

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Alliance Health at West Acres		STREET ADDRESS, CITY, STATE, ZIP CODE 804 Pleasant Street Brockton, MA 02301	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>48362</p> <p>Based on interview and record review, the facility failed to ensure residents were provided care in accordance with professional standards of practice for one Resident (#49), out of a sample of 23 residents. Specifically, the facility failed to ensure a medication to increase blood pressure was administered to the Resident as ordered by the physician.</p> <p>Findings include:</p> <p>Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised 4/11/18, indicated but was not limited to: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error.</p> <p>Review of the facility's policy titled Medication Administration - General Guidelines, undated, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - Medications are prepared only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to prepare and administer medications. - Medications are administered in accordance with written orders of the prescriber. <p>Resident #49 was admitted to the facility in September 2023 with diagnoses including paraplegia and hypertension.</p> <p>Review of Resident #49's active Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - 9/18/23: Midodrine (used to treat low blood pressure) 2.5 milligram (MG) tablet, one tablet twice daily, hold for systolic blood pressure (SBP) over 130. <p>Review of the July 2024 Medication Administration Record (MAR) indicated the Midodrine was given outside of physician prescribed parameters on the following days:</p> <ul style="list-style-type: none"> - 7/20/24, 9:00 A.M. dose: Blood Pressure (BP) 132/76 <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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 7/20/24, 2:00 P.M. dose: BP 132/76</p> <p>Review of the August 2024 MAR indicated the Midodrine was given outside of physician prescribed parameters on the following days:</p> <p>- 8/10/24, 9:00 A.M. dose: BP 136/82</p> <p>- 8/10/24, 2:00 P.M. dose: BP 132/76</p> <p>During an interview on 8/29/24 at 10:38 A.M., Resident #49 said he/she receives a BP medication twice a day. Resident #49 said he/she receives the medication to make sure his/her BP does not go too high or low when getting out of bed.</p> <p>During an interview on 8/29/24 at 10:45 A.M., the Assistant Director of Nursing (ADON) said Resident #49 receives Midodrine twice daily to ensure his/her BP values are stable when changing positions throughout the day. The ADON said the medication has parameters to ensure the Resident's BP does not increase too much during position changes. The ADON reviewed Resident #49's medical record and said the medication was given outside of parameters on 7/20/24 and 8/10/24. The ADON said she would expect the medication to be held if the SBP was greater than 130.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742</p> <p>Based on observation, interview, and document review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections when the facility was currently experiencing an outbreak of COVID-19 infection. Specifically, the facility failed to:</p> <ol style="list-style-type: none"> 1. Perform a COVID-19 related investigation and conduct contact tracing for a single new resident case to prevent, to the extent possible, the onset and spread of infection and ensure staff and resident COVID-19 surveillance line listings were maintained; 2. Ensure proper COVID-19 outbreak testing procedures were implemented for four of four facility staff members reviewed representing two (Station 1 Unit and Station 3 Unit, both COVID-19 affected units) out of three units; 3. Ensure staff rapid antigen COVID-19 testing (BinaxNOW) was conducted in a manner that is consistent with current standards of practice and manufacturer's instructions for use for one of one staff member observed; and 4. Ensure staff performed appropriate hand hygiene and implemented appropriate use of personal protective equipment (PPE) for the care of a COVID-19 positive resident to prevent unnecessary exposure and the potential spread of COVID-19 infection. <p>Findings include:</p> <p>During an interview on 8/26/24 at 2:12 P.M., the Assistant Director of Nursing (ADON) said the Infection Preventionist (IP) would not be present during the survey period, but she had a certificate of training and could speak to infection control policies and procedures in the IP's absence. The ADON said the facility used Massachusetts Department of Public Health (DPH), Centers for Disease Control and Prevention (CDC), and Centers for Medicare and Medicaid Services (CMS) guidance.</p> <p>Review of the current outbreak documentation (handwritten by the IP) provided by the ADON on 8/26/24 at 4:05 P.M. indicated the facility had 15 residents on the Station 1 Unit (short-term rehab) who were currently COVID-19 positive and one resident on the Station 3 Unit (long-term care) who had recovered on 8/23/24. The Station 2 Unit (long-term care) was unaffected. The documentation also indicated nine total staff members had tested positive for COVID-19.