and the surveyor reviewed Resident #34's dialysis book and when asked why it was blank the ADON said he/she must have lost it at dialysis. The DON said Resident #34 should have a filled-out dialysis book. The ADON and the surveyor reviewed Resident #34's paper medical chart and the ADON was unable to answer why no dialysis information including Resident #34's pre and post dialysis weights were documented since 2/24/24. During a phone interview on 7/8/24 at 1:21 P.M., the facility's oversight Registered Dietitian (RD) who schedules which RD's are working at the facility said the facility just started using this company for consulting registered dietitians. The RD continued to say that the facility should be obtaining pre and post dialysis weights to have an accurate weight for Resident #34 as dialysis treatment can cause a lot of change in the Resident's fluids. The RD continued to say monthly weights cannot be relied on since weight trends need to be observed by obtaining pre and post dialysis weights as Resident #34 goes to dialysis three times per week.

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	225147	A. Building B. Wing	07/09/2024

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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** 45984 Based on observation, policy review, record review, and interview the facility failed to ensure staff provided professional standards of care related to replacing the oxygen tubing as ordered by the physician and maintaining the nasal cannula in a sanitary condition for one Residents (#22) out of a total sample of 27 residents. Findings include: Review of the facility policy titled Oxygen Use, dated and revised April 2022, indicated the following: - Verify that there is a physician's order for this procedure. Review the Physician's orders or facility protocol for oxygen administration. Resident #22 was admitted to the facility in April 2016 with diagnoses including Chronic Obstructive Pulmonary Disease, shortness of breath and schizophrenia. Review of Resident #22's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 11 out of a possible 15 indicating that the Resident has moderate cognitive impairment. Further review of the MDS indicated that Resident #22 received oxygen therapy. The surveyor made the following observations: - On 7/2/24 at 9:42 A.M., Resident #22 was lying in his/her bed, not using his/her oxygen. The oxygen tubing had a piece of tape on it with the date 6/17 written on it. The nasal cannula (the part that goes into the resident's nose to breath in the oxygen) part of the oxygen tubing was directly on the floor. - On 7/2/24 at 12:25 P.M., Resident #22's oxygen tubing had a piece of tape on it with the date 6/17 written on it. - On 7/3/24 at 7:37 A.M., Resident #22 was sleeping in his/her bed, not using his/her oxygen. The oxygen tubing had a piece of tape on it with the date 6/17 written on it. The nasal cannula part of the oxygen tubing was directly on the floor. - On 7/8/24 at 7:41 A.M., Resident #22 was lying in his/her bed, not using his/her oxygen. The oxygen tubing had a piece of tape on it with the date 6/17 written on it. The nasal cannula part of the oxygen tubing was directly on the floor. Resident #22 said he/she uses his/her oxygen at nighttime to breathe better. The resident continued to say that staff have not changed the tubing in a few weeks since they are always busy. (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/8/24 at 7:48 A.M., Nurse #1 said oxygen tubing should be changed weekly and it should be documented when it happens. Nurse #1 and the surveyor went into Resident #22's room and observed the oxygen tubing with a piece of tape on it with the date 6/17 written on it as well as the nasal cannula directly on the floor. Nurse #1 said the tubing should have been changed since then and the tubing should not be on the floor as it is dirty. Nurse #1 proceeded to change the tubing. Review of Resident #22's physician's orders indicated the following: - Dated 4/28/24: Change oxygen tubing one time each week on Mondays 11-7 shift as needed - Dated 5/1/24: Change O2 (oxygen) tubing once a week every Monday night 11-7 every evening shift every Mon (Monday) - Dated 7/2/24: Oxygen 2-4L (liters) NC (nasal cannula) as needed for spo2 (oxygen concentration) less than 90%. Review of Resident #22's Treatment Administration Record (TAR) for June and July 2024 indicated that his/her oxygen tubing was documented as being changed on 6/17/24, 6/24/24 and 7/1/24. Review of Resident #22's oxygen therapy PRN (as needed) care plan, last revised on 7/19/23, indicated the following interventions: -Dated 3/21/22: Change O2 tubing weekly every Wednesday on 11-7 - Dated 7/2/24: Use of O2 2-4L PRN During an interview on 7/8/24 at 8:40 A.M., the Assistant Director of Nursing (ADON) said oxygen tubing should be changed weekly. The surveyor showed the ADON photos of Resident #22's oxygen tubing with the tape on it dated 6/17, the ADON said regardless of the tubing being dated 6/17 she said she can assure it was changed. The surveyor then asked if the tubing was documented as being changed three times since the date of 6/17, why would staff put a piece of tape back on the new tubing with the old date of 6/17. The ADON was unable to answer. The surveyor then asked the ADON if the oxygen tubing was on the directly on the floor should it be changed, and the ADON said only if it is visibly dirty. The surveyor asked the ADON if the tubing could be dirty without visible dirt on it and the ADON was unable to answer the question. The ADON said oxygen tubing should not be directly on the floor. During an interview on 7/8/24 at 8:52 A.M., Nurse #1 said she is not sure why an old date was written on Resident #22's oxygen tubing. Nurse #1 said Resident #22 is alert and oriented and able to make sense of his/her surroundings.

