STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225260	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Milford	20 Claflin 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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement their abuse policy when one Resident (#162), was involved in a resident to resident altercation, in a total sample of 16 residents. Specifically, the facility failed to ensure staff, who were aware of the incident and notified the Administrator, implemented their abuse protocol by notifying the local authorities of the potential abuse or implemented a system of follow up with interventions to prevent potential future incidents. Findings include: Review of the facility's policy titled Abuse Prevention Policy and Procedure, dated as reviewed 4/2024, indicated but was not limited to the following: - the purpose of the policy is to promote prevention, protection, prompt reporting and interventions in response to an alleged, suspected or witnessed abuse of any resident - reporting requirements: in general each covered individual shall report to the secretary and 1 or more law enforcement entities in which the facility is located any reasonable suspicion of a crime (as defined by the law) against any individual who is a resident; timing: if the event that caused the suspicion did not result in serious bodily injury, then the suspicion shall be reported not later than 24 hours after forming the suspicion - it is the responsibility of the staff to monitor/supervise the care and treatment of residents of the facility to identify abuse and/or inappropriate care and treatment and to promote an environment where no resident is subject to abuse - the procedural and investigational requirement for serious reportable events (procedure #0607), defines facility management responsibilities for conducting comprehensive investigations of allegations of abuse and steps to take to ensure resident safety post-allegation, and state and federal reporting Review of the facility's Investigational Guide for Resident to Resident Altercation, form #CN-019, reviewed 12/2024, indicated but was not limited to the following: - immediately separate the residents and implement safeguards to ensure they do not have access to each other during the cooling down period (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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- SNF's - determination must be made if reasonable suspicion of a crime against a resident of the facility. If there is reasonable suspicion that a crime has been committed against a resident of the facility the staff forming the suspicion must timely report the events to local law enforcement (in cases not involving serious bodily injury to the resident report must be made within 24 hours of forming reasonable suspicion) - conduct assessments of involved residents, identify if injury was sustained and conduct interviews with the involved residents; if aggressive behavior of one or both involved residents is a change in mental status/baseline, conduct urine dip and/or request MD orders for urinalysis culture and sensitivity (U/A C&S), additional lab studies, medical record review and work up as required - identify staff who require interviews and obtain statements, review cameras to identify if event was captured on video, identify if involved residents have any history of conflict and any previous intervention and if interventions were followed - if the residents are roommates consider offering room changes on a space available basis, if appropriate - complete the online report for submission to the required State licensing authority - Executive director (administrator) signature and date are requested at the bottom of the form Review of the Massachusetts Assault and Battery Introduction Guide under G.L.c 265, § 13A, dated as revised June 2019, indicated but was not limited to the following: - Assault and battery includes three things: 1. the aggressor/defendant touched the person/victim; 2. the aggressor/defendant intended to touched the person/victim; and/or 3. that the touching was likely to cause bodily harm or was offensive. - Touch can be direct or indirect and any contact no matter how slight is physical contact: direct is when someone physically strikes someone & indirect is when one person sets in motion some force or instrument to strike another. Review of the facility's policy titled Resident to Resident Altercation, revised 4/2025, indicated but was not limited to the following: - purpose: to create and maintain a safe environment for all residents - an altercation free culture will be promoted through appropriate staff and resident screening, supervision and support - reporting, protection and investigation: all staff are to report any suspected resident to resident altercations immediately to their nurse, once the supervisor/nurse is aware they shall complete a resident accident/observed on floor/fall report (CN-124); all staff are to ensure the safety and welfare of all residents involved in the altercation during and after the investigational process; the reporting will adhere to the Department of Public Health guidelines (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-response and follow-up: a system of follow up with an emphasis to prevent further altercations will be in place, such as: updated care plans to incorporate recommendations in addition to immediate updates that may have occurred at the time of the incident or proactively prior to the altercation and identified staff educational needs will be identified and provided Resident #162 was admitted to the facility in March 2025 with diagnoses including sciatica left sided, Parkinsonism, and bipolar disorder. Review of the Brief Interview for Mental Status, dated 3/22/25, indicated the Resident was moderately cognitively impaired with a score of 11 out of 15. Review of the medical record indicated Resident #162 was involved in a resident to resident altercation on 4/27/25 and was the