

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Care One at Northampton		STREET ADDRESS, CITY, STATE, ZIP CODE 548 Elm Street Northampton, MA 01060	

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)
<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>44129</p> <p>Based on interviews and records reviewed for one of three sampled residents (Resident #1) who had a Nurse Practitioner's (NP) order, dated 01/14/25, to obtain a urine specimen for suspected urinary tract infection, the Facility failed to ensure that nursing notified the NP when they were unable to obtain the specimen as ordered, to determine next steps or obtain new orders. Resident #1 was transferred and admitted to the Hospital on 01/18/25 and was diagnosed with Urosepsis (a serious complication when the body has a life threatening response to an infection which can lead to organ failure, tissue damage, or death).</p> <p>Findings include:</p> <p>Review of the Facility's Policy titled, Change in Resident's Condition or Status, revised February 2021 indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident rights, etc.). - The nurse will notify the resident's attending physician or physician on call when there has been a (an) need to alter the resident's medical treatment significantly, and refusal of treatment or medication two or more consecutive times. <p>Resident #1 was admitted to the Facility in December 2024, diagnoses included, Urinary Retention (a condition where a person is unable to empty their bladder completely), Stiff Person Syndrome (SPS, a rare autoimmune neurological disorder characterized by muscle stiffness, spasms, and other neurological symptoms), Acute Focal Neurological Deficit (a problem with nerve, spinal cord, or brain function that can affect movement and sensation), and Functional Neurological System Disorder with abnormal movement (FND, a condition that affects how the brain and body communicate).</p> <p>Review of Resident #1's Physician's Orders for January 2025, indicated he/she had an order, dated 01/14/25, for nursing to obtain a urine specimen and send to the laboratory for urinalysis (U/A, a laboratory test that examines a person's urine to detect and evaluate various health conditions) with culture and sensitivity (C&S, a laboratory test that identifies the cause of an infection and determine the best treatment) every shift and discontinue the order once the urine specimen was obtained.</p> <p>(continued on next page)</p>

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
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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Treatment Administration Record (TAR) related to the Physician's Order, dated 01/14/25, to obtain a urine specimen indicated nursing documentation and coding (per the code key provided on the last page of the TAR) was as follows:</p> <ul style="list-style-type: none"> - 01/14/25, Evening Shift, a checkmark (per nursing means the order was acknowledged, but does not indicate the specimen was obtained) - 01/14/25, Night Shift, 9 (the code indicates, other, see nursing note) with no corresponding nursing note - 01/15/25, Day Shift, a checkmark - 01/15/25, Evening Shift, 2 (the code indicates resident refusal) - 01/15/25, Night Shift, 7 (the code indicates resident was asleep) - 01/16/25, Day, Evening and Night shift, a checkmark - 01/17/25, Day Shift, a checkmark - 01/17/25, Evening Shift 13 (the code indicates absence of condition, not applicable) - 01/17/25, Night Shift 9 (with a corresponding nursing note that it was attempted, but the Nurse was unsuccessful) <p>Review of Resident #1's Medical Record, which included diagnostic testing results and Progress Notes indicated there was no documentation to support his/her urine sample was ever obtained, and no documentation to support Nursing staff notified the Nurse Practitioner (NP) that the urine specimen had not been obtained.</p> <p>During an interview on 02/19/25 at 3:10 P.M., (which included a review of Resident #1's January 2025 TAR with the surveyor), Nurse #4 said that it did not appear nursing ever obtained a urine specimen from Resident #1. Nurse #4 said that if a nurse was unable to obtain a specimen, the expectation was to communicate that information to the nurse on the next shift and document why they were unable to obtain the specimen either on the TAR or in a Nursing Progress Note. Nurse #4 said after two unsuccessful attempts, it was expected the nurse notify the Provider (Physician or NP) and document that notification in a Nursing Progress Note.</p> <p>During an interview on 02/20/25 at 9:15 A.M., Unit Manager #1 said it did not appear that nursing staff ever obtained a urine specimen from Resident #1 and that the NP or Physician should have been notified. Unit Manager #1 said there was no documentation in Resident #1's record to indicate that Nursing staff notified the NP or Physician that the specimen was not obtained, as ordered.</p> <p>During an interview on 02/20/25 at 10:15 A.M., the Nurse Practitioner said she wrote an order to obtain a urine specimen from Resident #1, and said she was aware on 01/15/25 during the day shift that the specimen had not yet been obtained because she accessed the computerized laboratory system and did not see that the lab work was pending.</p> <p>(continued on next page)</p>		