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	225147	A. Building B. Wing	07/09/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observation, record review and interview, the facility failed to ensure services consistent with professional standards were provided for one Resident (#34) who required dialysis (a procedure to remove waste products and excess fluid from the body when the kidneys stop working properly), out of total sample of 27 residents. Specifically, the facility failed to keep an updated communication book for dialysis care and ensure it was accompanying Resident #34 to and from dialysis care. Findings include: Review of the facility policy titled Dialysis Patients, undated, indicated the following: - A dialysis communication form will be sent with the patient in case of documentation with the facility and the dialysis center Resident #34 was admitted to the facility in August 2023 with diagnoses including end stage renal disease and type 2 diabetes mellitus. Review of Resident #34's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident has a Brief Interview for Mental Status score of 15 out of a possible 15 indicating intact cognition. Further review of the MDS indicated that Resident #34 requires staff assistance with activities of daily living. The surveyor made the following observation: -On 7/2/24 at 11:46 A.M., Resident #34 was observed returning from dialysis from a transportation vehicle. As the Resident entered the building, he/she did not have a dialysis communication book with him/her. Review of Resident #34's Dialysis book located at the first floor nursing station indicated that the entire book was blank and no information was written in it. Review of Resident #34's physician's order dated 8/23/23 indicated the following: - Patient goes to dialysis every Tuesday, Thursday and Saturday, pick up at 5am Review of Resident #34's dialysis care plan revised and dated 9/19/23 indicated the following intervention: - Dated 2/20/24: Ensure Resident #34 to go for the scheduled dialysis appointments 3x weekly. Review of Resident #34's paper medical chart indicated the following days where communication forms were completed for dialysis treatment: - 8/31/23, 9/12/23, 9/23/23, 9/28/23, 10/5/23, 10/7/23, 10/19/23, 11/2/23, 11/30/23, 12/2/23, 12/16/23, 12/21/23, 12/30/23, 1/2/24, 1/4/24, 1/9/24, 1/18/24, 1/25/24, 1/29/24, 2/6/24 and 2/24/24. (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No communication forms were identified since 2/24/24. During an interview on 7/8/24 at 11:06 A.M., Nurse #1 said when a resident goes to dialysis they should be taking their dialysis communication book with them and someone from the facility reviews it when they return for any relevant information. Nurse #1 and the surveyor looked through Resident #34's dialysis book and Nurse #1 was not sure why it was empty. During an interview on 7/8/24 at 12:38 P.M., the Assistant Director of Nursing (ADON) said each resident who receives dialysis has their own communication book they take to and from dialysis treatment. The ADON and the surveyor reviewed Resident #34's dialysis book and when asked why it was blank the ADON said he/she must have lost it at dialysis. The ADON said Resident #34 should have a filled-out dialysis book. The ADON and the surveyor reviewed Resident #34's paper medical chart and the ADON was unable to answer why no dialysis information was documented since 2/24/24.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36431 Based on records reviewed and interviews, the facility failed to have sufficient staffing. Specifically, the facility failed to provide sufficient staffing, particularly on the weekend shift, during FY 24 (fiscal year) Quarter 2. Findings include: Review of the Centers of Medicare and Medicaid (CMS) PBJ (payroll-based journal) Staffing Data Report FY (fiscal year) Quarter 2 (January 1-March 31) indicated the facility triggered for excessively low weekend staffing. Review of the Facility's Assessment 2024 indicated the following: The facility services individuals who have one or more chronic or co-morbid conditions. Our overall resident consists of residents with diagnosis (sic) of CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease, high blood pressure and diabetes. -Staffing plan. The interdisciplinary team along with the Nurses CNAs (certified Nursing assistants) review each resident and assignment. Resident care needs are reviewed and updated (as needed) to assist both resident and staff to provide consistent care. The Director of Nursing reviews with the scheduler the staffing patterns on each floor to ensure staffing patterns are appropriate. The facility does engage with staffing agencies to assist in filling critical vacancies. During an interview on 7/08/24 at 4:06 P.M., the Administrator said the said the PPD (referring to Hours Per Patient Day) ideally should be 3.1 or better. The Administrator said he recently started at the facility and did not know the facility reported low weekend staffing on the PBJ report for Quarter 2. During an interview on 7/3/24 at 8:51 A.M., CNA #4 said the second floor is scheduled to have four CNAs on the day shift. CNA #4 said sometimes we may have only three (CNAs) so we divide the assignments giving each CNA 12 or 13 residents each to care for which takes longer because many require 2-person assistance and about 8 residents require assistance to be fed. CNA #4 said weekends can be messy, they are not always able to fill holes in the schedule. CNA #4 said there is