STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225199	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worcester Rehabilitation & Health Care Center	119 Providence Street Worcester, MA 01604

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. 37086 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had a Physician's Order for the administration of Suboxone (a narcotic medication used for the maintenance of opioid dependence), the Facility failed to ensure nursing notified Resident #1's Physician when his/her medication was unavailable to be administered in accordance with his/her Physician orders, as a result Resident #1 did not receive his/her scheduled doses for five days (missing a total of 15 doses). Findings include: Review of the accessdata.fda.gov website related to Suboxone, indicated the following: -The medication contains buprenorphine, a partial opioid agonist (produces a similar response to the intended chemical and receptor), and naxolone, an opioid antagonist (stops the receptor from producing a response), and is indicated for the maintenance of opioid dependence. -When discontinuing treatment, gradually taper to avoid signs and symptoms of withdrawal. Review of the Report submitted by the Facility, via the Health Care Facility Reporting System (HCFRS), dated 05/03/24, indicated that Resident #1 was admitted to the Facility in April 2024, and had not received his/her Physician ordered Suboxone until 05/01/24 (missing a total of 15 doses). Resident #1 was admitted to the Facility in April 2024, diagnosis included history of cocaine use disorder (in remission). Review of Resident #1's Physician's Orders, dated 04/25/24, indicated he/she was to receive Suboxone Sublingual (under the tongue) Film 8-2 milligrams (mg) one film sublingually three times a day (8:00 A.M., 2:00 P.M. and 8:00 P.M.) related to substance abuse. Review of Resident #1's Medication Administration Record (MAR), for the month of April 2024, indicated that Resident #1's Suboxone was not administered by nursing on the following dates, and that on each of the dates the MAR were initialed and signed off by nursing with charting code 9, which indicated to see the Nurse's Notes: -04/26/24 at 2:00 P.M. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	-04/27/24 at 2:00 P.M. -04/28/24 at 8:00 A.M. and 2:00 P.M. -04/29/24 at 8:00 A.M., 2:00 P.M. and 8:00 P.M. -04/30/24 at 8:00 A.M., 2:00 P.M. and 8:00 P.M. Review of Resident #1's Nurse Progress Notes, dated 04/28/24, 04/29/24 and 04/30/24, all indicated his/her Suboxone was unavailable. The Notes indicated that despite nursing use chart code 9 on 04/26/24 and 04/27/24 (see Nurses Note), there was no nursing documentation specific to the administration of Suboxone on those dates. Further review of Resident #1's Medical Record indicated there was no documentation to support that upon Resident #1's admission to the Facility, or before 04/30/24, of nursing staff ever having notified the Physician that Resident #1 had not received his/her Suboxone as ordered, or to request that the Physician send a prescription for the Suboxone to the pharmacy. During a telephone interview on 05/16/24 at 1:32 P.M., the Pharmacy Manager said the pharmacy required a prescription for Suboxone before the medication could be dispensed and the first prescription for Resident #1's Suboxone was received on 04/30/24. Review of the Controlled Substance Log (a book used by nursing to keep an accurate count of all narcotics and to record administration of narcotics), indicated the first entry for receipt of Resident #1's Suboxone (30 films) was on 05/01/24. During an interview on 05/15/24 at 12:22 P.M., Nurse #1 said that he was on duty and cared for Resident #1 on 04/26/24 during the 7:00 A.M. through 3:00 P.M. shift and also administered his/her 2:00 P.M. scheduled medications on 04/27/24. Nurse #1 said that Resident #1's Suboxone was unavailable. Nurse #1 said he did not notify the Physician that Resident #1 had not received the Suboxone as ordered and that the Suboxone was unavailable. During an interview on 05/15/24 at 3:34 P.M., Nurse #2 said that she was on duty and cared for Resident #1 on 04/26/24 and 04/27/24 during the 3:00 P.M. through 11:00 P.M. shift. Nurse #2 said Resident #1's Suboxone was unavailable. Nurse #2 said that she told her nursing supervisor that the medication was unavailable, but that she (Nurse #2) did not notify the Physician. During a telephone interview on 05/15/24 at 1:14 P.M., the Nursing Supervisor said that she was on duty on 04/27/24 and 04/28/24, and had not administered Suboxone to Resident #1 because it was unavailable. The Nursing Supervisor said she probably got side-tracked and forgot to follow-up, that she should have called Resident #1's provider to request a prescription for his/her Suboxone to be faxed to the pharmacy and to notify the provider that Resident #1 had not received his/her Suboxone as ordered. (continued on next page)

