

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 - Few	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** 42690 Based on interview, record and policy review, the facility failed to provide a dignified experience for one Resident (#19) out of a total sample of 23 residents. Specifically, for Resident #19, the facility failed to provide incontinence care after the Resident was incontinent of bowel and prior to engaging in a group activity. Findings include: Review of the facility policy titled Dignity, revised May 2024, indicated the following: -That 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. -Demeaning practices and standards of care that compromise dignity are prohibited. -Staff are expected to promote dignity and assist residents; for example: .promptly responding to a resident's request for toileting assistance . Resident #19 was admitted to the facility in August 2024, with diagnoses including repeated falls, Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Adult Failure to Thrive (a syndrome of global decline in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment, weight loss, decreased appetite or poor nutrition and inactivity), need for assistance with personal care, and unsteadiness on feet. Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating the Resident was cognitively intact. Review of Resident #19's individualized care plan indicated the following: -Resident is incontinent of bladder and bowel due to physical limitations, initiated on 8/26/24 (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: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 - Few	-Clean peri-area with each incontinence episode, initiated on 8/26/24 -Resident has an ADL (Activities of Daily Living) performance deficit due to disease process, initiated on 8/29/24 -Personal Hygiene: Resident requires assist of one staff, initiated on 8/29/24 and revised on 9/5/24 -Toilet Use: Resident requires assist of one staff, initiated on 8/29/24 and revised on 9/5/24 -Transfers: Resident requires assist of one staff, two assist when fatigued, initiated on 8/29/24 and revised on 9/5/24 -Resident can smoke with supervision, initiated on 8/16/24 Review of the facility smoking schedule titled, Smoking Time and Location, updated on 9/15/24, provided by the facility during the entrance conference indicated the following daily smoking times: -9:30 A.M. -1:30 P.M. -4:30 P.M. -7:00 P.M. During an interview on 10/15/24 at 11:34 A.M., Resident #19 said that last week, around the 9:30 A.M. smoking time, the Resident told Nurse #4 that he/she had a bowel movement and needed to be changed before going downstairs to smoke. Resident #19 said that he/she was told by Nurse #4 that if he/she did not go out to the scheduled smoking time at 9:30 A.M., that the Resident would not be able to go out for a cigarette until the 1:00 P.M., scheduled smoking time. Resident #19 said that he/she did not want to miss the 9:30 A.M. smoking time and did not want to wait until the next scheduled smoking time at 1:00 P.M. The Resident said that he/she went outside to have his/her cigarette while sitting in a bowel movement. Resident #19 said that it was embarrassing and he/she sat away from everyone while smoking outside. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 - Few	During an interview on 10/16/24 at 10:13 A.M., Nurse #4 said that she was in the Resident's room around 9:15 A.M., when the interaction between her and Resident #19 occurred. Nurse #4 said that other residents had already been brought downstairs to the smoking area. Nurse #4 said that Resident #19 was in mid-transfer to a wheelchair when Resident #19 told her that he/she had a bowel movement and needed to be cleaned. Nurse #4 said that she gave the Resident three options: 1) be cleaned now and wait until the 1:00 P.M. scheduled smoking time, 2) go downstairs now for his/her smoking time and get cleaned up when the Resident came back upstairs, or 3) get cleaned up now and maybe Nurse #4 could find someone to bring the Resident down at some point in the morning to have a cigarette. Nurse #4 said that it was hard because she is only one Nurse to 24 residents with two Certified Nurses Aide (CNAs) and that it was not possible for a Nurse or the CNAs to leave the unit for an extended period of time to take a Resident to smoke. Nurse #4 said that the Resident was sometimes incontinent of bowels but felt that it was a behavior, and that Resident #19 knows when he/she needed to use the bathroom. Nurse #4 said that she gave the Resident three options, and the Resident chose to go downstairs to smoke. During a follow-up interview on 10/16/24 at 10:25 A.M., Nurse #4 said that CNA #4 was also in the Resident's room when the interaction occurred and that she was not alone with the Resident. During an interview on 10/16/24 at 10:31 A.M., Unit Manager (UM) #3 said that to maintain dignity for the Resident, incontinence care should have been provided and then the Resident should have been brought down to the smoking area. UM #3 said that since it was 9:15 A.M., before the scheduled smoking time, care should have been provided. UM #3 said that someone else, like the Activities Aide is down in the smoking area and provided supervision. UM #3 said that the nursing staff (cart Nurse or the CNA's) would not have been required to sit with the Resident. During a follow-up interview on 10/16/24 at 10:52 A.M., UM #3 said that she talked with the staff and learned that the Resident was adamant that he/she go downstairs and smoke, to the point where he/she was trying to self-transfer from the bed into the wheelchair. UM #3 said that the staff informed her that the Resident had already been cleaned up two to three times prior to Resident #19 notifying the staff that he/she had another bowel movement. During an interview on 10/16/24 at 11:04 A.M., CNA #4 said that Resident #19 said that the he/she had a bowel movement while in the middle of transferring with a mechanical lift from the bed to the wheelchair. CNA #4 said that the Resident became agitated, because he/she did not want to miss the smoking time and said that he/she would change when he/she came back upstairs. CNA #4 said that the Resident refused to sit on the toilet and that this is an ongoing situation. During an interview on 10/16/24 at 4:41 P.M., the Director of Nursing (DON) said that she talked with Nurse #4 prior to this conversation and the situation was explained. The DON said that the smoking time is not exactly a hard and fast time and that since other residents had been brought down 15 minutes earlier than the scheduled 9:30 A.M. smoking time, Resident #19 could have been cleaned up and then brought down to have his/her cigarette.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37400 Based on interview, record review and policy review, the facility failed to notify a Resident Representative of a change in condition, for one Resident (#5) out of a total sample of 23 residents. Specifically, the facility failed to notify Resident #5's Representative when the Resident developed a skin rash which required an outpatient appointment to a Dermatologist and medication to treat the condition. Findings include: Review of the facility policy titled Notification of Changes, reviewed/revised May 2024, indicated the facility promptly informs the resident, consults with the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. The policy included the following: -Circumstances requiring notification include: >significant change in the resident's physical condition .which may include clinical complications . >circumstances that require a need to alter treatment . and may include a new treatment >a transfer .from the facility -Competent individuals: >the facility will notify the resident's representative, if known >when a resident is mentally competent, a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally . -Resident incapable of making decisions: >the representative would make any decisions that would have to be made >the resident should still be told what is happening to him or her Resident # 5 was admitted to the facility in October 2023, with a diagnosis of Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment). Review of the October 2024 Physician's orders indicated the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-invoke (put into effect) the Resident's Health Care Proxy (HCP: the person chosen as the healthcare decision maker when the individual is unable to do so for themselves) as of 9/6/23, initiated 9/7/23 Review of the Minimum Data Set (MDS) Assessment, dated 10/4/24, indicated Resident #5: -had moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 8 out of 15. -required partial to moderate assistance with activities of daily living (ADLS: basic tasks like bathing, dressing and eating). Review of the Resident #5's clinical record included the following: -Nursing Progress Note, dated 10/8/24, indicated that the Resident was complaining of being very itchy and was observed to have a raised rash on his/her bilateral (both) hands. The Nurse requested the Wound Team assess the areas, and an outside appointment was made with Dermatology for 2:00 P.M. that day. -Wound Consultation Note, dated 10/8/24, indicated the Resident had an evaluation for scabies (contagious skin rash caused by infestation of tiny burrowing human itch mites that causes intense itching and a pimple-like rash) rash on his/her abdomen, chest, neck, hands, and bilateral legs. The areas had linear indurated (thickening and hardening of the skin in a line pattern) rash with erythema (redness) and itchiness that worsened at night. -Nurse Practitioner (NP) Progress Note, dated 10/9/24, (late entry for 10/8/24), indicated the Resident presented with a rash and intermittent itchiness to his/her arms, neck and right leg. There was concern for scabies and it was recommended that the Resident be seen by Dermatology for definitive diagnosis and for the facility to maintain precautions. -Dermatology Consult, dated 10/8/24, indicated the Dermatologist was unable to determine if scabies was present, but recommended treatment for scabies which included Permethrin Cream (scabicide) and Triamcinolone Cream (topical corticosteroid cream used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions). Review of the October 2024 Physician's orders, indicated the following order was initiated on 10/8/24 at 4:00 P.M. (upon the Resident's return from the Dermatology Consult): -Permethrin Cream 5% from the neck down, then shower eight hours later, and repeat the treatment on 10/18/24 (one week later), for treatment of Scabies. -Triamcinolone Cream 1% two times daily for two weeks, then daily for one month. Review of the Medication Administration Record (MAR) for October 2024, indicated the Permethrin Cream for Scabies treatment was administered to Resident #5 on 10/11/24. Review of the Resident's clinical record indicated no documented evidence that the Resident's Representative was notified of the Resident's change in condition. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/24 at 7:21 A.M., the Director of Nursing (DON) said she was unable to find evidence that the Resident's Representative was notified of his/her change in condition that occurred on 10/8/24, and subsequent treatment for scabies. The DON said a change of condition should have been completed after the Resident was identified as having the skin rash and the Resident Representative should have been notified. The DON said Resident #5's Representative was contacted on 10/17/24, after the surveyor inquiry. Refer to F880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on interview, and record review, the facility failed to ensure that Minimum Data Set (MDS) Assessments were coded accurately for two Residents (#72 and #83) out of a total sample of 23 residents. Specifically, the facility failed to: 1. For Resident #72, ensure Tobacco use was coded accurately when Resident #72 was an active smoker. 