less support on the weekend and that the nursing staff do try to help. During an interview with the facility scheduler on 7/9/24 at 10:59 A.M., she said the first part of the year was difficult for staffing. That they were not always able to fill holes in the schedule. The Scheduler said they make calls to find replacements, but it is hard to get people to work. The Scheduler said for day shift the first floor is scheduled to have 2 licensed staff nurses and four CNAs, the second shift is scheduled to have 2 licensed nurses and three CNAs, and the night shift is scheduled to have one licensed nurse and two CNAs. For the second floor the scheduler said the first shift is scheduled to have two licensed nurses and four CNAs, evening shift two licensed nurses and three CNAs and night shift, one licensed nurse and two CNAs. (continued on next page)

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	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the weekend staffing for 2024 Quarter 2 (January 1-March 31) indicated the following: The facility census average for January 2024 was 71.7. Reivew of the weekend staffing for January 2024 indicated the following: -Saturday January 20, 2024, had a PPD of 3.12. -Sunday January 21, 2024, had a PPD of 3.17. -Saturday January 27, 2024, had a PPD of 3.14 and the day shift had two aids scheduled on the fist floor and one called out. The facility census average for February 2024 was 70.9 Review of the weekend staffing for February 2024 indicated the following: -Saturday February 3, 2024, had a PPD of 3.09 -Sunday February 4, 2024, had a PPD of 3.14 -Saturday February 24, 2024, had a PPD of 3.14 -Sunday February 25, 2024, had a PPD of 3.14. The facility census average for March 2024 was 70.2 -Saturday March 2, 2024, had a PPD of 3.14 -Sunday March 3, 2024, had a PPD of 3.14 -Sunday March 10, 2024, had a PPD of 3.09. -Saturday March 16, 2024, had a PPD of 2.90 -Sunday March 17, 2024, had a PPD of 3.14 -Saturday, March 23, 2024, had a PPD of 3.05 -Saturday March 30, 2024, had a PPD of 3.16 -Sunday March 31, 2024, had a PPD of 2.10 Of 26 weekend days from January 1, 2024, through March 31, 2024, five were below a PPD of 3.1 and ten were just above 3.1.

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	225147	A. Building B. Wing	07/09/2024

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on interviews and record review, the facility failed to provide substance use services for one Resident (#221) out of a sample of 27 Residents. Specifically, the facility failed to: 1. Provide mental health services for Resident #221, who had a recent substance use relapse. 2. Offer and provide Resident #221 support programs that include Alcoholic Anonymous (AA) and Narcotics Anonymous (NA) meetings. 3. Have qualified staff to manage the support program meetings, AA and NA in the facility. Findings include: A review of the facility policy titled 'Substance Use Disorder Policy' with a revision date of November 2017 indicated the following: -The purpose of this policy is to identify residents prior to admission as they relate to substance use disorder. To identify all appropriate diagnoses or specific services needed as they relate to substance abuse/use on addiction and to determine risk for relapse and the level of supervision needed. -The clinical liaisons/admission coordinators will be responsible to alert the Director of Nurses and Social Services of a screen with risk for relapse. -If the patient is admitted , the nursing staff must be alerted by the admission coordinator of the risk of relapse. -Social Service staff will alert the contacted mental health service staff of the need for the resident to be seen specifically for management of relapse risk or maintenance of sobriety. -Social Service will assess the resident to identify risk and to put a plan of care in place. -The resident will also be assessed to determine current substance use history per the following criteria: Active use history-0-3 months, Early remission-4-12 months, Remote history-12 months or greater. -Mental health services clinicians need to see the resident at risk. -Mental health services clinicians need to report back to the Director of Social Services or Director of Nurses after consult to ensure that the appropriate follow through is being conducted. -Social services will work on setting up support groups in collaboration with the Activities department to provide adequate support to the residents, as allowed by the resident. -The Nursing staff and Social Services staff will provide education on relapse risk and prevention, as allowed by the resident. (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #221 was admitted to the facility in June 2024 with diagnoses including opioid dependence, alcohol use unspecified with alcohol induced mood disorder and bacteremia. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 indicating intact cognition. Further review of the MDS indicated that the Resident was receiving medication through Intravenous (IV) therapy. During an interview on 7/2/24 at 12:54 P.M., Resident #221 said he/she has a history of ingesting drugs and alcohol. He/she said he/she relapsed on 5/24/24, he/she said he/she used cocaine and heroin. Resident #221 said he/she has never met the facility Social Worker and has never been offered AA or NA meetings. The Resident said he/she is interested in the meetings. Resident #221 said he/she has not met with a Psychiatric Nurse Practitioner. Resident #221 said he/she signed a consent to receive behavioral health services at admission. A review of the hospital discharge summary dated 5/27/24-6/17/24 indicated the following: -Patient endorses drug and alcohol use but does not report on time of last use. Does report a history of complicated withdrawals from alcohol including seizures. Urine drug screen on admission positive for cocaine, fentanyl, buprenorphine, and benzodiazepines. Further review of the hospital discharge summary dated 5/28/24 indicated the following: -Social history: He/she reports current drug use. Drugs: Heroin, Fentanyl, Marijuana, and Crack cocaine A review of the social services evaluation admitted d 6/25/24 indicated the following psychosocial evaluation: -Drug or ETOH (Alcohol) Abuse: Yes -History of ETOH/Drug Abuse: Yes -Describe History-N/A (Not Applicable) A review of the social service admission notes dated 6/25/24 indicated the following: -Resident was admitted to the facility on [DATE] following an extended inpatient hospitalization (05/27/24 -6/18/24). Resident presented to hospital ED (Emergency Department) with back pain and elevated inflammation following a physical assault and a history of complicated withdrawals from ETOH including seizures. Past medical issues include Polysubstance Abuse, Hepatitis, Abscess of right lower limb, and Bacteremia. A referral has been placed to Health Drive for 1:1 counseling as necessitates. Resident is alert and oriented x3 and demonstrates the requisite thoughtfulness dialogue involved in finding capacity. He/she is able to articulate preferences and identify risks and benefits of treatment or lack of treatment. (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the health drive referral form signed and dated on 6/18/24 by the Resident indicated that the Resident had requested to be seen for behavioral health services. During a telephone interview on 7/8/24 at 11:47 A.M., the Psychiatric Nurse Practitioner said she comes to the facility weekly, she said she has not received Resident #221's behavioral health referral, she said the Resident would benefit from mental health services especially since he/she had just relapsed. She said the Resident is at high risk for relapse without support. During an interview on 7/9/24 at 8:30 A.M., The Activities Director said the facility has not had a qualified substance abuse counselor for at least five months. The Activities Director said the residents are currently running their own AA meetings every Thursday, he said the resident council president runs the meeting. During an interview on 7/9/24 at 9:11 A.M., the resident council president, Resident #45 said he/she announces and runs the AA meeting every Thursday. He/she said the meeting has not had a qualified substance abuse counselor for a year. He/she said at least three other Residents attend the AA meeting regularly. He/she said the Residents need the meetings for support and since the facility does not have a qualified substance abuse counselor, he/she runs the meeting. A review of Resident #45's most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Status (BIMS) score of 15 out of a possible 15 indicating intact cognition. During an interview on 7/8/24 at 9:02 A.M., the Social Worker said she was not aware the Resident had just relapsed before being hospitalized , she said she was not aware of the different types of drugs the Resident ingests. She said she did not read the hospital discharge summary thoroughly therefore she did not write a thorough social service admission note. The Social Worker said she did not complete a thorough psychosocial assessment when she met with the Resident. She said she was not aware that the Psychiatric Nurse had not yet seen the Resident. The Social Worker said the Resident signed the consent to be seen by the Psychiatric Nurse on 6/18/24. The Social Worker said based on her admission note and assessment, she did not offer support group services, AA and NA meetings to the Resident. The Social Worker said she was not aware how long the facility has not had a qualified substance abuse counselor; she said Residents run the AA meetings on their own. The Social Worker said residents should have a qualified substance abuse counselor during the AA/NA meetings. During an interview on 7/8/24 at 12:49 P.M., the Assistant Director of Nurses (ADON) said Resident #221 should receive services by behavioral health if he/she gave consent at admission and because he/she is a high risk for relapse. The ADON said all residents with an active history of substance abuse should be seen by the Psychiatric Nurse Practitioner. She said she did not know how long the facility has not had a qualified substance abuse counselor, she said all residents with a history of substance abuse should be offered substance abuse support group services at admission. During an interview on 7/9/24 at 10:30 A.M., the Administrator said residents with a history of substance abuse should be offered support services and be provided mental health services if they have consented. He said the facility has not had a substance abuse counselor for a period of 5-12 months. He said his marketing team just sent an email on 6/25/24 looking for a qualified substance abuse counselor. The Administrator provided a list of 14 Residents currently in the facility with a history of substance use. He said the facility should always have a qualified substance abuse counselor if they admit residents with a history of substance abuse. He said residents should not be running AA meetings without a qualified substance abuse counselor.