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/27/24 at 3:50 P.M. with the Administrator, Director of Nursing (DON), ADON, and Consulting Staff #1, the ADON said the facility was currently experiencing a COVID-19 outbreak which started on 8/15/24 on the Station 3 Unit when a resident had tested positive. They said all residents and staff on the Station 3 Unit were being tested as part of outbreak testing procedures. They said the Station 1 Unit became affected on 8/18/24 after a staff member had tested positive. The DON said unit-based testing was initiated on 8/19/24 and included all Station 1 residents, staff, and rehabilitation staff. She said outbreak testing for staff and residents was being conducted on the affected units starting within 48 hours after the potential exposure, then every 48 hours thereafter until the facility goes seven days without a new COVID-19 case. She said the Station 3 Unit completed outbreak testing on 8/20/24 with no new positives, however, the Station 1 Unit had not met the criteria yet. She said any resident or staff who had recovered from COVID-19 in the past 30 days were exempt from outbreak testing as long as they were asymptomatic.</p> <p>1. Review of CDC guidance titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, revised May 2023, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Healthcare facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed. -A single new case of SARS-CoV-2 infection in any healthcare personnel (HCP) or resident should be evaluated to determine if others in the facility could have been exposed. -Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. <p>Review of Massachusetts DPH Memorandum titled Update to Infection Prevention and Control Considerations When Caring for Long-Term Care Residents, including Visitation Conditions, Communal Dining, and Congregate Activities, dated 5/10/23, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Close contact means being within 6 feet for 15 minutes or more (in a 24-hour period), of someone diagnosed with COVID-19, while that individual was potentially infectious. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/26/24 at 4:15 P.M., the surveyor reviewed handwritten documentation on an August 2024 calendar and on a separate piece of paper provided by the ADON stating it was the IP's notes as it pertained to the current COVID-19 outbreak in the facility. The documentation was unclear as to the events that had occurred at the start of the outbreak with the first case dated as 8/14/24 when a resident had tested positive on the Station 1 Unit. The documentation did not indicate a proper investigation or contact tracing for the new COVID-19 resident case was conducted to determine if any staff or residents were potentially exposed. The documentation also failed to indicate that a COVID-19 tracking report had been maintained for each staff and resident who were either symptomatic or positive to include symptoms and the date of onset or follow up. The ADON said the resident who had tested positive on 8/14/24 on the Station 1 Unit was admitted the day prior from the hospital into a private room but did not have an admitting diagnosis of COVID-19 so was not placed on isolation precautions until the day after when he/she had tested positive. The ADON said the facility did not do contact tracing to identify any potential staff that may have been exposed while the resident was potentially infectious prior to his/her diagnosis but would confirm with the IP over the phone. The ADON further said the documentation provided to the surveyor did not reflect an adequate COVID-19 line listing as the documentation was unclear as to the names listed, there were no symptoms listed for any of the staff or residents, if any, and there were no dates of onset or follow up. She said it was not proper surveillance for the current outbreak. The surveyor requested additional documentation pertaining to the current outbreak including surveillance line listings.</p> <p>During an interview on 8/26/24 at 4:53 P.M., the ADON and DON said they spoke to the IP who said the documentation provided to the surveyor was her line listing and there was nothing else. She said she just wrote it down on the calendar and piece of paper and did not list any symptoms or dates on onset. The ADON and DON said they could not answer if any of the COVID-19 positive residents or staff were symptomatic and, if so, when the symptoms began and could not speak to any follow up from looking at the documents provided. They said the documentation was not maintained to reflect a true surveillance line listing.</p> <p>During an interview on 8/28/24 at 10:31 A.M., the Administrator, ADON, DON, and Consulting Staff #1 said the start of the current COVID-19 outbreak at the facility was on 8/15/24 on the Station 3 Unit, not on 8/14/24 as that resident case was assumed to be hospital acquired. They said once positive on 8/14/24, the resident was placed on isolation precautions and staff were notified. They said they identified two rehab staff that may have been exposed but one always wore a surgical mask and the other tested negative that day at their other job, so they were not concerned. They said they did not do contact tracing for any other staff or residents who may have been identified as a close contact. They said at the time, staff were not wearing source control so there could have been potential exposure. They further said they could not speak to specific staff members that may have been potentially exposed and had nothing to show to indicate an investigation had been conducted or what the plan was.