2. For Resident #83, attempt/complete the Brief Interview of Mental Status (BIMS) Assessment to determine the level of cognition when the Resident was identified as able to understand and could be understood. Findings include: 1. Resident #72 was admitted to the facility in August 2023. Review of the Resident #72's Smoking Care Plan, initiated on 8/9/24, indicated Resident #72 preferred to actively participate in smoking. Review of Resident #72's Smoking and Safety Assessment, dated 8/9/24, indicated the Resident was a supervised smoker. Review of Resident #72's August 2024 Activity Log, indicated Resident #72 actively participated in smoking daily from 8/9/24 through 8/15/24. Review of the MDS assessment dated [DATE], indicated Resident #72 had not utilized Tobacco in the seven days prior to the Assessment Reference Date (ARD) of 8/15/24. During an interview on 10/17/24 at 9:27 A.M., the MDS Nurse said the MDS assessment dated [DATE], was coded incorrectly for Resident #72, as he/she utilized tobacco within the seven day look back period before the ARD of 8/15/24 and the MDS Assessment needed to be modified. 37400 2. Resident #83 was admitted to the facility in December 2021, with diagnoses of Alzheimer's Disease (a progressive disease beginning with mild memory loss and leading to the loss of the ability to carry on a conversation and respond to the environment, that is severe enough to interfere with daily life). Review of the MDS Assessment, dated 9/12/24, under Section B indicated Resident #83 was understood and understands. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Further review of the MDS Assessment under Section C indicated the BIMS Assessment was not attempted because Resident #83 was rarely understood and a staff interview was completed. On 10/16/24 at 12:36 P.M., the surveyor observed Resident #83 standing by the nurses station and requesting water, which was provided by the staff. On 10/18/24 at 3:55 P.M., the MDS Nurse reviewed the MDS assessment dated [DATE], and said Section B was miscoded. The MDS Nurse said if the Resident was understood and understands, then a BIMS Assessment to determine his/her level of cognition should have been attempted/completed under Section C. The MDS Nurse said the 9/12/24, MDS Assessment would have to be modified.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 42741 Based on interview, and record review, the facility failed to ensure that a Preadmission and Resident Review Level I (initial PASRR - initial pre-screening completed prior to admission to a Nursing Facility that assess for Serious Mental Illness[SMI] or Developmental Disabilities[DD]) screen was completed prior to admission to the facility for one Resident #72) out of a total sample of 23 residents. Specifically, the facility failed to ensure that a Level I screen was completed prior to admission to the facility when Resident #72 had active diagnoses of mental disorders. Findings include: Review of the facility policy titled Resident Assessment-Coordination with PASARR Program {sic}, reviewed/revised September 2024, indicated the following: -All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. -PASARR Level 1-initial pre-screening that is completed prior to admission {sic} Resident #72 was admitted to the facility in August 2023, with diagnoses of Paranoid Schizophrenia (type of Schizophrenia characterized by paranoia [distrust, suspicious, and fearful without any good reason], delusions and hallucinations), Major Depressive Disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy), and Anxiety Disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities). Review Resident #72's PASRR Level I, dated 8/17/24, indicated it was completed after the Resident was admitted to the facility. During an interview on 10/16/24 at 10:53 A.M., Social Worker (SW) #1 said Resident #72's PASRR Level I was completed post admission to the facility and should have been completed prior to his/her admission to the facility. SW #1 further said she was aware PASRR Level Is were being completed post admission but there was not always a Social Worker in the building to complete the Level I PASRR if a resident was admitted after hours or on a weekend. SW #1 said no other staff members in the facility had been trained to complete the PASRR Level I screening.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 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. 42741 Based on interview, and record review, the facility failed to ensure that professional standards of care were maintained for diabetic management for one Resident (#8) out of a total sample of 23 residents. Specifically, for Resident #8, the facility failed to ensure that Physician's orders were implemented and Physician notification occurred when the Resident experienced periods of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar). Findings include: Review of the facility policy titled Blood Glucose Monitoring, undated, indicated the following: -The facility will perform blood glucose monitoring as per Physician's orders. -License Nurse to follow Physician orders set for high and low parameters. Review of the facility policy titled Hypoglycemia Management, reviewed/revised February 2024, indicated the following: -Diabetic residents will have their blood sugar tested as per Practitioner's (Physician/ Nurse Practitioner) orders. -If the blood glucose (blood sugar) reading is 60 milligram (ml)/deciliter (dL) [ml/dL: a unit of measure used for blood glucose testing] or below, the Nurse will utilize the hypoglycemic protocol as per the Practitioner's orders, will follow up blood glucoses as indicated, and notify the Practitioner of the results as ordered. Resident #8 was admitted to the facility in August 2013, with a diagnosis of Type I Diabetes (insulin-dependent-diabetes: a lifelong condition where the pancreas makes little or no insulin, which leads to changes in blood sugar levels). Review of Resident #8's Diabetic Care Plan, initiated 4/13/18, indicated the following: -Attempt to resolve hypo-hyperglycemia for blood sugar outside parameters for this Resident per house protocol. -Report to Medical Doctor (MD) PRN (pro re nata: as needed) as indicated for blood sugar (BS) outside designated parameters. Review of Resident #8's October 2024 Physician's orders indicated the following orders: -If blood sugar is less than 60 ml/dL administer: >4 ounces (oz) juice or (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>6 oz regular soda or >1 tube of glucose gel (medication used to increase blood sugar), -Repeat BS in 15 minutes, if still less than 60 ml/dL: >repeat 4 oz juice. -If no change in 15 minutes, report to MD as needed, start date 2/9/19 -Admelog SoloStar Subcutaneous Solution Pen-Injector 100 Unit/ML (insulin medication used to treat diabetes), inject as per sliding scale . -Blood sugar greater than 400 ml/dL, update Primary Care Provider (PCP)/Nurse Practitioner (NP). Review of Resident #8's August 2024 Medication Administration Record (MAR) indicated the following: -8/15/24: blood sugar result of 50 ml/dL. Review of the August MAR and the Nursing Progress Notes from 8/15/24, indicated: -no documentation that the Resident had been offered juice, soda, or glucose gel -no documentation that the Resident's blood sugar had been retested after 15 minutes to determine if the blood sugar had increased. Review of Resident #8's September 2024 MAR indicated the following: -9/11/24: blood sugar result was 58 ml/dL -9/15/24: blood sugar result was 58 ml/dL -9/21/24: blood sugar result was 441 ml/dL at 11:00 A.M. and 9:00 P.M. Review of the September MAR and the Nursing Progress Notes from 9/11/24 and 9/15/24 indicated: -no documentation that the Resident had been offered juice, soda, or glucose gel -no documentation that the Resident's blood sugar had been retested after 15 minutes to determine if the blood sugar had increased on 9/11/24 or 9/15/24. -no documentation that the Resident's PCP had been updated that the Resident had blood sugar levels over 400 ml/dL two times on 9/21/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/15/24 at 4:40 P.M., Nurse #1 said if a Resident had a blood sugar lower than 60 ml/dL the Nurse should provide the Resident with juice, soda, or glucose gel as per the Physician's order. Nurse #1 said then the blood sugar would be retested to make sure it had increased. Nurse #1 said this should be documented on the MAR to show which treatment was provided to raise a low blood sugar. Nurse #1 further said if a Resident had a blood sugar over 400 ml/dL the Nurse should notify the Resident's PCP and get orders on how much additional insulin to administer to the Resident to lower the blood sugar. Nurse #1 said this would be documented in the Nursing Progress Notes. During an interview on 10/15/24 at 5:02 P.M., Unit Manager (UM) #1 said each Resident who is at risk for hypo/hyperglycemia will have Physician's orders with the parameters for blood sugars and what should be done if a Resident becomes hypo/hyperglycemic. The surveyor and UM #1 reviewed Resident #8's Physician's orders and UM #1 said if the Resident had a blood sugar level less than 60 ml/dL, staff should have administered juice, soda, or glucose gel as ordered and rechecked the Resident's blood sugar after 15 minutes and documentation should be completed on the MAR. UM #1 further said if Resident #8 had a blood sugar level over 400 ml/dL, the Resident's PCP should have been contacted for orders on lowering the Resident's blood sugars and documentation of the conversation and instructions from the PCP should be documented in a Nursing Progress Note. UM #1 reviewed the following dates on the Resident's MAR and Nursing Progress Notes: 8/15/24, 9/11/24, 9/15/24, and 9/21/24, and said she could find no documentation to show what treatment was implemented when the Resident had experienced episodes of hypoglycemia on 8/15/24, 9/11/24, and 9/15/24. UM #1 also said she could find no documentation to show the PCP had been updated when the Resident experienced two episodes of hyperglycemia on 9/21/24.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45435 Based on observation, interview, record and policy review, the facility failed to maintain an environment that is free of accidents and hazards for two Resident (#103 and #45) out of a total sample of 23 Residents. Specifically, the facility staff failed to: 1. For Resident #103, ensure potentially hazardous smoking materials were stored in a secure area, putting the facility Residents at risk for injury due to inappropriate usage when the Resident was smoking in his/her room. 2. For Resident #45, ensure that an elopement assessment was completed timely and safety interventions were implemented when the Resident demonstrated exit seeking behaviors, resulting in the Resident eloping from the secure (locked) unit via a door that was malfunctioning. Findings include: 1. Review of the facility policy titled Smoking Policy, undated, indicated the following: -Residents are not permitted to have any smoking paraphernalia in their room or on their person. Resident #103 was admitted to the facility in March 2024, with diagnoses including Vascular Dementia (a condition that occurs when the brain does not get enough blood flow, damaging brain tissue and impairing thinking, memory, and behavior) and Diabetes Mellitus (DM - disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in elevated blood glucose [sugar] levels in the blood). Review of Resident #103's Smoking Care Plan, initiated 4/8/24, indicated the following: -Resident prefers to actively participate in smoking while residing in facility. -Instruct Resident about the facility policy, location, times, safety concerns. -Notify charge Nurse immediately if it is suspected Resident has violated facility smoking policy. -Resident can smoke with supervision. Review of Resident #103's Smoking and Safety Assessment, dated 8/9/24, indicated the following about the Resident. -smokes tobacco -balance problems while sitting or standing (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-follows the facility's policy on location and time of smoking -unable to use ashtray to extinguish tobacco or marijuana -unable to light tobacco or marijuana safely -Resident is able to participate in supervised smoking in [sic] facility. Review of the Minimum Data Set (MDS) Assessment, dated 9/24/24, indicated the following: -Brief Interview for Mental Status (BIMS) score of 10 out of a total score of 15 indicating moderate cognitive impairment. -Required substantial/maximal assistance (helper does more than half of the effort) for hygiene and dressing. Review of the facility Resident Smokers list, dated 10/11/24, indicated the following: -All smoking materials will be stored in red box at nurses station and brought out with smokers so that smoking materials can be utilized at time designated for supervised smoking. -Residents regardless of smoking status should keep all smoking materials in the red box. -Resident #103 was identified as a supervised smoker. Review of the October 2024 Physician's orders indicated the following: -Resident may participate in supervised smoking in [sic] facility, date initiated 8/9/24. Review of the Kardex (abbreviated care plan used by direct care givers to receive information quickly relative to providing care) indicated the following: -The Resident can smoke with supervision -Instruct Resident about the facility policy on smoking: locations, times, safety concerns. Review of the Nurses Progress Note, dated 4/17/24, indicated the Resident was observed smoking a lit cigarette in his/her room. The Nurses Progress Note further indicated that a Nurse intervened and extinguished the lit cigarette and removed all smoking material including a lighter from the Resident's room. The Nurses Progress Note indicated that the Nurse met with the Resident to review facility smoking policy and to educate him/her regarding safety risk of flammables in locations that use Oxygen (medical gas used for inhalation therapy and resuscitation that is capable of being ignited and burning) as well as re-education regarding the outside facility smoking location and need for staff supervision with smoking. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/15/24 at 8:42 A.M., Resident #103 said that he/she smokes cigarettes three times a day. The Resident said he/she kept his/her cigarettes and lighter in the nightstand in his/her room. The Resident showed the surveyor a pack of cigarettes and two lighters in the top drawer of his/her nightstand. During an interview on 10/15/24 at 3:53 P.M., the Resident said he/she had gone out to smoke twice that day, and was expecting to go out to smoke again around 4:00 P.M. Resident #103 said that he/she was not sure what the facility policy was about storage of cigarettes and lighters but that he/she kept his/her cigarettes in his/her room because of fear that they will be stolen. The surveyor observed a pack of cigarettes and two lighters in the top drawer of the Resident's nightstand. On 10/15/24 at 3:59 P.M., the surveyor observed Resident #103 being escorted from the nursing unit by Activity Assistant (AA) #1 to the smoking area. The surveyor observed AA #1 provide cigarettes from a red tackle box to some Residents, but did not observe AA #1 provide a cigarette to Resident #103. Resident #103 was observed to be smoking a cigarette. During an interview on 10/15/24 at 4:06 P.M., AA #1 said that she did not give Resident #103 a cigarette because he/she had his/her own. AA #1 said Resident #103 had been keeping cigarettes in his/her room for a while. AA#1 further said that the facility policy was that the Resident's cigarettes and lighters were supposed to be placed in the red tackle box that were kept behind the nurses station. During an interview on 10/15/24 at 4:39 P.M., Nurse #3 said Residents should never have cigarettes or lighters in their rooms. The surveyor observed Nurse #3 enter the Resident's room and ask to check his/her nightstand. The surveyor heard the Resident say the cigarettes have already been taken and that he/she had kept them in his/her room for a long time and everybody knew about it. The Resident said he/she was just going to get more and keep them in his/her room. During an interview on 10/15/24 at 4:45 P.M., the Director of Nursing (DON) said Residents were not permitted to have cigarettes and lighters in their rooms. 37400 2. Resident #45 was admitted to the facility in May 2024, with diagnoses including Cerebrovascular Disease (conditions that affect blood flow to your brain and include stroke, brain aneurysm, brain bleed and carotid artery disease), Dementia (a group of symptoms that affects memory, thinking and interferes with daily life) with agitation, unsteadiness on feet, syncope (fainting resulting from certain stressful triggers which lead to sudden drop in blood pressure and heart rate and collapse), repeated falls, fracture of left femur (thigh bone), Osteoarthritis (occurs when the protective cartilage that cushions the ends of the bones wears down over time) of knees and wandering. Review of the facility policy titled Elopement and Wandering, dated May 2024, indicated the center ensures that residents who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering and/or elopement. The policy also included the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Wandering is a random or repetitive locomotion that may be goal-directed (e.g. the person appears to be searching for something such as an exit) or aimless. -Elopement occurs when a resident leaves the premises or a safe environment without authorization and/or any necessary supervision to do so. -The center is equipped with door locks/alarms to help avoid elopements. -The center shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. -Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering: >Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. >Upon completion of assessment if a resident is determined to be an elopement risk, the facility may utilize a personal alarm/device that will alert staff of a residents attempt to leave a secured area. >The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. >The effectiveness of interventions will be evaluated, and changes will be made as needed. Any change or new interventions will be communicated to relevant staff. -Procedure Post-Elopement >A nurse will perform a physical assessment, skin assessment and pain assessment document, and report findings to physician. >Staff may be educated on the reasons for elopement and possible strategies for avoiding such behavior. >Documentation in the medical record will include: findings from nursing and social service assessments, physician/family notification, care plan discussions and consultant notes as applicable. Review of the Minimum Data Set (MDS) Assessment, dated 7/12/24, indicated Resident #45: -had moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 8 out of 15. -utilized a walker and wheel chair. -required partial/moderate assistance with transfers. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-required supervision with ambulating 10 feet to 50 feet. -ambulating 150 feet and on uneven surfaces was not attempted due to medical conditions or safety concerns. Review of a Nursing Progress Note, dated 8/13/24, indicated Resident #45 was very confused and determined that he/she was not supposed to be in the facility. The Nursing Progress Note indicated the Resident was observed self-propelling around the facility's enclosed courtyard while seated in the wheelchair, and was provided distant supervision from staff for safety because he/she declined returning to the facility. The Resident's Health Care Proxy (HCP: the person (s) chosen as the healthcare decision maker when the individual is unable to do so for themselves) was contacted and was agreeable to have the Resident move to a more secure (locked) unit at this time. Review of the clinical record indicated Resident #45 was transferred to the East Two Unit (secured unit) located on the third floor of the facility on 8/13/24. Review of the Nursing Progress Note, dated 8/14/24, indicated Resident #45 became agitated, wanted to go home, and was standing by the secured (unit) door, was trying to unlock the door and was exiting seeking throughout the whole day. Review of the Nursing Progress Note, dated 8/15/24, indicated the Resident was observed walking down the hallway on the first floor. The Nursing Progress Note indicated when the Resident returned to the secure East Two Unit located on the third floor, the Resident said he/she fell down a flight of stairs. The Nursing Progress Note indicated that the Resident's wheelchair was observed in the back stairwell (leaving the secure unit), the stairwell was assessed, and there was no evidence of a fall. The Nursing Progress Note further indicated that the Resident was assessed, and no injuries were present. The Provider (Physician/ Nurse Practitioner [NP]) and HCP were updated and a wanderguard (device that alarms when in close proximity to alarmed doors) was placed on the Resident. Review of the Elopement Assessment, dated 8/15/24, indicated Resident #45 was considered an elopement risk related to: -Wandering behavior which was a pattern or goal directed. -Recently admitted or readmitted and had not accepted the situation. Review of Resident #45's clinical record indicated no documented evidence that the facility completed an Elopement Assessment prior to the one completed on 8/15/24 (after the Resident had eloped) nor evidence that an investigation was completed to determine the circumstances of how the Resident was able to leave the secured unit without staff awareness on 8/15/24. On 10/17/24 at 9:18 A.M., Resident #45 was observed dressed, seated in a wheelchair and propelling in a hallway on the secured unit. The surveyor observed a wanderguard device on the Resident's wrist. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/18/24 on 1:01 P.M., Unit Manager (UM) #1 said Resident #45 was transferred to the secured unit on 8/13/24 because of his/her risk of elopement. UM #1 said she was not present during the (elopement) incident on 8/15/24, when Resident #45 was found off the secured unit, but said she remembered the Resident was found by staff ambulating on the first floor of the facility. UM #1 said the doors on the secured unit were able to be opened when pushed for 15 seconds, but when opened this way, they would alarm. UM #1 said an investigation should have been completed to determine how the Resident was able to exit the secured unit without staff awareness, but she was not a part of this process. UM #1 further said the Director of Nursing (DON) would know more about the elopement incident. On 10/18/24 at 1:20 P.M., the surveyor and UM #1 tested the door to the back hallway on the secured unit. After pressing the door handle for approximately 15 seconds, the alarm sounded, and the door was able to be opened to allow access into the stairwell on the opposite side of the door. The surveyor observed a landing and open railing (approximately lower hip height) and an open stairwell were present beyond the alarmed door. The alarm continued to sound when the surveyor and UM #1 were present in the stairwell after the door closed, and was turned off by pressing the key code inside the secured unit. During an interview at the time, UM #1 said she would have concerns if Residents were able get into the stairwell area. UM #1 said it was not safe for Residents to be in this location (the stairwell) because they could be seriously injured. During an interview on 10/18/24 at 1:45 P.M., the DON said she was present when Resident #45 was in the facility courtyard on 8/13/24. The DON said the Resident attempted to shake and open the gate in the back courtyard wanting to leave and was eventually redirected by staff after several attempts to have him/her return inside the facility. The Resident's family was contacted and agreed to move him/her to a more secure unit for safety. The DON said the Resident was moved to the East Two secured unit on 8/13/24 and an elopement assessment should have been completed at that time, but one was not completed. The DON further said an investigation should have been completed when the Resident was found off the secured unit and located on the first floor but an investigation was not completed. The DON said she was not sure how the Resident was able to leave the secured unit without staff awareness because the alarmed doors should have sounded and needed to be manually turned off by staff once the alarm was sounding. The DON said there was a night when the alarms were not working, but she would have to check into this. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During follow-up interviews on 10/18/24 at 2:30 P.M. and 4:00 P.M., the DON said neither she nor the Administrator were in the building during the time of the incident on 8/15/24 with Resident #45, and the Assistant Director of Nurses (ADON), who no longer worked at the facility, had been in charge. The DON said the Resident was found by the Receptionist ambulating on the first floor dressed in a hat, coat and holding a bag. The [NAME] said the Receptionist thought it was a visitor and then recognized the Resident and called for staff assistance. The DON said she was in the process of completing an investigation as one had not been completed during the time of the incident, that the alarms to the secured doors on one unit had not been working during the time, and that she was not aware if any other doors had been affected. The DON said Resident #45 had exited into the back hallway of the secured unit, left his/her wheelchair on the landing, and must have walked down several flights of stairs to get onto the first floor of the facility. The DON said the back doorway to the secure unit was checked after the Resident was located and was observed to be not alarming by staff. The DON said the ADON had alerted her to the Resident's whereabouts and the DON had instructed the ADON to place two stop signs at the back hallway door prior to exiting the secured unit and to have a staff person seated on the other side of the door (on the landing where the stairwell was located) until the electrician could fix the alarmed doors. The DON said she was not sure how long the alarmed doors were not functioning. During an interview on 10/18/24 at 4:34 P.M., the Director of Maintenance (DOM) said the alarming doors for Units South Two and East Two (located in the front part of the facility) were affected during a quarterly fire alarm inspection on 8/14/24. The DOM said when the Unit South Two door was observed to not be alarming, he contacted the electrician who instructed him to check the other facility doors. The DOM said during the checks, he found the Unit East Two (secured unit) door to the back stairwell was not working. The DOM said he contacted administration to alert them of the issue and thought that he was instructed to add a door alarm to the door (alarm that chimed when the door was opened and would shut off when the door was closed), which he said he did. The DOM said typically when an alarmed door was not working, facility staff would be assigned to ensure that no one exited the unit, but was he was unsure if this occurred during the time the secured unit door was not functioning. The DOM said the electrician returned and fixed the doors, but then shortly after the doors were identified to not be working again. The DOM said the electrician returned and had to have a part ordered. The DOM provided the surveyor with an invoice for the door repair dated 8/22/24 (8 days after the door was observed to not be functioning appropriately). The DOM said there were two different alarm systems on the secured unit and during the time frame from 8/14/24 through 8/22/24. The DOM said the wanderguard alarm system was still functioning but would only alert staff if a resident with a wanderguard alarm was near the exit doors. The DOM said he checked the wanderguard alarms weekly and checked the other door alarms quarterly. The DOM said he would not know if the alarmed doors were not functioning between these checks (weekly and quarterly) and would expect the staff to alert him. During an interview on 10/18/24 at 5:12 P.M., the Staff Development Coordinator (SDC) said she was present during the (elopement) incident with Resident #45 on 8/15/24. The SDC said she heard the Receptionist call for assistance and saw Resident #45 ambulating without assistance while leaning against the wall on the first-floor hallway. The SDC said she went to retrieve a wheelchair, and the Resident was assisted back to the secured unit at that time. The SDC said she was not sure what happened after the Resident was returned to the unit. The SDC said the incident occurred around 7:00 A.M. - 7:30 A.M., that she worked until 5:00 P.M. on 8/15/24, and could not recall any instructions about the Resident's elopement at that time. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/18/24 at 5:20 P.M., UM #3 said she received a call from the ADON on 8/15/24 and assisted on the East Two Unit (secured unit). UM #3 said Resident #45 was on the unit at that time and had stated that he/she fell down the stairs. UM #3 said she and the ADON observed the back hallway to the unit and discovered the Resident's wheelchair on the landing. UM #3 said she assessed the hallway and stairwell and observed no signs of an accident or injury and could not recall the alarm sounding when leaving the secured unit and said she would automatically enter the code to exit the unit (despite the Director of Maintenance stating he placed a door alarm on the door). UM #3 said she thought a stop sign was put into place but could not recall other measures put into place at that time and could not recall what was done to ensure the other residents on the secure unit were safe and accounted for. During an interview on 10/18/24 at 5:27 P.M., the Administrator said he was not made aware that several alarmed doors to the facility units were not functioning (on 8/14/24). The Administrator said if this occurred, he would expect facility staff to notify him immediately to determine a plan. The Administrator said a staff person would have been assigned to guard the doors continuously until the affected doors were fixed, and that residents on the affected units would be checked to ensure they were accounted for. The Administrator said he could not verify that the doors were continuously monitored or that residents were accounted for during the dates the doors were first identified as not to be working (8/14/24). The Administrator said he returned to work on 8/20/24 after the event and was not aware of any outcome, did not check to see if there was an incident report about Resident #45 eloping from the secured unit and had just found out that there were multiple times that the alarmed doors had not been functioning during that time.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 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. 42741 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services in accordance with professional standards of practice for two Residents (#35 and #23) out of a total sample of 23 residents. Specifically, the facility failed to: 1. For Resident #35, ensure that Physician's orders were in place to address the liter flow (LPM-flow rate of Oxygen that is received from an oxygen delivery device) of Oxygen and appropriate maintenance and storage were in place for the Resident's nebulizer (machine that administers medication via a mist that is inhaled) device. 2. For Resident #23, notify the Provider timely for updated orders/interventions when there was a change in the Resident's condition and Oxygen was no longer being administered continuously per Physician's orders. Findings include: Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf indicates: -All oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Oxygen therapy should be administered in accordance with the Physician prescription. -Undesirable results or events may result from noncompliance with Physicians' orders or inadequate instruction for oxygen therapy. Review of the facility policy titled Oxygen Administration, date reviewed/revised May 2024, indicated the following: -Oxygen is administered to resident who need it, consistent with professional standards of practice -Oxygen is administered under orders of a physician . -The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as but not limited to: -The type of oxygen delivery system. -When to administer, such as continuous or intermittent and/or when to discontinue. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Equipment setting for prescribed flow rates. -Cleaning and care of equipment shall be in accordance with facility policies for such equipment. -Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations . 1.Resident #35 was admitted to the facility in January 2022 with a history of tobacco use. Review of the Physician Progress Note dated 10/11/24, indicated the Resident had a new onset of cough and congestion and was started on supplemental Oxygen set at 2 LPM. On 10/15/24 at 9:29 A.M., the surveyor observed Resident #35 in his/her room, seated in a wheelchair, and receiving supplemental Oxygen set at 2 LPM via a nasal cannula (NC: a thin flexible tube that provides supplemental oxygen through the nose via nasal prongs). The surveyor observed a nebulizer machine on the Resident's bedside table with the aerosol mask (mask attached to the nebulizer machine and applied to the face when a mouthpiece device cannot be used) was uncovered and a plastic storage bag (used to store the oxygen tubing and nebulizer mask when not in use) dated 10/12/24, laying on the bedroom floor. On 10/16/24 at 10:37 A.M., the surveyor and Nurse #2 observed the Resident in his/her room, seated in a wheelchair, receiving Oxygen set at 2 LPM via nasal cannula. The Resident's nebulizer was observed on the Resident's bedside table, covered with the plastic bag dated 10/12/24. Review of Resident #35's October 2024 Physician's orders indicated the following order: -Apply O2 (Oxygen) via NS [sic] to maintain pox (pulse oximetry/ oxygen saturation/SpO2 - method of monitoring Oxygen in the blood as a percentage of the maximum Oxygen the blood could carry) at 90% or above every shift for shortness of breath (SOB), start date 10/11/24. Further review of the October 2024 Physician's orders indicated no order for the liter flow (LPM) of Oxygen that the Resident should be receiving. During an interview on 10/16/24 at 10:43 A.M., the surveyor shared with Nurse #2 the photo taken on 10/15/24 of the plastic storage bag dated 10/12/24 laying on the floor in Resident #35's room. Nurse #2 said someone should not have placed the plastic bag back on the Resident's nebulizer mask and tubing after it had touched the floor. Nurse #2 said a new storage bag should have been obtained, as a storage bag for respiratory equipment coming into contact with the floor is an infection control concern. During a follow-up interview on 10/16/24 at 11:03 A.M., Nurse #2 said she had reviewed Resident #35's Physician's orders and she was unable to locate an order for the LPM the Resident's Oxygen should be set at. Nurse #2 further said the Physician order should indicate what the prescribed LPM is, so the facility staff could set the oxygen delivery equipment correctly. 