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	225147	A. Building B. Wing	07/09/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, record review, interview and policy review, the facility failed to ensure medications were stored as required for one Resident (#27), out of a total of 27 sampled residents and ensure staff stored drugs and biologicals in accordance with State and Federal laws. Specifically, the facility failed to: 1. Ensure that medication cart was not left open and medications were not left on top of the medication cart unsupervised during medication pass. 2. Ensure that medications were properly labeled in the medication cart. 3. Ensure a medication cart was functioning properly resulting in it not locking and the medication storage room was locked on the first-floor unit. 4. Ensure that medication was not left at the bedside for Resident #27 while unsupervised by staff. Findings include: Review of the facility policy titled Administering Medication, undated, indicated the following: - During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. - The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. - Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. Review of the facility policy titled Storage of Medications, undated, indicated the following: - Drugs and biological's used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. - The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. - Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biological's are locked when not in use. Unlocked medication carts are not left unattended. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During medication pass on 7/3/24, at 8:30 A.M., the surveyor observed Nurse #5 leave the medication cart open, walk down the hall to the medication storage room to get a medication that was not in the medication cart. The surveyor then observed Nurse #5 at 8:35 A.M., leave 2 medications on top of the medication cart and enter a room to administer medication to a resident. The surveyor then observed Nurse #5 at 8:41 A.M., leave 2 medications on top of the medication cart and walk down the hallway to obtain a blood pressure cuff. During an interview on 7/3/24, at 8:42 A.M., Nurse #5 said that he should not have left the medication cart open and should not have left the medications on top of the medication cart. 2. On 7/6/24, at 9:33 A.M., the surveyor observed the following in the medication cart on second floor: 1 bottle of Latanoprost eye drops open and without a date. 1 bottle of Visine eye drops open and without a date. 2 bottles of Artificial tears open and without a date. 1 tube of Erythromycin eye ointment open and without a date. 1 tube of Neomycin and Polymyxin B ointment open and without a date. 1 bottle of liquid protein open and without a date. Review of the manufacture's directions indicated the protein expires three months after opening. On 7/6/24, at 9:33 A.M. Nurse #6 said that the eye medication should all be dated when they are opened because they expire 28 days after opening. Nurse #6 did not know how long the liquid protein was good for after opening. 45984 3. The surveyor made the following observation: - On 7/2/24 at 1:25 P.M., the door to the medication storage room was left opened, the surveyor was able to push it open, no staff were in the medication room. On the door was a sign that said 1/1/23 Please lock the med room at all times. During an interview, Nurse #1 said the medication room should be locked at all times. - On 7/3/24 at 8:20 A.M., the surveyor observed an unattended medication cart on the first floor, no staff were within sight of the cart. The surveyor was able to pull open the drawers of the medication cart containing medication. Nurse #3 came back to the cart and said the cart should be locked when unattended. Nurse #3 proceeded to lock the cart but the surveyor was able to open the cart when it was locked. Nurse #3 said it is not locking properly. The Maintenance Director approached the cart and said the cart is not locking properly as it should not be able to be opened when it is in the locked setting. The Assistant Director of Nursing said the cart needs to be locked properly and the cart is not functioning properly. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #27 was admitted to the facility in March 2024 with diagnoses including post laminectomy syndrome, unspecified syndrome to the head, Alzheimer's disease and dysphagia. Review of Resident #27's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 7 out of a possible 15 indicating that he/she has moderate cognitive impairment. Further review of the MDS indicated that Resident #27 is dependent on staff for activities of daily living. On 7/2/24 at 8:37 A.M., the surveyor observed Resident #27 lying in his/her bed. Resident #27's bedside table was next to the Resident within reach, on the bedside table was a medication cup containing two orange medication tablets and one white medication tablet. No staff members were present in the resident's room. Resident #27 said staff sometimes leaves the medication for him/her to take on his/her own. During an interview on 7/2/24 at 8:40 A.M., the surveyor asked Nurse #2 to observe the medication at Resident #27's bedside. Nurse #2 said the Resident should not have medication at the bedside while unattended by a nurse. Nurse #2 and the surveyor reviewed Resident #27's medical record and Nurse #2 said the pills were Percocets (a pain medication) and Senna (a pill for constipation). Nurse #2 said the night nurse was supposed to