</p> <p>2. Review of the Massachusetts DPH Memorandum titled Update to Infection Prevention and Control Considerations When Caring for Long-Term Care Residents, Including Visitation Conditions, Communal Dining, and Congregate Activities, dated 5/10/23, indicated but was not limited to the following:</p> <p>- Long-term care facilities are required to perform outbreak testing of residents and staff as soon as possible when a case is identified.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- If the long-term care facility identifies that the resident or staff member's first exposure occurred less than 24 hours ago, then they should wait until 24 hours after any exposure, if known.</p> <p>-Once a new case is identified in a facility, following outbreak testing, long-term care facilities should test exposed residents and staff at least every 48 hours on the affected unit until the facility goes seven days without a new case unless the DPH epidemiologist directs otherwise.</p> <p>-Residents and staff who are recovered from COVID-19 in the last 30 days can be excluded from this testing.</p> <p>Review of the facility's policy titled Rapid Antigen Point of Care COVID-19 Testing, revised March 2023, indicated but was not limited to the following:</p> <p>Purpose:</p> <p>-To promptly identify potentially positive COVID-19 individuals and initiate swift treatment. Rapid antigen testing kits should be used for testing symptomatic staff and residents in the LTC facility, testing asymptomatic staff and residents at the facility as part of the required outbreak testing, and testing staff who feel they are at increased risk of exposure.</p> <p>-Once a new case is identified in the facility, following the requisite outbreak testing, the facility is required to test all residents and staff every 48 hours on the affected unit until the facility goes seven days without a new case or assigned epidemiologist directs otherwise. In addition, facilities should immediately test any symptomatic resident, staff member, or newly exposed resident or staff member.</p> <p>-Residents and staff who have recovered from COVID-19 in the last 30 days can be excluded from testing.</p> <p>-During an outbreak situation, testing is required every 48 hours until seven days without a positive case and then once a week until the facility goes fourteen days without a new case unless DPH epidemiology directs otherwise.</p> <p>On 8/27/24 at 4:19 P.M., the surveyor reviewed timecards and schedules worked with the ADON for four randomly sampled direct care staff (Staff #1, Staff #2, Staff #3, and Staff #4) who worked on the affected COVID-19 units and were to be included in the facility's current COVID-19 outbreak testing protocol. The staff were as follows:</p> <p>a. Review of Staff #1's August 2024 timecard indicated that he/she had worked on the following days since the start of the current COVID-19 outbreak that occurred on 8/15/24 on the Station 3 Unit after a resident had tested positive:</p> <p>-August 16th, August 17th, August 19th, on the Station 3 Unit</p> <p>Review of the staff August 2024 Testing Logs failed to indicate Staff #1 conducted COVID-19 outbreak testing as required for any of the dates worked.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/27/24 at 4:19 P.M., the DON said Staff #1 was eligible for outbreak testing and there were no test results for the days worked. She said Staff #1 did not complete outbreak testing as required.</p> <p>b. Review of Staff #2's August 2024 timecard indicated that he/she had worked on the following days since the start of the current COVID-19 outbreak that occurred on 8/18/24 on the Station 1 Unit after a direct care staff member had tested positive with the first resident testing positive on 8/19/24:</p> <p>-August 21st, August 22nd, August 23rd, August 26th, and August 27th, on the Station 1 Unit</p> <p>Review of the staff August 2024 Testing Logs failed to indicate Staff #2 conducted COVID-19 outbreak testing as required for any of the dates worked.</p> <p>During an interview on 8/27/24 at 9:23 A.M., Staff #2 said he/she tested that morning at the facility before the start of the shift but didn't document the results and was negative. Staff #2 said he/she doesn't usually document results and would go retest and document the results.</p> <p>During an interview on 8/27/24 at 4:22 P.M., the ADON said staff could test at home or at the facility, but the process was to document on the log if testing was done at the facility. She said staff will only notify them if they tested positive at home but there was no oversight to ensure home testing was being done or the results of the testing. The ADON said no one was keeping track. She said Staff #2 was eligible for outbreak testing and it was not done per protocol.</p> <p>c. Review of Staff #3's August 2024 timecard indicated that he/she had worked on the following days since the start of the current COVID-19 outbreak that occurred on 8/18/24 on the Station 1 Unit after a direct care staff member had tested positive with the first resident testing positive on 8/19/24:</p> <p>-August 18th and August 23rd, on the Station 1 Unit</p> <p>Review of the staff August 2024 Testing Logs failed to indicate Staff #3 conducted COVID-19 outbreak testing as required for the dates worked.</p> <p>During an interview on 8/27/24 at 4:25 P.M., the ADON said Staff #3 was eligible for outbreak testing and there was no documentation by Staff #3 on the testing logs to indicate that he/she had completed outbreak testing as required.