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F 0580 Level of Harm - Actual harm Residents Affected - Few	<p>The NP said she spoke with Unit Manager #1 on 01/15/25 and told her that she needed to ensure Resident #1's urine specimen was obtained soon. The NP said if she had known the nurses were unable to obtain a urine specimen, she could have altered her treatment to include an order for an antibiotic based on Resident #1's symptoms.</p> <p>On 01/18/25, Resident #1 experienced a significant decline in status, was transferred and admitted to the hospital and was diagnosed with Urosepsis and pneumonia.</p> <p>During an interview on 02/20/25 at 11:05 A.M., the Director of Nursing (DON) said it did not appear that nursing staff obtained a urine specimen from Resident #1, as ordered. The DON said if the nurse on one shift was unable to obtain the specimen, it was the expectation the nurse would communicate that information at shift change to the oncoming nurse to attempt, and if after the second time the nurse was unable to obtain the specimen, the NP or Physician should have been notified to allow them the opportunity to alter the treatment plan (such as order an antibiotic based on symptoms).</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>44129</p> <p>Based on interviews and records reviewed for one of three sampled residents (Resident #1), who on 1/14/25, had a physician's order for nursing to obtain a urine specimen for a suspected urinary tract infection, the Facility failed to ensure they maintained a complete and accurate medical record, when nursing documentation related to obtaining the urine specimen was incomplete, including but limited to no documentation to support nurses communicated from shift to shift that the urine specimen still needed to be obtained.</p> <p>Findings include:</p> <p>Resident #1 was admitted to the Facility in December 2024, diagnoses included, Urinary Retention (a condition where a person is unable to empty their bladder completely), Stiff Person Syndrome (SPS, a rare autoimmune neurological disorder characterized by muscle stiffness, spasms, and other neurological symptoms), Acute Focal Neurological Deficit (a problem with nerve, spinal cord, or brain function that can affect movement and sensation), and Functional Neurological System Disorder with abnormal movement (FND, a condition that affects how the brain and body communicate).</p> <p>Review of Resident #1's Physician's Orders for January 2025, indicated he/she had an order, dated 01/14/25, (written by the Nurse Practitioner), for nursing to collect a urine specimen and send it to the lab for urinalysis (U/A, a laboratory test that examines a person's urine to detect and evaluate various health conditions) with culture and sensitivity (C&S, a laboratory test that identifies the cause of an infection and determine the best treatment) every shift and to discontinue the order once the specimen was obtained.</p> <p>Review of Resident #1's Treatment Administration Record (TAR) for January 2025, related to the Physician's Order, dated 01/14/25, to obtain a urine specimen indicated the following:</p> <ul style="list-style-type: none"> - 01/14/25, Evening Shift, a checkmark (per nursing means the order was acknowledged, but does not indicate the specimen was obtained) - 01/14/25, Night Shift, 9 (the code indicates, other, see nursing note) with no corresponding nursing note - 01/15/25, Day Shift, a checkmark - 01/15/25, Evening Shift, 2 (the code indicates resident refusal) - 01/15/25, Night Shift, 7 (the code indicates resident was asleep) - 01/16/25, Day, Evening and Night shift, a checkmark - 01/17/25, Day Shift, a checkmark - 01/17/25, Evening Shift 13 (the code indicates absence of condition, not applicable) <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 01/17/25, Night Shift 9 (with a corresponding nursing note that it was attempted, but the Nurse was unsuccessful)</p> <p>Review of Resident #1's Medical Record, which included laboratory results and Nursing Progress Notes, indicated there was no documentation to support that nursing staff obtained the urine specimen except for one Nursing Progress Note, dated 01/18/25, that indicated a nurse attempted to obtain the specimen but was unsuccessful in doing so.</p> <p>During an interview on 02/19/25 at 3:10 P.M., (which included a review of Resident #1's January 2025 TAR with the surveyor), Nurse #4 said that upon reviewing the TAR, it did not appear nursing ever obtained a urine specimen for Resident #1. Nurse #4 said a checkmark on the TAR did not mean the specimen was obtained, and there are certain codes nursing staff could use when documenting in the TAR. Nurse #2 said a nurse would use code 2 to indicate if a resident refused. Nurse #4 said there were other codes a nurse could enter such as 5 for held, and 9 for other, but said if those codes were used, the nurse was required to indicate a reason why the specimen could not be obtained.</p> <p>During a telephone interview on 02/20/25 at 2:00 P.M., Nurse #2 said she did not obtain a urine specimen from Resident #1 during the evening shift of 01/14/25 and said she could not remember if she reported this to the oncoming night shift nurse.</p> <p>During a telephone interview on 02/21/25 at 2:50 P.M., Unit Manager #1 said nursing staff never obtained a urine specimen from Resident #1, and if they were unable to obtain the specimen, they should have documented the reason as to why on either the TAR or in a Nursing Progress Note. Unit Manager #1 said the only documentation related to the nursing staff's reason why they did not obtain a urine specimen was in a Nursing Progress Note on 01/18/25, and the TAR on 01/15/25 for both the evening and overnight shift (refused and asleep).</p> <p>Unit Manager #1 said there was no additional nursing documentation on 01/14/25 (evening shift), 01/15/25 (day shift), 01/16/25 (any shift), or on 01/17/25 (any shift), to indicate why Resident #1's urine specimen had not been obtained.</p> <p>During an interview on 02/20/25 at 11:05 A.M., the Director of Nursing (DON) said nursing staff never obtained a urine specimen from Resident #1, as ordered. The DON said if the nurse on one shift was unable to obtain the specimen, it was the expectation the nurse would communicate that information at shift change to the oncoming nurse, so they knew to attempt to do so during their shift.</p> <p>The DON said the checkmarks on Resident #1's January TAR indicated that nursing staff acknowledged the order, however it did not mean the specimen was obtained. The DON said if nursing was unable to obtain the specimen, nursing was expected to select a code on the TAR (i.e., refused, asleep) and if there was not a specific code to indicate a reason, she said nursing should have documented a reason in a Nursing Progress Note.</p>		