administer the medications to Resident #27 and he was not sure why the night nurse did not and left them at the Resident's bedside. Review of Resident #27's physician's orders indicated the following: - Dated 6/8/24: Senna Oral Tablet (Sennosides) Give 2 tablets by mouth at bedtime for Constipation - Dated 6/17/24: Percocet Oral Tablet 5-325 MG (milligrams) (Oxycodone w/Acetaminophen) Give 1 tablet by mouth three times a day related to low back pain, unspecified. Review of Resident #27's Medication Administration Report (MAR) indicated that the Resident received the Senna Oral Tablet and Percocet Oral Tablet during the night shift on 7/1/24. Review of Resident #27's self-administration of medications care plan dated 5/10/24 indicated the following intervention: - Remind Resident #27 daily to administer eye drop as prescribed Review of Resident #27's document titled Self-Administration of Medication, dated 5/10/24 indicated the following: - Eye Drops/ointments: fully capable - Topical medications, ear drops, suppositories, inhalants/inhalers, subcutaneous injections: N/A (not applicable) The Self-Administration of Medication document failed to indicate that Resident #27 was capable of self-administering medication by mouth. (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/2/24 at 8:49 A.M., the Assistant Director of Nursing (ADON) said medication should not have been left at Resident #27's bedside as he/she cannot self-administer. During an interview on 7/2/24 at 4:20 P.M., Nurse #7, (the night nurse who provided Resident #27 the medication left at the bedside) said she put Resident #27's medication down and she was doing multiple tasks for the resident which is why she left them by mistake. Nurse #7 continued to say Resident #27 can self-administer eye drops but no other medication, and it was her error leaving the medication there.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observations, record review and interviews, the facility failed to provide dental services to one Resident (#22) out of a total sample of 27 Residents. Findings include: Review of the facility policy titled Dental Services, undated, indicated the following: -Routine and 24-hour emergency dental services are provided to our residents through: -a contract agreement with a licensed dentist that comes to the facility - referral to the resident's personal dentist - referral to community dentists - referral to other health care organizations that provide dental services - Resident's have the right to select dentists of their choice when dental care or services are needed - Social services representatives will assist residents with appointments, transportation arrangements - All dental services provided are recorded in the resident's medical record. A copy of the resident's dental record is provided to any facility to which the resident is transferred Resident #22 was admitted to the facility in April 2016 with diagnoses including chronic obstructive pulmonary disease, shortness of breath and schizophrenia. Review of Resident #22's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 11 out of a possible 15 indicating that the Resident has moderate cognitive impairment. During an interview on 7/2/24 at 7:46 A.M., the surveyor observed Resident #22 missing many teeth with visible dark stains on the remaining teeth. Resident #22 said he/she would like to see a dentist as he/she does not remember the last time he/she has seen one. Review of Resident #22's Physician's order dated 4/8/2020 indicated the following: - May be seen by Dentist as needed Review of Resident #22's care plan with a focus on having an established legal guardian and Roger's treatment dated and revised 9/1/20 indicated the following interventions: (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Inform Resident #22/Guardian of any change in status or care needs - Provide Legal Guardian with sufficient information to make an informed decision Review of Resident #22's care plans indicated that he/she has an active care plan with a focus on Nutritional risk d/t (due to) poor dentition dated and revised 1/12/24 Review of Resident #22's nursing progress notes indicated the following: - Dated 9/21/22: Resident would [sic] to see a dentist. - Dated 9/28/22: Resident still ask to see a dentist. - Dated 10/5/22: Resident still ask to see a dentist. Review of Resident #22's electronic medical record and paper medical record failed to indicate any records of Resident #22 seeing a dentist since admission. During an interview on 7/8/24 at 12:02 P.M., the Administrator said he cannot find any evidence that Resident #22 has seen a dentist or find a consent to be treated by a dentist. He said his expectation is that every resident including Resident #22 should receive consent to be seen by a dentist and if a resident requests to be seen by a dentist the facility would arrange that as soon as possible. During an interview on 7/8/24 at 12:38 P.M., the Assistant Director of Nursing (ADON) said Resident #22 sees his/her own dentist and his/her guardian would need to be contacted if he/she has been to the dentist as the ADON did not know. During a phone interview on 7/8/24 at 1:36 P.M., Resident #22's legal guardian said Resident #22 is very verbal about what he/she wants. If Resident #22 said he/she wants to see his/her own dentist, then she would need to provide approval for Resident #22 to leave the building. Resident #22's Guardian continued to say she has no memory of the building contacting her about Resident #22 going to see a dentist.

