

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/07/2026
NAME OF PROVIDER OR SUPPLIER  Blaire House of Milford		STREET ADDRESS, CITY, STATE, ZIP CODE  20 Claffin Street Milford, MA 01757	

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 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>Based on record reviews and interviews for one of three sampled residents (Resident #1) who had a Legal Guardianship (person designated by the court to make health care decisions on behalf of a person determined to not be able to make those decisions) in place, the Facility failed to ensure nursing honored his/her Guardian's request and Physician's Order regarding the administration of his/her as needed (PRN) psychotropic medications used to help treat his/her mood and behavior. Findings include: Review of the Facility Policy titled Resident Rights, dated as last reviewed 07/2025, indicated the Resident (or Legal Representative) has the right to participate in the planning and treatment of care. Review of the Facility Policy titled Administering Medications, dated as last revised, April 2019, indicated medications are administered in accordance with prescriber's orders, including any time frame. Review of the Facility Policy titled Psychotropic Medication Use, dated as last revised, February 2025, indicated psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or representative. During a telephone interview on 04/03/26 at 2:18 P.M., the Guardian said on 02/18/26, the care team discussed and agreed nursing would administer PRN Ativan (benzodiazepine, used to treat anxiety) prior to trying PRN Trazadone (antidepressant) to help manage Resident #1's aggressive behaviors. The Guardian said that her observation and experience with Resident #1 was that he/she responded positively to the Ativan without notable side effects and said when he/she received Trazadone, Resident #1 appeared to become sleepier instead of helping manage his/her behaviors of yelling and aggressive behaviors. Resident #1 was admitted to the Facility in August 2023, diagnoses include a Traumatic Brain Injury (TBI) related to a motor vehicle accident, depression, anxiety and behavioral disturbances. Review of Resident #1's Decree and Order of Appointment of Guardian for an Incapacitated Person Form, dated 04/01/25, indicated that a Guardian had been appointed by the court. Review of Resident #1's Nurse Progress Notes, dated 02/05/26, written by the Director of Nurses (DON), indicated she met with Resident #1's Guardian to discuss her concern with his/her PRN Ativan and PRN Trazadone administration. The Note indicated Resident #1's Guardian preferred nurses to administer Ativan first and if the Ativan was not effective then nursing could administer Trazadone as needed. The Note indicated that Resident #1's Physician would be made aware of the request. Review of Resident #1's Physician's Orders, dated 02/05/26, indicated to administer Trazadone Hydrochloride (antidepressant) 25 milligrams (mg) by mouth every six (6) hours PRN for agitation. The Order also indicated to try Ativan first before giving this (Trazadone). Review of Resident #1's Medication Administration Record (MAR) dated 02/05/26 through 02/28/26, indicated the following doses of PRN Trazadone were administered to him/her by prior to being medicated with PRN Ativan as directed in his/her physician's orders and according to the Guardians request; -02/06/26 PRN Trazadone administered at 7:36 P.M., with no administration of Ativan; -02/17/26 PRN Trazadone administered at 10:38 A.M., with Ativan administered at 8:26 P.M.; -02/19/26 PRN Trazadone administered at 11:08 P.M., with no Ativan administered; -02/20/26 PRN Trazadone administered at 12:18 P.M., with no Ativan administered; and -02/24/26 PRN Trazadone administered at 12:10 P.M., with no Ativan administered. Review of Resident #1's Medication Administration Record (MAR) dated 03/01/26 through 03/31/26, indicated the following (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 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>doses of PRN Trazadone were administered to him/her by prior to being medicated with PRN Ativan as directed in his/her physician's orders and according to the Guardians request;-03/01/26 PRN Trazadone administered at 8:47 A.M. and 4:26 P.M., with no Ativan administered;-03/03/26 PRN Trazadone administered at 3:53 P.M., with Ativan administrated 5:20 P.M.;-03/10/26 PRN Trazadone administered at 4:40 P.M., with no Ativan administered; and-03/20/26 PRN Trazadone administered at 