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Worcester Rehabilitation & Health Care Center	119 Providence Street Worcester, MA 01604

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Nurse Progress Notes, indicated on 04/28/24 at 8:27 A.M. and 3:17 P.M., and on 04/29/24 at 2:32 P.M., Nurse #4 entered that Resident #1's Suboxone was ordered but not yet received. During an interview on 05/15/24 at 12:01 P.M., Nurse #4 said that she was on duty and assigned to Resident #1 on 04/28/24 and 04/29/24 during the 7:00 A.M. through 3:00 P.M. shift. Nurse #4 said Resident #1's Suboxone was unavailable. Nurse #4 said she had heard from other nursing staff (exact names unknown) that Resident #1's Suboxone was on order. Nurse #4 said she did not notify Resident #1's provider that he/she had not received the scheduled Suboxone doses or that he/she needed a prescription for Suboxone to be sent to the Pharmacy. During an interview on 05/15/24 at 11:38 A.M., the Nurse Practitioner (NP) said that she was in to see Resident #1 at the Facility on 04/28/24 and nursing staff did not tell her that Resident #1 needed a prescription for his/her Suboxone or that Resident #1 had not received any doses of his/her Suboxone since admission. The NP said that once she was notified by nursing that Resident #1 needed a prescription (04/30/24), she sent it to the pharmacy, the NP said it had been several days and doses of the Suboxone that Resident #1 had not received as ordered. The NP said that as a general rule, not even one dose of Suboxone should be missed. During a telephone interview on 05/16/24 at 11:45 A.M., the Director of Nurses (DON) said that nursing should have notified Resident #1's provider immediately when Resident #1's Suboxone was not administered as ordered and when it was identified by nursing that Resident #1 did not have any Suboxone available. The DON said the Facility did not have a specific policy for Physician notification related to medications being unavailable or not administered because it was a basic standard of nursing practice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 37086 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had a Physician's Order for the administration of Suboxone (a narcotic medication used for the maintenance of opioid dependence), the Facility failed to ensure he/she was free from a significant medication error when he/she was not administered his/her narcotic medication multiple days in a row (missing a total of 15 doses), which placed him/her at increased risks for adverse side effects as a result of abruptly stopping the medication. Findings include: Review of the Facility Policy titled Medication Error Reporting, dated April 2015, indicated that a medication error is any preventable event that may cause or lead to inappropriate medication use, which the medication is in the control of the health care professional. The Policy indicated a Medication Error Report is to be completed immediately after an error is discovered to ensure proper resident/patient follow-up. Review of the Facility Policy titled Medication Administration, dated June 2015, indicated the following: -Verify the medication order on the Medication Administration Record (MAR) against the physician order -Identify the Resident -Verify the medication label to the resident's MAR -Verify the medication is being administered at the proper time, in the prescribed dose and by the correct route -Document medication administration. Review of the accessdata.fda.gov website related to Suboxone, indicated the following: -The medication contains buprenorphine, a partial opioid agonist (produces a similar response to the intended chemical and receptor), and naxolone, an opioid antagonist (stops the receptor from producing a response) and is indicated for the maintenance of opioid dependence. -When discontinuing treatment, gradually taper to avoid signs and symptoms of withdrawal. Review of the Report submitted by the Facility, via the Health Care Facility Reporting System (HCFRS), dated 05/03/24, indicated that Resident #1 was admitted to the Facility in April 2024, and had not received his/her Physician ordered Suboxone until 05/01/24 (missing a total of 15 doses). Resident #1 was admitted to the Facility in April 2024, diagnosis included history of cocaine use disorder (in remission). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 05/02/24, indicated Resident #1 scored 11 on the Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). During an interview on 05/15/24 at 10:55 A.M., Resident #1 said that he/she did not receive Suboxone during the first several days of his/her admission. Review of Resident #1's Physician's Orders, dated 04/25/24, indicated he/she was to be administered Suboxone Sublingual (under the tongue) Film 8-2 milligrams (mg) one film sublingually three times a day (8:00 A.M., 2:00 P.M. and 8:00 P.M.). Review of Resident #1's MAR for the month of April 2024, indicated that Resident #1's Suboxone was not administered by nursing on the following dates and each of the dates on the MAR were initialed and signed off by nursing with charting code 9, which indicated to see the Nurse's Notes: -04/26/24 at 2:00 P.M. -04/27/24 at 2:00 P.M. -04/28/24 at 8:00 A.M. and 2:00 P.M. -04/29/24 at 8:00 A.M., 2:00 P.M. and 8:00 P.M. -04/30/24 at 8:00 A.M., 2:00 P.M. and 8:00 P.M. Review of Resident #1's Nurse Progress Notes, dated 04/28/24, 04/29/24 and 04/30/24, all indicated his/her Suboxone was unavailable. Review of the Nursing Notes, dated 04/26/24 and 04/27/24, indicated that despite nursing use chart code 9 in the MAR, there was no documentation by nursing specific to the Suboxone on those dates. Review of Resident #1's Nurse Progress Notes, indicated on 04/28/24 at 8:27 A.M. and 3:17 P.M., and on 04/29/24 at 2:32 P.M., Nurse #4 entered that Resident #1's Suboxone was ordered but not yet received. During a telephone interview on 05/16/24 at 1:32 P.M., the Pharmacy Manager said the pharmacy required a prescription for Suboxone before the medication could be dispensed and the first prescription for Resident #1's Suboxone was received by the Pharmacy on 04/30/24 (six days after his/her admission). Review of the Controlled Substance Log (a book used by nursing to keep an accurate count of all narcotics and to record administration of narcotics), indicated the first entry for receipt of Resident #1's Suboxone (30 films) was on 05/01/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/24 at 12:22 P.M., Nurse #1 said that he was on duty and cared for Resident #1 on 04/26/24 during the 7:00 A.M. through 3:00 P.M. shift and also administered his/her 2:00 P.M. scheduled medications on 04/27/24. Nurse #1 said that he coded a 9 on Resident #1's MAR because his/her Suboxone was unavailable. Nurse #1 said Resident #1's Suboxone was also unavailable on 04/26/24 at 8:00 A.M. and although he documented that Resident #1 received the medication, he/she had not. During an interview on 05/15/24 at 3:34 P.M., Nurse #2 said that she was on duty and cared for Resident #1 on 04/26/24 and 04/27/24 during the 3:00 P.M. through 11:00 P.M. shift. Nurse #2 said that Resident #1's Suboxone was not available at that time, and said although she documented that Resident #1 received the medication, he/she had not. During a telephone interview on 05/15/24 at 1:14 P.M., the Nursing Supervisor said that she was on duty on 04/27/24 and 04/28/24, and she administered medications to Resident #1 on 04/27/24 at 8:00 A.M. and on 04/28/24 at 8:00 P.M. The Nursing Supervisor said that Resident #1 had not received his/her Suboxone as ordered because it was unavailable. During an interview on 05/15/24 at 11:38 A.M., the Nurse Practitioner (NP) said that she was in to see Resident #1 at the Facility on 04/28/24 and that nursing staff did not tell her that Resident #1 needed a prescription for his/her Suboxone. The NP said that once she was notified by nursing that Resident #1 needed a prescription (on 04/30/24), she sent it to the pharmacy, but that there were several days and doses of the Suboxone that Resident #1 had not received, as ordered. The NP said that as a general rule, not even one dose of Suboxone should be missed. During a telephone interview on 05/16/24 at 11:45 A.M. and 05/17/24 at 12:21 P.M., the Director of Nurses (DON) said that nursing should have notified Resident #1's provider immediately when Resident #1's Suboxone was not administered as ordered and when it was identified by nursing that Resident #1 did not have any Suboxone available. The DON said nursing should not have documented that the Suboxone was administered when it was not. The DON said she did not complete a medication incident report because she did not consider omission of a medication to be an error.