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	225147	A. Building B. Wing	07/09/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45984 Based on observations, interviews and policy review, the facility failed to 1. properly store food items in the kitchen to prevent the risk of foodborne illness and in accordance with professional standards for food service safety and 2. failed to ensure food was stored in the meal carts to prevent the risk of foodborne illness and in accordance with professional standards for food service safety. Findings include: Review of the facility policy titled Food Storage, undated, indicated the following: - Chemicals must be clearly labeled, kept in original containers, when possible, kept in a locked area and stored away from food. - All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods. - Date marking will be visible on all high-risk food to indicate the date by which a ready-to-eat, TCS (Time and Temperature Contol Foods) food should be consumed, sold, or discarded. - Refrigerated food storage: All foods should be covered, labeled and dated. All foods will be checked to assure the foods (including leftovers) will be consumed by their safe use by dates, or frozen, or discarded. 1. The surveyor made the following observations in the dry storage room during the initial kitchen tour on 7/2/24 at 7:06 A.M.: - A rack of bread was stored directly on the grease trap - Containers of chemicals feeding through the wall to the dish machine on the other side of the wall were stored directly next to ready-to-eat food. The surveyor made the following observations in the reach-in refrigerator during the initial kitchen tour on 7/2/24 at 7:06 A.M.: - A container labeled as mushrooms with a date written as 6/19/24 - A container labeled as red pepper with a date written as 6/24/24 - A container labeled as jello with a date written as 6/20/24 During an interview with the Food Service Director on 7/2/24 at 7:12 A.M., she said all food items stored in the refrigerators should be labeled and dated and used within three days of the date written. She continued to say that the outdated containers of food should have been discarded. (continued on next page)

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	225147	A. Building B. Wing	07/09/2024

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the revisit to the kitchen on 7/8/24 at 11:22 A.M., the surveyor made the following observations in the food dry storage area: - Containers of chemicals feeding through the wall to the dish machine on the other side of the wall were stored directly next to ready-to-eat food. During an interview on 7/8/24 at 12:51 P.M., the Food Service Director said the dish machine chemicals should not be stored where ready-to-eat food is located and food should not be stored directly on the grease trap. 36797 2. On 7/3/24, at 8:19 A.M., the surveyor observed a resident's undelivered meal tray with food ready to be delivered in the meal delivery cart with a contaminated/used meal tray above and below. At 8:20 A.M., the surveyor observed a Certified Nurse's Aide remove the unused (now potentially contaminated) meal tray and deliver it to a resident. During an interview on 7/3/24, at 8:25 A.M., Nurse #5 said that the used meal trays should not have been put in the meal tray cart with trays that have not been delivered yet.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45984 Based on record review, observations and interview, the facility failed to maintain accurate medical records. Specifically, staff signed off on the Treatment Administration Record (TAR) that oxygen tubing was changed, when it had not been changed, for one Resident (#22) out of a total sample of 27 residents. Findings include: Review of the facility policy titled Oxygen Use, dated and revised April 2022, indicated the following: - Verify that there is a physician's order for this procedure. Review the Physician's orders or facility protocol for oxygen administration. Resident #22 was admitted to the facility in April 2016 with diagnoses including Chronic Obstructive Pulmonary Disease, shortness of breath and schizophrenia. Review of Resident #22's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 11 out of a possible 15 indicating that the Resident has moderate cognitive impairment. Further review of the MDS indicated that Resident #22 received oxygen therapy. The surveyor made the following observations: - On 7/2/24 at 9:42 A.M., Resident #22 was lying in his/her bed, not using his/her oxygen. The oxygen tubing had a piece of tape on it with the date 6/17 written on it. The nasal cannula (the part that goes into the resident's nose to breath in the oxygen) part of the oxygen tubing was directly on the floor. - On 7/2/24 at 12:25 P.M., Resident #22's oxygen tubing had a piece of tape on it with the date 6/17 written on it. - On 7/3/24 at 7:37 A.M., Resident #22 was sleeping in his/her bed, not using his/her oxygen. The oxygen tubing had a piece of tape on it with the date 6/17 written on it. The nasal cannula part of the oxygen tubing was directly on the floor. - On 7/8/24 at 7:41 A.M., Resident #22 was lying in his/her bed, not using his/her oxygen. The oxygen tubing had a piece of tape on it with the date 6/17 written on it. The nasal cannula part of the oxygen tubing was directly on the floor. Resident #22 said he/she uses his/her oxygen at nighttime to breathe better. The resident continued to say that staff have not changed the tubing in a few weeks since they are always busy. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/8/24 at 7:48 A.M., Nurse #1 said oxygen tubing should be changed weekly and it should be documented when it happens. Nurse #1 and the surveyor went into Resident #22's room and observed the oxygen tubing with a piece of tape on it with the date 6/17 written on it as well as the nasal cannula directly on the floor. Nurse #1 said the tubing should have been changed since then and the tubing should not be on the floor as it is dirty. Nurse #1 proceeded to change the tubing. Review of Resident #22's physician's orders indicated the following: - Dated 4/28/24: Change oxygen tubing one time each week on Mondays 11-7 shift as needed - Dated 5/1/24: Change O2 (oxygen) tubing once a week every Monday night 11-7 every evening shift every Mon (Monday) - Dated 7/2/24: Oxygen 2-4L (liters) NC (nasal cannula) as needed for sao2 (oxygen concentration) less than 90%. Review of Resident #22's Treatment Administration Record (TAR) for June and July 2024 indicated that his/her oxygen tubing was documented as being changed on 6/17/24, 6/24/24 and 7/1/24 when it has not been. During an interview on 7/8/24 at 8:40 A.M., the Assistant Director of Nursing (ADON) said oxygen tubing should be changed weekly. The surveyor showed the ADON photos of Resident #22's oxygen tubing with the tape on it dated 6/17, the ADON said regardless of the tubing being dated 6/17 she said she can assure it was changed. The surveyor then asked if the tubing was documented as being changed three times since the date of 6/17, why would staff put a piece of tape back on the new tubing with the old date of 6/17 and how can she be assured it was changed. The ADON was unable to answer. During an interview on 7/8/24 at 8:52 A.M., Nurse #1 said she is not sure why an old date was written on Resident #22's oxygen tubing. Nurse #1 said Resident #22 is alert and oriented and able to make sense of his/her surroundings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 36797 Based on observation and interview, the facility failed to maintain an infection control program designed to provide a safe and sanitary environment to help prevent the transmission of disease and infection. Specifically: 1. the facility failed to develop a water management program to prevent the spread of water borne diseases and, 2. failed to disinfect reusable medical equipment between residents. Findings include: 1. Review of the facility policy titled Water Management- Quarterly Flush dated 5/16/19, indicated that an initial assessment will be completed by members of the water management team, documenting at risk areas. Review of the water management program binder given to the surveyor failed to indicate that an initial assessment was completed and ongoing assessments were completed by members of the water management team. During an interview on 7/08/24, at 2:20 P.M., with the Administrator and the Maintenance Director they said that the facility had not developed a complete water management program. They said that the facility had not performed an assessment to identify where the at risk areas in the facility were, for the potential contamination of the water system with water borne diseases due to low flow of water through the system. 2. During medication pass on 7/3/24, the surveyor observed Nurse #5 to obtain a blood pressure cuff from the other end of the hallway. The surveyor then observed Nurse #5 to take a resident's blood pressure without disinfecting the blood pressure cuff first. During an interview on 7/3/24, at 8:43 A.M., Nurse #5 said that he should have disinfected the blood pressure cuff before he used it because he could not be sure if the previous user had disinfected it after they used it.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation and interview, the facility failed to ensure one Resident (#9), out of a total sample of 27 residents had a bed that was in operating condition. Specifically, Resident #9's top part of his/her bed was leaning toward his/her left side and was not level. Findings include: Resident #9 was admitted to the facility in February of 2007 and has diagnoses that include but not limited to major depressive disorder, osteoporosis, anemia, limitation of activities due to disability and epilepsy. Review of Resident #9's Minimum Data Set (MDS) assessment dated [DATE] indicated staff assessed Resident #9's with a severely impaired cognition and required substantial/maximal assistance from staff for bathing and transfers. On 7/ 2/24 at 7:56 A.M., Resident #9 was observed resting in his/her bed. The upper top of the bed was leaning to his/her left and Resident #9 was leaning to the left side of the bed towards the wall. Resident #9 said he/she was okay in his/her position. Resident #9 said he/she does not get out of bed. Resident #9 did not know how long his/her bed was leaning towards his/her left. The observation made by the surveyor could not determine the cause of the bed leaning towards Resident #9's left. On 7/2/24 at 3:23 P.M., Resident #9 was observed in bed, with the top part of the bed tilted to Resident #9's left. The headboard was observed as not level. On 7/3/24 at approximately 11:30 A.M., the upper position of Resident #9's bed was leaning towards his/her left. At this time Certified Nursing Assistant (CNA) #4 observed Resident #9's bed and said it was leaning and she did not know why or how long it had been that way. During an interview on 7/3/24 at 3:15 P.M., the Director of Maintenance said he determined Resident #9's bed frame was bent/tilted and needed to be replaced. The Administrator, who was also present during the interview, said he would expect residents to have beds that are in good condition.