50563 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #23 was admitted to the facility in July 2016, with diagnoses including Chronic Respiratory Failure (a condition that occurs when the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body, identified with symptoms of trouble breathing and fatigue), Heart Failure (HF: when the heart is unable to pump blood as it should resulting in fluid buildup in the feet, arms, lungs and other organs) and Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment). Review of Resident #23's Physician orders indicated the following: -Oxygen at 2 liters per minute via nasal cannula continuously to maintain SPO2 of 90% or better, initiated 4/12/24 with no stop date. Review of Resident #23's Nursing Progress Notes indicated that Oxygen was not administered (not being used continuously) on the following dates/times: -8/5/24 at 4:42 P.M. -8/6/24 at 9:11 A.M. -8/9/24 at 12:15 P.M. -8/13/24 at 11:40 A.M. -8/16/24 at 5:11 P.M. -9/24/24 at 5:02 P.M. -9/27/24 at 1:22 P.M. -9/30/24 at 4:48 P.M. -10/1/24 at 5:47 P.M. -10/4/24 at 12:53 P.M. -10/8/24 at 1:22 P.M. -10/16/24 at 3:57 P.M. Further review of Resident #23's Nursing Progress Notes indicated the following documented SPO2 levels: -9/6/24: SPO2 level on room air (no supplemental Oxygen use) documented as 91% -10/1/24: SPO2 level on room air documented as 96% -10/16/24: SPO2 level on room air documented as 93% (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #23's Oxygen Use Care Plan, initiated on 4/12/24, indicated to administer Oxygen as ordered. The surveyor observed Resident #23 without Oxygen in use on the following date and times: -10/15/24 at 9:46 A.M. -10/16/24 at 8:42 A.M. -10/16/24 at 2:45 P.M. -10/17/24 at 9:29 A.M. -10/18/24 at 8:36 A.M. -10/18/24 at 10:05 A.M. During an interview on 10/18/24 at 10:08 A.M. the surveyor and Nurse #9 reviewed Resident #2's oxygen order. Nurse #9 said the order indicated Oxygen was to be administered continuously which meant it should be on all the time. Nurse #9 further said that the Resident's SPO2 levels had been good but that until reviewed with the Provider and a new order is obtained to administer Oxygen as needed (PRN) instead of continuously, that the oxygen should not have been removed. During an interview on 10/18/24 at 10:13 A.M., the surveyor and the Nurse Practitioner (NP) reviewed Resident #23's order for continuous Oxygen administration. The NP said that Nurse #9 had reviewed this with her today and she gave an order for as needed (PRN) Oxygen administration as the Resident was not requiring Oxygen continuously any longer. The NP further said that before today she does not recall ever being notified that the Resident was not requiring continuous Oxygen or having a Nurse request an order change relative to Oxygen administration. During an interview on 10/18/24 at 12:42 P.M., Unit Manager (UM) #1 said that if an order reads to administer Oxygen continuously that the expectation is the Oxygen would be on at all times. UM #1 further said that the expectation is if a Nurse identified the Resident was not requiring Oxygen continuously any longer, that they should notify the Provider and obtain an order change before removing the Oxygen.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 42741 Based on interview, and record review, the facility failed to ensure that a recommendation made by the Behavioral Health Care Team was implemented for one Resident (#104) out of a total sample of 23 residents. Specifically, for Resident #104, the facility failed to ensure that a recommendation made by the Psychiatric Nurse Practitioner to increase the Resident's antianxiety medication after he/she experienced an increase in Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations) was reviewed by the Physician and implemented or alternate treatments were put into place. Findings include: Resident #104 was admitted to the facility in February 2024, with diagnoses including Generalized Anxiety Disorder and Major Depressive Disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy). Review of the Psychiatric Nurse Practitioner's Note dated 10/9/24, indicated the following: -The Resident was seen due to increased Anxiety and recurrence of past behaviors, including increased complaining and attention seeking. -Recommendation to start Ativan (Lorazepam: antianxiety medication) 0.5 milligrams (mg) two times a day (BID). Review of Resident #104's October Physician's order indicated the following: -Lorazepam (Ativan) 0.5 mg (give 1/2 tablet [0.25 mg]) by mouth three times a day, related to Anxiety Disorder, start date of 5/15/24. Review of the October 2024 Certified Nursing Behavior Monitoring/Intervention Flowsheets indicated Resident #104 continued to have verbal and socially inappropriate behaviors daily: -from 10/10/24 through 10/14/24 -and on 10/16/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 4:42 P.M., Nurse #5 said notes from the Psychiatric Nurse Practitioner are available the day after she sees a resident. Nurse #5 said the Psychiatric Nurse Practitioner's note gets reviewed by the Unit Manager (UM) and then is placed in the Medical Doctor (MD)/Nurse Practitioner's (NP) book (binder kept on the unit that provides communication between Resident's Health Care Providers and/or Nursing) so it can be reviewed. She said the either the MD or NP is in the building every day so she would expect the recommendation would be reviewed within a couple of days of the recommendation being made. Nurse #5 further said the MD or NP would let nursing know if they wanted to increase the Ativan as recommended or provide alternate treatment and nursing should make a note with the MD or NP's decision or get an order to begin the new medication. Nurse #5 reviewed the MD/NP book and the Resident's medical record and said she was unable to find any documentation the MD or NP had reviewed the Psychiatric Nurse Practitioner's recommendation from 10/9/24. During an interview on 10/17/24 at 4:57 P.M., UM #1 said recommendations made by the Behavioral Health Care Team should be reviewed by the MD or NP within a couple of days of the recommendation being made. UM #1 said she could find no documentation the MD or NP had reviewed the Psychiatric Nurse Practitioner's recommendation to increase Resident #104's Ativan medication.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 45435 Based on interview, and record review, the facility failed to ensure that recommendations made by the Consultant Pharmacist during a monthly Medication Regimen Review (MRR) were acted upon as required for one Resident (#59), of five applicable residents reviewed for unnecessary medications, out of a total sample of 23 residents. Specifically, the facility failed to act upon the Consultant Pharmacist recommendations dated 8/21/24 and 9/18/24, to include an evaluation and/or stop date for a PRN (as needed) psychotropic (medication that affects how the brain works and causes changes in mood, awareness, thoughts, feelings or behavior) medication. Findings include: Resident #59 was admitted to the facility July 2024, with diagnoses including unspecified Dementia (the loss of cognitive function, thinking, remembering and reasoning, to such an extent that it interferes with a person's daily life and activities). Review of the October 2024 Physician's orders, indicated the following: -Lorazepam (anti-anxiety medication) oral tablet 0.5 milligrams (mg), give 0.5 mg by mouth every 12 hours as needed (PRN) for Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations), start date 8/3/24. Review of the Consultant Pharmacist Recommendations, dated 8/21/24 and 9/18/24, indicated the following: -Lorazepam PRN order needs a stop date/re-evaluation date added to order. Review of the Clinical Record, dated 8/21/24 through 10/16/24 indicated no documented evidence the Consultant Pharmacist recommendations dated 8/21/24 and 9/18/24, had been acted upon. During an interview on 10/17/24 at 1:30 P.M., the Director of Nursing (DON) said that after the Pharmacist has reviewed the residents, the DON and the Unit Mangers (UM), would receive an e-mail with the Pharmacist's Recommendations. The DON said the facility process for pharmacy recommendations was that the UM prints the recommendations for the Physician and puts them in them in a folder for the Physician to address. Once the pharmacy recommendation was addressed, the UM would enter any new orders into the medical record. The DON said that she did not have a system in place for verifying that the pharmacy recommendations had been addressed and said the surveyor should check with the UM. During an interview on 10/17/24 at 1:47 P.M, Nurse #7 said that she had never seen the Consultant Pharmacist's Recommendations for Resident #59 dated 8/21/24 and 9/18/24. Nurse #7 reviewed the Physician Communication book and said she could not find any of the recommendations. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 1:48 P.M., UM #2 said that when she receives the Pharmacist's Recommendations via e-mail, she prints them and puts them in the Physician's book. UM #2 said once the recommendations were approved, she would enter any new orders into the resident's medical record. UM #2 said she did not recall seeing the Pharmacist's Recommendations dated 8/21/24 and 9/18/24, for Resident #59, and offered to look for them. During a follow-up interview on 10/17/24 at 2:13 P.M., UM #2 said she was unable to find any documented evidence that the Pharmacist's Recommendations dated 8/21/24, had been addressed because she had not taken the position as UM until September 2024. UM #2 further said that she had missed the Pharmacist's Recommendations dated 9/18/24. (Refer to F758)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45435 Based on record review, policy review and interview, the facility failed to ensure that as needed (PRN) orders for psychotropic (medication that affects how the brain works and causes changes in mood, awareness, thoughts, feelings or behavior) medications were only used when necessary and PRN use is limited for one Resident (#59), of five applicable residents reviewed for unnecessary medications, out of a total sample of 23 residents. Specifically, for Resident #59, the facility failed to ensure that PRN Lorazepam (Ativan: antianxiety medication) was limited to 14 days, unless otherwise documented by the Attending Physician or Prescribing Practitioner that it was appropriate to extend beyond 14 days. Findings include: Review of the facility policy titled Use of Psychotropic Medications, dated March 2024, indicated the following: -PRN orders for all psychotropic drugs shall be used only when medication is necessary to treat a diagnosed specific condition that is documented in the clinical record and for a limited duration (i.e.14 days). -If the Attending Physician or Prescribing Practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order. Resident # 59 was admitted to the facility July 2024 with a diagnosis of unspecified Dementia (the loss of cognitive function, thinking, remembering and reasoning, to such an extent that it interferes with a person's daily life and activities). Review of the October 2024 Physician's orders, indicated the following: -Lorazepam (anti-anxiety medication) oral tablet 0.5 milligrams (mg), give 0.5 mg by mouth every 12 hours as needed (PRN) for Anxiety, start date 8/3/24. Review of the August 2024 Medication Administration Record (MAR), indicated the Resident received Lorazepam 0.5 mg by mouth as needed (PRN) for Anxiety, with effect on: -8/6/24 through 8/8/24 -8/10/24 through 8/14/24 -8/19/24 -8/28/24 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/29/24 -8/31/24 Review of the September 2024 MAR, indicated the Resident received Lorazepam 0.5 mg by mouth PRN for Anxiety, with effect on: -9/3/24 -9/21/24 Review of the October 2024 MAR, indicated the Resident received Lorazepam 0.5 mg by mouth PRN for Anxiety, with effect on: -10/5/24 -10/8/24 -10/10/24 -10/16/24 Review of the Behavioral Health Group Progress Notes, dated 9/4/24 and 9/11/24, indicated no documented evidence of a rationale to extend the use of Lorazepam 0.5 mg every 12 hours as needed (PRN) past 14 days after the medication was initiated on 8/3/24. Review of the Physician's Progress Note, dated 10/7/24, indicated no documented evidence of a rationale to extend the use of Lorazepam 0.5 mg every 12 hours as needed (PRN) past 14 days after the medication was initiated on 8/3/24. During an interview on 10/17/24 at 2:17 P.M, Unit Manager (UM) #2 said the facility policy was that PRN psychotropic medications could not be used after 14 days. UM #2 said there should have been a stop date, or a re-evaluation date added to Resident #59's Lorazepam PRN order but there had not been, and the Resident had received the medication for more than 14 days.