2:28 P.M., with no Ativan administered.During an interview on 04/07/26 at 2:08 P.M., Nurse #3 said that she was aware that Resident #1's Guardian had requested that nurses administer his/her PRN Ativan prior to using the PRN Trazadone.Nurse #3 said she administered Resident #1's PRN Trazadone prior to utilizing his/her PRN Ativan and said that she thought the PRN Trazadone was more effective. During a telephone interview on 04/09/26 at 10:54 A.M., Nurse # 4 said that she had given Resident #1 PRN Trazadone before trying his/her PRN Ativan several times.Nurse #4 said she was aware Resident #1's PRN Trazadone order stated to try medicating with Ativan prior to using the PRN Trazadone.During an interview on 04/07/26 at 4:14 P.M., the Director of Nurses (DON) said that Resident #1's Guardian had come to her and requested that, when utilizing PRN Trazadone and Ativan, that the Nurses use the PRN Ativan first for his/her behaviors and if that was not effective then the nurse could medicate with the PRN Trazadone if still needed.The DON said that she informed the Physician and the direction to try PRN Ativan first before the PRN Trazadone was added to his/her Physician's Order. The DON said it is the Facility's expectation that all Nurses follow a Physician's Order when administering medications, including directions.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had lost his/her upper and lower dentures and had been seen by the Dentist to have new dentures made, the Facility failed to ensure they obtained a signed consent in a timely manner from his/her Legal Guardian, resulting in a delay of several months before his/her new dentures could be fabricated. Findings include: Review of the Facility Policy titled Medication and Treatment Orders, Dental Services, dated as last revised 2/2014, indicated that all orders for the treatment of the resident's dental problems must be in writing and signed and dated by the dentist providing the service. The Policy further indicated that all orders must be charted and made part of the resident's medical record and care plan. Resident #1 was admitted to the Facility in August 2023, diagnoses include a Traumatic Brain Injury (TBI) related to a motor vehicle accident, depression, anxiety and behavioral disturbances. Review of Resident #1's Decree and Order of Appointment of Guardian for an Incapacitated Person, dated 04/01/25, indicated that a Guardian had been appointed by the court. During a telephone interview on 04/03/26 at 2:18 P.M., Resident #1's Guardian said that he/she has not had dentures for some time and said she does not know when they went missing. Review of Resident #1's Dental Evaluation Form (completed by the Dentist), dated 10/14/25, indicated that Resident #1 had lost his/her upper and lower partial dentures and that upper and lower partial dentures will aid in mastication (chewing). The Dental Form, further indicated under action required by nursing home staff, to have responsible party [Guardian] sign consent for denture form, so the dentist could make the partial plates for Resident #1. Review of Resident #1's Dental Evaluation Form (written by the Dentist), dated 02/05/26, indicated that Resident #1 would like upper and lower partial dentures. The Dental Form, further indicated under action required by nursing home staff, to have his/her responsible party [Guardian] sign consent for dentures form so the dentist could make the partial plates for Resident #1. Review of Resident #1's Medical Record indicated that there was no documentation to support that nursing obtained signed Dental Consent Form from his/her Guardian to have both upper and lower partial dentures made. During an interview on 04/07/26 at 11:51 A.M., Resident #1 said he/she does not know how long he/she has been without dentures but said that he/she would like them. During an interview on 04/07/26 at 1:21 P.M., Certified Nurse Aide (CNA) 1 said that Resident #1 did have dentures at one point but does not remember the last time that she saw them. During an interview on 04/07/26 at 1:54 P.M., CNA #3 said that she has been taking care of Resident #1 for some time and said she his/her dentures have been lost for a very long time. During an interview on 04/07/26 at 4:14 P.M., the Director of Nurses (DON) said that she was not aware of Resident #1 missing dentures. The DON said that it is the Facility's expectation to promptly follow up on any recommendations given to nursing by any outside provider and obtain consent to treat as needed should be obtained promptly.</p>		