</p> <p>d. Review of Staff #4's August 2024 timecard indicated that he/she had worked on the following days since the start of the current COVID-19 outbreak that occurred on 8/18/24 on the Station 1 Unit after a direct care staff member had tested positive with the first resident testing positive on 8/19/24:</p> <p>-August 22nd, August 23rd, and August 26th, on the Station 1 Unit</p> <p>Review of the staff August 2024 Testing Logs failed to indicate Staff #4 conducted COVID-19 outbreak testing as required for the dates worked.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/27/24 at 4:26 P.M., the DON said Staff #4 was eligible for outbreak testing and worked on the short-term rehab unit. She said Staff #4 did not test per protocol.</p> <p>3. Review of the [NAME] BinaxNOW COVID-19 Ag Card product insert, revised April 2021, indicated but was not limited to the following:</p> <p>-The BinaxNOW COVID-19 Ag Card is a lateral flow immunoassay for the qualitative detection of the nucleocapsid protein antigen to SARS-CoV-2 directly from the anterior nasal (nares) swab specimens collected from individuals who are suspected of COVID-19 by their healthcare provider within seven days of the onset of symptoms.</p> <p>Precautions:</p> <p>-Proper sample collection, storage, and transport are essential for correct results.</p> <p>-Inadequate or inappropriate sample collection, storage, and transport may yield false test results.</p> <p>Test Procedure:</p> <p>-Read result in the window 15 minutes after closing the card. In order to ensure proper test performance, it is important to read the result promptly in 15 minutes, and not before. Results should not be read after 30 minutes.</p> <p>On 8/27/24 at 6:54 A.M., the surveyor observed Certified Nursing Assistant (CNA #1, orientee) perform COVID-19 outbreak testing prior to her shift at the testing station in the main lobby of the facility. CNA #2 was assisting. At 6:58 A.M., the surveyor observed CNA #1 insert her sample into the bottom hole of the testing card then seal the test card. CNA #1 did not label the card with her name, date, or time. A timer was observed on top of the testing cart but was not utilized. CNA #1 sat in the chair waiting for her results while CNA #2 left the testing area. At 7:07 A.M., nine minutes later, CNA #2 returned to the testing station and documented CNA #1's negative test result onto the testing log then disposed of the test card.</p> <p>During an interview on 8/27/24 at 7:07 A.M., CNA #1 said the test was done because there was a control line there and didn't know she had to wait 15 minutes. CNA #2 said they should have waited the full 15 minutes before reading the results.</p> <p>During an interview on 8/27/24 at 4:13 P.M., the ADON said the test should have been read at 15 minutes and not prior.</p> <p>4. Review of the Massachusetts DPH Memorandum titled Comprehensive Personal Protective Equipment (PPE) Guidance, dated May 2023, indicated but was not limited to the following:</p> <p>-DPH recommends that a fit-tested N95 filtering facepiece respirator or alternative and eye protection be used when caring for patients with suspected or confirmed COVID-19. If there is any contact with potentially infectious material, an isolation gown and gloves should also be used.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policy titled Use of PPE- Post PHE, revised May 2023, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Appropriate PPE will be used to care for the residents during the various stages of their infectious disease process, this includes facemasks. -Staff will be required to use full PPE upon room entry (gown, gloves, facemask, eye protection). N95 filtering respirator should be used for residents who are presumed or confirmed infected with COVID-19. <p>Review of the facility's policy titled The Infection Prevention Program, dated August 2017, indicated but was not limited to the following:</p> <p>When to Wash Hands:</p> <ul style="list-style-type: none"> -Before and after entering isolation, precaution setting <p>On 8/27/24 at 1:32 P.M., the surveyor observed Rehabilitation Services Staff (RSS) #1 enter a COVID-19 positive resident's room wearing a gown, gloves, face shield, and surgical facemask. An isolation contact/droplet precaution sign was posted outside the resident's room indicating that staff were required to wear eye protection, a gown, an N95 facemask, and gloves prior to entering the room. RSS #1 did not don (put on) an N95 respirator prior to entering the room. A PPE cart was located directly outside the resident's room stocked with N95 respirators.</p> <p>During an observation with interview on 8/27/24 at 1:35 P.M., the surveyor observed RSS #1 exit the resident's room still wearing the surgical facemask. RSS #1 did not perform hand hygiene upon exiting the room and did not change his surgical face mask before starting to proceed down the hallway. When stopped by the surveyor, RSS #1 said he had transferred the resident from the wheelchair to the bed and should have worn an N95 facemask in the room and should have changed his facemask and sanitized his hands upon exiting the room.</p> <p>During an interview on 8/27/24 at 3:50 P.M. with the Administrator, ADON, DON, and Consulting Staff #1, the ADON said full PPE with N95 facemask was required prior to entering COVID-19 positive resident rooms. She said all PPE should be doffed (taken off) inside the room at the entryway prior to exiting. The ADON said RSS #1 should have had an N95 facemask on, changed his surgical mask, and sanitized his hands when exiting the room. The Administrator said the facility was fully stocked with PPE.</p>		