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on observation, interview, and policy review, the facility failed to adhere to safe food practices to prevent contamination of food and beverage items intended for resident consumption in the facility's main kitchen. Specifically, the facility failed to implement safe food practices in the main kitchen relative to: -labeling/dating, storage guidelines. -use of hair restraints in order to reduce the risk of cross contamination/spoilage of food items. -maintaining the facility kitchen in a clean, sanitary, and free of dust and debris manner. Findings include: Review of the facility policy titled Dietary Rules, dated July 2020, included the following: -Personal items: should be stored in the office. No bags, jackets, sweaters or purses should be kept in the kitchen . -Drinks and food: Drinks should never be brought into the kitchen from outside. Food from the outside is not allowed in the kitchen for personal consumption. Food may not be consumed in the kitchen except for taste testing (trying food). -Hairnets (hair restraints): must be worn whenever working in the kitchen. A cap may be worn, but if the hair is hanging out of the back (of the cap), it must be in a hairnet under the cap. -Beards: must be kept neat, clean and trimmed. If a beard is not kept short, it must be under a beard/hairnet. Review of the Food and Drug Administration (FDA) Food Code, dated January 2023, included the following: -Consumers are particularly sensitive to food contaminated by hair. Hair can be both a direct and indirect vehicle of contamination. Food employees may contaminate their hands when they touch their hair. A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair. -Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single use articles (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-an employee shall eat, drink, or use any form of tobacco products only in designated areas where the contamination of exposed food; clean equipment, utensils, and linens; unwrapped single-service and single-use articles; or other items needing protection can not result. -a food employee may drink from a closed beverage container if the container is handled to prevent contamination of: (1) The employee's hands; (2) The container; and (3) Exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles -Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. During an initial walk-through of the facility kitchen on 10/15/24 at 7:22 A.M., with the Food Service Director (FSD), the surveyor observed the following: -a large fan located in the kitchen near the beverage preparation area that was dust laden. -the front vent of the reach-in refrigerator by the cook's area was dust laden. -the ceiling tile between the cook's stovetop and reach-in refrigerator had observable dust hanging downwards. -the exhaust fan located in the window near the preparation sink was dust laden and sticky to the touch. -the spray hose under the exhaust fan had observable dust and was sticky to the touch. -shelving that had clean pans located near the ovens had dust. -an enclosed bin that had numerous clean measuring cups, spoons and other utensils had food debris on the bottom of the drawers where the items were located. -a pan of covered meat patties, opened wrapped sliced deli cheese, and an opened wrapped deli meat without labels or dates were in the reach-in refrigerator. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-pulled unopened clear package of cut up white colored meat without a label or a date in the walk-in refrigerator. -dietary staff personal beverages observed on the lower shelf of the cook's preparation area and on the upper shelf beverage preparation area During an interview at the time, the FSD said the utensils and other items located in the clear bin under the cook's preparation bench needed to be cleaned. The FSD said any food and beverage items located in the refrigerators needed to be labeled and dated when stored for future use. The FSD said personal employee beverages were allowed as long as they were covered and stored below the food preparation areas. The FSD further said the dust on the fans, ceiling, refrigerator vents and shelving needed to be cleaned. During a follow-up walk through of the facility kitchen on 10/18/24 at 2:00 P.M., the surveyor observed the following: -dietary employees observed with facial hair not covered by a beard net in the kitchen. -an employee beverage in a [NAME] Donuts cup and a cell phone charger and cord on a shelf with the cups and covers used for resident service. During an interview at the time, the FSD said that dietary employees with facial hair less than a quarter of an inch or less were not required to wear a beard net. The FSD further said that dietary employee personal items including the beverage and the cell phone charger should not have been stored in the food preparation areas.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 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. 42741 Based on interview, and record review, the facility failed to ensure that documentation was maintained in the medical record that weekly skin checks had been completed for one Resident (#72) out of a total sample of 23 residents. Specifically, for Resident #72, the facility failed to ensure that weekly skin check documentation was completed for the Resident who was at risk of skin break down, and maintained in the medical record putting the Resident at risk for having skin break down go untreated. Findings include: Review of the facility policy titled Skin Assessment, reviewed/revised June 2024, indicated the following: -A full body, or head to toe, skin assessment will be conducted by a Licensed or Registered Nurse upon admission/re-admission, daily for three days, and weekly thereafter. -Documentation of skin assessment: include date and time of the assessment, your name, and position title. Resident #72 was admitted to the facility in August 2023, and had diagnoses including a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) to his/her coccyx (tail bone) and a history of skin break down. Review of Resident #72's October 2024 Physician's orders indicated the following order: -Weekly skin checks. Please see room assignment for accurate date and shift. Order created on 6/11/24. Review of the Resident's medical record indicated no documentation that weekly skin checks had been completed after 9/16/24. During an interview on 10/16/24 at 11:37 A.M., Unit Manager (UM) #2 said 9/16/24 was the last weekly skin check documentation she was able to find for Resident #72. UM #2 said there had been an issue with the facility's electronic medical record (EMR) and skin check orders were not being triggered weekly. UM #2 further said no staff member in the facility had been auditing to ensure that nursing staff were completing weekly skin checks as ordered when the EMR was not prompting nursing to complete skin checks weekly. UM #2 said nursing staff should complete and document weekly skin assessments, and this was not being done for Resident #72.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 42741 Based on interview, and record review, the facility failed to ensure the Arbitration Agreement was explained to one Resident's (#59) Resident Representative, out of a total sample of four arbitration agreements reviewed. Specifically, the Resident Representative for Resident #59 was not given the opportunity to have the Arbitration Agreement explained to him/her by the facility when it was determined that Resident #59 was cognitively impaired. Findings include: Review of the facility policy titled Binding Arbitration Agreements, reviewed/revised November 2023, indicated the following: -When explaining the arbitration agreement, the facility shall: >Ensure the resident or his or her representative acknowledges that he or she understands the agreement. Resident #59 was admitted to the facility in August 2024, with a diagnoses of Cognitive Communication Deficit (difficulty paying attention to conversation, remembering information, and responding accurately), Dementia with Agitation (progressive disease with impairment in memory and functioning that includes symptoms such as agitation), and Disorientation. Review of the Nursing Progress Note dated 7/11/24, indicated Resident #59 was unable to complete the admission paperwork due to his/her Health Care Proxy (HCP) being activated and his/her HCP needed to come in to sign paperwork and consents. Review of the HCP Activation form, dated 5/31/23, indicated the Attending Physician had previously activated the Resident's HCP due to a diagnosis of Dementia and the duration of the incapacity was permanent. Review of Resident #59's Massachusetts Health Care Proxy Form, signed 8/31/21 by the Resident, indicated Family Member #1 was Resident #59's primary HCP. Review of the Alternate Dispute Resolution (ADR) Agreement (the facility's arbitration agreement), dated 7/12/24, indicated the Resident him/herself had completed the ADR agreement with the facility Concierge (staff member who assisted with getting admission forms completed at the time of admission) and there was no documentation to show Family Member #1 had been in attendance when Resident #59 signed the ADR Agreement. During an interview on 10/17/24 at 12:16 P.M., Family Member #1 who was Resident #59's HCP said he/she was unable to recall ever signing the facility ADR Agreement or ever being explained what the ADR Agreement was by a staff member at the facility. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 1:49 P.M., with the Concierge and the Administrator, the Concierge said she was the primary staff member who completed the ADR Agreement paperwork with Residents and/or their Resident Representatives. The Concierge said when an ADR Agreement is completed the Resident's name is automatically populated as the person signing the agreement. The Concierge further said she thought Resident #59's HCP had been in attendance, but she would need to look to see if there was any documentation to show Resident #59's HCP had been in attendance when the ADR Agreement was completed on 7/12/24. The facility did not provide any documentation by the end of the survey to the surveyors to show Resident #59's HCP had the ADR Agreement explained and he/she understood the ADR Agreement that had been signed on 7/12/24.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on observation, interview, record and policy review, the facility failed to adhere to infection control practice standards in the facility laundry room and for three Resident (#18, #23, and #5) out of a total sample of 23 residents. Specifically, facility staff failed to: 1. In the facility's clean laundry room, store clean mechanical lift (assistive device that allows people whose mobility is limited to be transferred between a bed and a chair or other similar resting places, by the use of electrical or hydraulic power) slings (fabric portion of a mechanical lift system that comes into direct contact with the person and supports their weight during transfers) and clean bath linens in a manner to reduce the risk for contamination by dust and debris. 2. For Resident #18, adhere to requirements relative to Enhanced Barrier Precautions (EBP: infection control measures that involve gown and glove use during high-contact resident care activities) for Resident #18 when the Resident had a pressure ulcer (PU: injury to the skin and the tissue below the skin due to pressure) and ileostomy (surgical opening in the belly [abdominal wall] for stool to leave the body), increasing the Resident's risk for infection. 3. Position Resident #23's indwelling catheter tubing off the floor, increasing the Resident's risk for infection. 4. For Resident #5 ensure that Contact Precautions (type of TBP used to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or patient environment) were implemented when the Resident was suspected to have Scabies (parasitic infestation caused by tiny mites that burrow into the skin and lay eggs, causing intense itching and a rash) infection increasing the risk of potential transmission to other residents. Findings include: 1. Review of the Centers for Disease Control and Prevention (CDC) guidance titled Healthcare-Associated Infections (HAIs), Appendix D - Linen and Laundry Management, Best Practices for Management of Clean Linen, dated 3/19/24, indicated: Sort, . and store clean linens in a manner that prevents risk of contamination by dust, debris, . On 10/17/24 at 2:30 P.M., the surveyor observed the following in the facility laundry's clean linen room: -One large plastic barrel with a heaping number of mechanical lift slings piled approximately 12 inches higher than the top of the barrel. -Several mechanical lift slings were hanging over the sides of the barrel and the sling straps were on the floor. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-that the floor in the clean linen room had dust and debris (spots of dried brown debris, pieces of torn plastic). -The tops of the washing machines (located in the clean linen room) were covered in dust and dripped, dried white debris. -Dust, dried brown debris, torn pieces of plastic covered in dust, a crumpled paper covered in dust, and one black glove covered in dust, in between the slats of, and under wood pallets next to one washing machine. -Laundry Aide #1 standing at the table in the clean laundry room, folding towels and stacking them on the table. During an interview on 10/17/24 at 2:40 P.M., Laundry Aide #1 said he worked full time at the facility and had worked at the facility for about one year. Laundry Aide #1 said that the mechanical lift slings piled in the barrel were all clean and that staff from resident units would come to the laundry room to retrieve slings as needed for residents in the facility. Laundry Aide #1 said that there was no other place to store the slings and that he had always been told to put them in the barrel. Laundry Aide #1 said that there was dust and debris on the floor in the clean linen room and that there was also dust and debris on the tops and sides of the washing machines. Laundry Aide #1 said that there was no cleaning schedule for the floor or equipment in the clean linen room and that laundry personnel would just clean the area when they noticed the area needed cleaning. Laundry Aide #1 said that he did not know when the clean linen room and its equipment had been cleaned last. During an observation and interview on 10/17/24 at 2:45 P.M., the surveyor observed the clean linen room with the Laundry Supervisor. The Laundry Supervisor said that laundry staff were required to clean the laundry room and that there was no cleaning schedule in place. The Laundry Supervisor said that the mechanical lift slings in the barrel were clean and that the slings touching the floor would be considered contaminated. The Laundry Supervisor also said it was important to keep the floor and equipment clean and free of dust and debris in the clean linen room as this was the room where clean linens were stored before being transported to the resident units. The Laundry Supervisor then said that he did not know when the areas were cleaned last and that he hoped that laundry staff would be able to clean the clean linen room by the upcoming weekend. During an interview on 10/18/24 at 12:15 P.M., the District Manager for Laundry Services said that laundry staff were responsible to maintain the clean linen room in a sanitary manner to reduce the risk for contamination of clean linens. The District Manager for Laundry Services said that the clean mechanical lift slings should have been stored in a manner to ensure they did not come in contact with the floor and that that floor and equipment in the clean linen room should have been free of dust and debris. 42690 2. Review of facility policy titled Enhanced Barrier Precautions, revised August 2024, indicated the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. -High-contact resident care activities include (in part): a. dressing b. bathing c. transferring d. providing hygiene g. Device care or in use: urinary catheters h. Wound care: any skin opening requiring a dressing -Enhanced Barrier Precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Resident #18 was admitted to the facility in August 2024, with diagnoses including Ileostomy Status, Pressure ulcer of the sacral Region (bottom of the spine), Pressure ulcer of the left heel, and a local infection of the skin and subcutaneous tissue (just under the skin). Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated the following in Section H (Bowel and Bladder): -Appliances: --Indwelling catheter --Ostomy (including ileostomy) Review of the Wound Care follow-up Progress Note dated 10/8/24, indicated the following: -Patient is being seen today for evaluation and treatment recommendations regarding pressure ulcers to coccyx, bilateral buttocks, left heel and right elbow. On 10/15/24 at 10:52 A.M., from the hallway outside of Resident #18's room, the surveyor observed the following: -EBP signage hanging on the door frame at the entrance of the Resident's room that indicated for Providers to wear gloves and a gown for high-contact resident care activities. High-Contact activities included: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-dressing, transferring, providing hygiene, changing briefs, device care (urinary catheter), wound care (any skin opening that required a dressing). -A three drawer bin containing PPE, that included gloves and gowns. -Resident #18's privacy curtains drawn and voices could be heard from behind the curtains. The surveyor observed CNA #3 exiting the room immediately after the observation on 10/15/24 at 10:52 A.M. The surveyor observed that CNA #3 was not wearing a gown or gloves. When the surveyor asked which of the three residents in the room were on EBP, CNA #3 said that he was not sure which of the three residents in the room were on EBP because he did not usually work on this side of the hallway. When the surveyor asked how CNA #3 would find out which resident in the room required EBP be donned (worn) when providing care, he said that he would have to ask the person he was working with, CNA #2. Immediately following the interview with CNA #3, CNA #2 opened the privacy curtains for Resident #18. When the surveyor asked CNA #2 what kind of care was being provided for Resident #18, CNA #2 said she and CNA #3 provided full body care and should have worn PPE, but just forgot. The surveyor observed that Resident #18 was lying in bed at this time. On 10/15/24 at 10:55 A.M., the surveyor and CNA #2 observed the EBP sign outside of Resident #18's room. CNA #2 said that PPE should be worn when performing the following activities: dressing, bathing, and transfers. The surveyor observed CNA #3 enter the room with a Hoyer lift (a mechanical lift used to transfer a resident from the bed to the wheelchair) and CNA #2 followed behind CNA #3 and closed the door. The surveyor did not observe either CNA #2 or CNA #3 don the appropriate PPE from the PPE cart located outside of the Resident's room, as required. The surveyor observed several minutes later, CNA #2 and CNA #3 exited the room, and Resident #18 could be seen in the room, seated in the wheelchair. The surveyor did not observe CNA #2 or CNA #3 doff (remove) any PPE when they exited the Resident's room. During an interview on 10/16/24 at 8:05 A.M., the Director of Nursing (DON) said that gowns and gloves should have been worn while care was provided for Resident #18 as EBP were in place due to the Resident having wounds, an ileostomy, and a urinary catheter. 50563 3. Review of the facility policy titled Catheter Care, Urinary, dated January 2024, indicated the following: -Infection Control: >Be sure the catheter tubing and drainage bag are kept off the floor. Resident #23 was admitted to the facility in July 2016, with diagnoses including Dementia (the loss of cognitive functioning including thinking, remembering and/or reasoning to such an extent that it interferes with a person's daily life). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 9:25 A.M., the surveyor observed Resident #23 seated in his/her wheelchair with the indwelling catheter bag below the wheelchair in a privacy bag. The surveyor observed the privacy bag was laying on the floor. On 10/16/24 at 2:45 P.M., the surveyor observed Resident #23 seated in his/her wheelchair with the indwelling catheter bag positioned below the wheelchair in a privacy bag. The surveyor observed the catheter tubing was intermittently touching the floor. On 10/17/24 at 9:29 A.M., the surveyor observed Resident #23 seated in his/her wheelchair with the indwelling catheter bag positioned below the wheelchair in a privacy bag. The surveyor observed the catheter tubing was laying on the floor. On 10/18/24 at 10:03 A.M., the surveyor and CNA #5 observed Resident #23. CNA #5 said that the indwelling catheter tubing was laying on the floor. CNA #5 further said that the catheter tubing being on the floor was an infection control concern. On 10/18/24 at 12:42 P.M., the surveyor reviewed the observations of the indwelling catheter privacy bag and tubing with Unit Manager (UM) #1. UM #1 said this was an infection control concern. On 10/18/24 at 1:00 P.M., the Director of Nursing (DON) said the expectation is that the indwelling catheter would be kept off the floor. 51466 4. Review of the Massachusetts Department of Public Health (MA DPH) Guidance titled Infection Prevention in Long Term Care Scabies, dated January 2019, included the following: -In addition to Standard Precautions, Contact Precautions should be used for the care of patients infested with scabies until 24 hours after beginning treatment with an appropriate scabicide (medication that kills the itch mite that causes scabies). -Contact Precautions can be discontinued if 24 hours have passed following the application of the scabicide. Review of the facility policy titled Head Lice and Scabies Exposure and Treatment, revised October 2024, indicated: -Residents who contract scabies are treated according to current standards of practice to eradicate the infestation and prevent further exposure and transmission. -Nursing will administer scabies treatment according to manufacturer's instructions. -Staff or residents who may have had potential contact with the affected resident should be assessed for signs of scabies infestation -Staff will follow appropriate transmission-based precautions- including Personal Protective Equipment (PPE), when providing care to the affected resident(s). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5 was admitted to the facility in October 2023, with diagnoses including Respiratory Failure (a serious condition that makes it difficult to breathe on your own that develops when the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body), Chronic Obstructive Pulmonary Disease (COPD- a chronic lung disease that causes obstructed airflow from the lungs and difficulty breathing) Coronary Artery Disease (CAD: heart condition that occurs when fatty deposits of plaque build up in the coronary arteries causing them to narrow and restrict blood flow to the heart), and Dementia. Review of the Minimum Data Set (MDS) Assessment, dated 10/4/24, indicated Resident #5 had moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 8 out of 15, and required partial to moderate assistance with activities of daily living (ADLS: basic tasks like bathing, dressing and eating). Review of the Resident #5's clinical record included the following: -Nursing Progress Note, dated 10/8/24, indicated the Resident was complaining of being very itchy and was observed to have a raised rash on his/her bilateral (both) hands. The Nurse requested the Wound Team assess the areas, and an outside appointment was made with Dermatology for 2:00 P.M. that day. -Wound Consultation Note, dated 10/8/24, indicated the Resident had an evaluation for scabies rash on his/her abdomen, chest, neck, hands, and bilateral legs. The areas had linear indurated (thickening and hardening of the skin in a line pattern) rash with erythema (redness) and itchiness that worsened at night. -Nurse Practitioner (NP) Progress Note, dated 10/9/24, (late entry for 10/8/24), indicated the Resident presented with a rash and intermittent itchiness to his/her arms, neck and right leg. There was concern for scabies and it was recommended that the Resident be seen by Dermatology for definitive diagnosis and for the facility to maintain precautions. -Dermatology Consult, dated 10/8/24, indicated the Dermatologist was unable to determine if scabies was present, but recommended treatment for scabies which included Permethrin Cream (scabicide) and Triamcinolone Cream (topical corticosteroid cream used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions). Review of the October 2024 Physician's Orders, indicated the following order was initiated on 10/8/24 at 4:00 P.M. (upon the Resident's return from the Dermatology Consult): -Permethrin Cream 5% from the neck down, then shower eight hours later and repeat the treatment on 10/18/24-1 week later, for treatment of Scabies, -Triamcinolone Cream 1% two times daily for two weeks, then daily for one month. Review of Administration Record (MAR) for October 2024, indicated the Permethrin Cream for Scabies treatment was administered to Resident #5 on 10/11/24 (3 days after the Dermatology Consult). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 10:09 A.M., the surveyor observed Resident #5 in his/her room. The surveyor observed that the Resident had a reddened raised rash with scattered scab-like areas and scratches to the top of his/her right hand and right upper arm. During an interview at the time, the Resident said the rash was from bugs. The surveyor observed the door outside of the Resident's room did not have signage indicating any precautions were in place, but a bin with three drawers which had PPE including gowns and gloves was located outside of the Resident's room. On 10/16/24, the surveyor observed the following: -7:45 A.M., a bin with PPE remained outside of Resident #5's room. There was no visible precautions signage. -8:28 A.M. Housekeeping Staff #1 entered the Resident's room with gloves that were previously worn cleaning other resident's rooms (Housekeeping Staff #1 did not doff, conduct hand hygiene and don new gloves) and hand hygiene was not performed prior to entering the Resident's room. Housekeeping Staff #1 exited the Resident's room shortly after wearing the same gloves, did not perform hand hygiene and proceeded to enter other resident rooms on the Unit. During an interview at 8:31 A.M., Housekeeping Staff #1 said he/she did not know why the PPE bin was outside of the Resident's room, and did not understand the surveyor's questions because he spoke French. -During an interview at 8:44 A.M., the SDC said the PPE bin outside of the Resident's room was for Enhanced Barrier Precautions (EBP: infection control intervention used to reduce the spread of organisms by utilizing PPE during high contact resident care activities). The SDC was observed to speak with Unit Manager (UM) #1 who said the Resident was on EBP related to a wound which had resolved. UM #1 said the PPE bin could be removed after breakfast. -9:04 A.M., Certified Nurses Aide (CNA) #7 said she did not know why Resident #5 had a precaution bin (PPE bin) outside of his/her room. -12:52 P.M., the PPE bin was no longer observed in front of the Resident's room. During an interview on 10/16/24 at 1:35 P.M., CNA #6 said she thought the Resident was on precautions for a respiratory infection. CNA #6 said if a Resident was put on precautions, the Nurse would notify the CNAs and a precaution sign would be posted outside of the room. CNA #6 further said she was not aware of any rashes or skin issues with any of the residents on the unit. During an interview on 10/16/24 at 1:58 P.M., UM #1 said Resident #5 was found to have a rash and was seen by the Wound Consultant for concern of scabies infection. UM #1 said the Resident was sent to a Dermatology appointment on the same day, and it was uncertain what caused the rash, but recommended treatment for scabies at that time. UM #1 said when Resident #5 left for the Dermatology appointment on 10/8/24, facility staff deep cleaned his/her room and performed skin checks on the other residents on the Unit. UM #1 said if a resident presents with a rash, the Nurse will notify the Physician and obtain orders including if precautions are warranted. UM #1 further said scabies could be contagious but would need to further clarify with the Infection Control Nurse because she is not very familiar with scabies and thought it was spread by touch. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/16/24 at 2:00 P.M., Nurse #8 said Resident #5 was treated for scabies and was put on Contact Precautions for 24 hours which started on 10/8/24 and ended on 10/9/24. Nurse #8 said if a Resident was put on Contact Precautions, a Physician's order would be obtained, staff would be made aware of the precautions, a sign is posted outside of the Resident's room and PPE would be used as indicated. The surveyor and Nurse #8 reviewed the Dermatology Consult, dated 10/8/24, and Nurse #8 said it was uncertain if Dermatology confirmed the diagnosis of scabies. Nurse #8 further said the Resident was treated for scabies due to the Dermatology recommendations and the Physician at the facility was in agreement with the recommendation and gave an order for treatment. During an interview on 10/17/24 at 9:42 P.M., the Director of Nursing (DON) said Resident #5 was found to have a rash during wound rounds on 10/8/24. The Wound Consultant felt strongly that it was scabies, so the Resident was put on Contact Precautions at that time. The DON said all items were removed from the Resident's room, including the mattress, and a deep clean was performed on 10/8/24 when he/she left for the Dermatology appointment. The DON said that she was filling in as the temporary Infection Control Nurse, was out of the building for a long weekend after the Resident's Dermatology appointment and the decision to keep the Resident on Contact Precautions would have been left for the Supervisor/ Unit Manager. The DON said was unaware that the precaution bin was still outside of the Resident's room until staff informed her on 10/16/24. The DON said if the Resident was placed on Contact Precautions, signage would be posted outside of the Resident's room to alert all staff that a gown and gloves were required to be worn prior to entering the room. The DON said there should have been a Physician's Order for Contact Precautions and a care plan should have been implemented indicating the rash and Contact Precautions that were in place. During an interview on 10/17/24 at 10: 08 A.M., UM #2 (who was also the Wound Nurse) said a wound assessment was requested for Resident #5 because a staff nurse had noted he/she had an itchy rash. UM #2 said the Resident's rash was evaluated by the Wound Consultant who noted that the Resident had self-inflicted scratches, had verbalized itchy skin, and had a rash on his/her abdomen, forehead, and hands. UM #2 said the Wound Consultant thought the rash could be scabies, a Dermatology appointment was obtained the same day, and the recommendation was made to treat the Resident for scabies. UM #2 said Resident #5 was immediately placed on Contact Precautions, and a PPE bin and signage were placed outside of the Resident's room. UM #2 said a deep cleaning of the Resident's room occurred on 10/8/24, and skin assessments were performed for other residents on the unit. UM #2 said Contact Precautions were put into place for 24 Hours, starting on 10/8/24 and were discontinued on 10/9/24. UM #2 said that the Wound Consultant reassessed the Resident's rash on 10/15/24, and noted scabs were present, but said there were no further complaints of itchiness, and was happy the facility was treating the Resident for scabies. UM #2 said when a resident required Contact Precautions, a Physician's order would be obtained, Nurses would verbally provide report about required precautions to the CNAs, and it would be documented in the Resident's care plan. During a follow-up interview on 10/17/24 at 11:09 A.M., UM #2 said Resident #5 was administered Permethrin Cream (treatment for scabies infection) on 10/11/24 (3 days after the Dermatology appointment). UM #2 said Contact Precautions were initiated on 10/8/24 and discontinued on 10/9/24 (where not in place until 10/12/24 as per the facility policy and MA DPH guidance), that the Resident's room was deep cleaned on 10/8/24 and had not been deep cleaned afterwards. UM #2 said she reviewed the Resident's clinical record and there was no Physician's order obtained for the Contact Precautions. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 1:17 P.M., the surveyor relayed concerns about the facility's infection control process relative to Resident #5 treatment of scabies infection. The DON said she did not know why Contact Precautions were not maintained until 24 hours after the Resident received his/her initial scabies treatment on 10/11/24.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on interview, and record review, the facility failed to offer an updated COVID-19 vaccine, in accordance with the Centers for Disease Control and Prevention (CDC) recommendations for one Resident (#11) out of five applicable sampled residents, out of a total sample of 23 residents. Specifically, the facility failed to offer an updated COVID-19 vaccine to Resident #11 when the Resident was not considered up-to-date with the COVID-19 vaccine, the updated COVID-19 vaccine was available to the facility, and the COVID-19 vaccine was not clinically contraindicated for the Resident, which increased the Resident's risk for acquiring COVID-19 infection and COVID-19 associated complications. Findings include: Review of the CDC Guidelines titled Use of an Additional Updated 2023-2024 COVID-19 Vaccine Dose for Adults Aged Greater than/Equal to [AGE] years: Recommendations of the Advisory Committee on Immunization Practices - United States, 2024, dated 4/25/24, indicated the Advisory Committee on Immunization Practices (ACIP) recommended a second dose of the 2023-2024 COVID-19 vaccine be administered to individuals greater than/equal to [AGE] years of age. Resident #11 was admitted to the facility in December 2019, with diagnoses including personal history of COVID-19 and Dementia (group of symptoms affecting memory, thinking and social abilities). Review of Resident #11's clinical record indicated the Resident received COVID-19 vaccinations on the following dates: -12/20/20 -1/18/21 -10/26/21 -4/29/22 -10/7/22 -7/10/23 Further review of the clinical record indicated the following: -The Resident was greater than [AGE] years of age. -The Resident's cognitive status for daily decision making was severely impaired. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Gardner Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Eastwood Circle Gardner, MA 01440	
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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident's Healthcare Proxy (HCP: individual designated to make medical decisions for a person when that person cannot make medical decisions for themselves) was invoked (put into effect). -There was no evidence the facility offered a second dose of the 2023-2024 COVID-19 vaccine for Resident #11 in accordance with the current CDC recommendations between 4/25/24 and 8/28/24. -The Resident tested positive for COVID-19 on 8/28/24. During an interview on 10/18/24 at 10:58 A.M., the Director of Nursing (DON) said that the most recent COVID-19 vaccine administered to Resident #11 was on 7/10/23. The DON said that she would have to look into whether a second dose of the 2023-2024 COVID-19 vaccine was offered to the Resident when an updated vaccine was recommended by the CDC in April 2024, and if the updated COVID-19 vaccine was available to the facility at the time. During an interview on 10/18/24 at 2:16 P.M., the Pharmacist said that the updated 2023-2024 COVID-19 vaccine was available to the facility when the CDC recommended a second dose of the 2023-2024 COVID-19 vaccine in April 2024. During an interview on 10/18/24 at 3:00 P.M., the DON said there was no evidence the facility offered a second dose of the 2023-2024 COVID-19 vaccine for Resident #11. The DON further said that the 2024-2025 COVID vaccine had recently been offered for the Resident, through the Resident's HCP. The DON said the Resident's HCP consented to the updated 2024-2025 COVID-19 vaccine and that the facility had the vaccine in stock, but the vaccine had not yet been administered to Resident #11.		