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37086 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had a Physician's Order for the administration of Suboxone (a narcotic medication used for the maintenance of opioid dependence), the Facility failed to ensure they maintained a complete and accurate medical record when nursing documented the narcotic medication was administered, despite the medication being unavailable at the Facility. Findings include: Review of the Facility Policy titled Medication Administration, dated June 2015, indicated the following: -Verify the medication order on the Medication Administration Record (MAR) against the physician order -Identify the Resident -Verify the medication label to the resident's MAR -Verify the medication is being administered at the proper time, in the prescribed dose and by the correct route -Document medication administration. Review of the Report submitted by the Facility, via the Health Care Facility Reporting System (HCFRS), dated 05/03/24, indicated that Resident #1 was admitted to the Facility in April 2024 and had not received his/her Physician ordered Suboxone until 05/01/24 (missing a total of 15 doses). Resident #1 was admitted to the Facility in April 2024, diagnosis included history of cocaine use disorder (in remission). Review of Resident #1's Physician's Orders, dated 04/25/24, indicated he/she was to be administered Suboxone Sublingual (under the tongue) Film 8-2 milligrams (mg) one film sublingually three times a day (8:00 A.M., 2:00 P.M. and 8:00 P.M.) related to substance abuse. During a telephone interview on 05/16/24 at 1:32 P.M., the Pharmacy Manager said the first prescription for Resident #1's Suboxone was received on 04/30/24. Review of the Controlled Substance Log (a book used by nursing to keep an accurate count of all narcotics and to record administration of narcotics), indicated the first entry for receipt of Resident #1's Suboxone (30 films) was on 05/01/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's MAR for the month of April 2024 indicated nursing had initialed and signed off on the MAR that his/her Suboxone had been administered on the following dates (despite there having been none in the Facility to administer to him/her): -04/26/24 at 8:00 A.M. and 8:00 P.M. -04/27/24 at 8:00 A.M. and 8:00 P.M. -04/28/24 at 8:00 P.M. During an interview on 05/15/24 at 12:22 P.M., Nurse #1 said that he was on duty and cared for Resident #1 on 04/26/24 on 7:00 A.M. through 3:00 P.M. shift. Nurse #1 said he should not have initialed and signed off on Resident #1's Suboxone as being administered on 04/26/24 at 8:00 A.M. on the MAR because Resident #1's Suboxone was unavailable at that time. During an interview on 05/15/24 at 3:34 P.M., Nurse #2 said that she was on duty and cared for Resident #1 on 04/26/24 and 04/27/24 during the 3:00 P.M. through 11:00 P.M. shift. Nurse #2 said she initialed and signed off on Resident #1's April 2024 MAR that she administered his/her Suboxone at 8:00 P.M. on both evenings, but that she coded the administration in error. Nurse #2 said that she must have made a mistake because Resident #1's Suboxone was not available at that time. During a telephone interview on 05/15/24 at 1:14 P.M., the Nursing Supervisor said that she was on duty on 04/27/24 and 04/28/24, and she passed medications to Resident #1 on 04/27/24 at 8:00 A.M. and on 04/28/24 at 8:00 P.M. The Nursing Supervisor said that she must have documented that she administered Resident #1's Suboxone to him/her in error. During an interview on 05/15/24 at 11:38 A.M., the Nurse Practitioner said that once she was notified by nursing that Resident #1 needed a prescription, she sent it to the pharmacy (04/30/24) but that it was several days and doses of the Suboxone that Resident #1 had not received as ordered. During a telephone interview on 05/16/24 at 11:45 A.M., the Director of Nurses (DON) said nursing should not have documented that the Suboxone was administered when it was not.