victim. During an interview on 5/22/25 at 11:28 A.M., Resident #162 said his/her roommate was rummaging through their belongings and he/she told them to knock it off. When it continued he/she yelled at his/her roommate leave it the hell alone. After that their roommate threatened him/her and then picked up a pillow off the middle bed in the room and threw it at him/her making contact with their face and left side. Resident #162 said he/she was surprised the roommate did that and told the roommate, you can't beat me up, I'll get up out of this bed and teach you a lesson. Then staff entered the room and took the roommate out. Review of the medical record for Resident #162 indicated the following: -Nursing note: 4/27/25: Resident #162 was involved in a resident to resident altercation on 4/27/25 at approximately 1:30 P.M. which resulted in Resident #162's roommate picking up a small pillow and striking him/her with it in the face and left flank area; no visible injuries observed; both residents heard yelling; staff intervened; Administrator, Director of Nurses (DON), Nurse practitioner (NP) and Power of attorney (POA) for Resident notified. The note proceeded to say no physical touch was made. The note failed to indicate that local law enforcement was contacted or any measures were put in place to potentially prevent future incidents. Review of Resident #162's care plan indicated: -Behavior related to diagnosis of Bipolar, resident can display behaviors of being socially inappropriate, verbally abusive, refusal out of bed. Sustained a resident to resident altercation as the victim on 4/27. (initiated: 3/24/25; revised: 5/6/25) The care plan failed to indicate any interventions were initiated or put in place on 4/27/25 following the resident to resident altercation to prevent further potential incidents. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/25 at 8:17 A.M., the Social Worker said he was made aware of the resident to resident altercation involving Resident #162. He said he was unsure if throwing a pillow and being struck by it would constitute abuse, but agreed that if someone throws an item at someone in the general public and strikes them with it then that counts as physical contact. He said he did not realize at the time this was a potential abuse situation, and he doesn't believe the facility abuse protocol was followed but he would have to check with the administrator. During an interview on 5/23/25 at 8:37 A.M., the DON said she did not have any incident reports or reports of a resident to resident altercation for Resident #162 from the time of admission in March 2025 to current. She said she was unaware that Resident #162 was involved in an incident in which he/she was struck with a pillow and said this is physical contact and the incident should have been investigated, reported and the abuse policy should have been implemented and it doesn't appear that it was. She said she would have to check with the Administrator to see if they are aware of the incident since she was just learning of it at this time. During an interview on 5/23/25 at 9:13 A.M., the Administrator said he was aware of the incident and investigated it but did not implement the abuse protocol because he thought that no physical contact was made between the two involved residents. He said the social worker had informed him today that the incident note indicates physical contact as Resident #162 was struck by their roommate with a pillow and that the abuse protocol should have been implemented and the police notified. He doesn't think the staff identified the incident as abuse, since he initially had not either, and believes being struck with a pillow, even if thrown, would constitute physical contact and potential abuse. During an interview on 5/23/25 at 10:31 A.M., the Administrator said he reviewed the investigation and incident involving Resident #162 on 4/27/25 and that he misinterpreted the situation. On review, he realized the incident was a potential assault on Resident #162 and the abuse protocol should have been implemented with the police being notified and the Resident having interventions in place to prevent future occurrences and that did not occur. During an interview on 5/23/25 at 10:39 A.M., Nurse #4 said he was the Nurse on duty at the time of the incident. He said Resident #162 was struck with a pillow by their roommate and the staff separated the two residents for the remainder of the shift. He said he reached out to the Administrator and DON for guidance, as he was unsure if the incident would constitute abuse and was not given the directive to implement the abuse policy. He said he did not contact local law authorities or complete an incident report or implement any interventions beyond separating the residents temporarily to potentially prevent further incidents. He said he thought physical contact would only occur if the two residents directly came in contact with each other but he realizes now that was a misinterpretation and someone striking someone else with an object directly or thrown would indeed be physical contact and therefore potential abuse. During an interview on 5/23/25 at 12:31 P.M., the Administrator said he does not have a completed incident report or CN-019 resident to resident altercation form completed and wasn't aware until review of the policies today that it was part of the facility process. He said he did notify local law enforcement of the incident on 4/27/25 today (26 days after the incident occurred) and the facility will look into interventions to prevent further incidents between the two roommates, who continue to be roommates at this time. He said it was an unfortunate circumstance in which the incident was misinterpreted and the abuse protocol should have been implemented and was not.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report a resident to resident altercation as potential abuse in which one Resident (#162) was struck with a pillow by their roommate, in a total sample of 16 residents. Findings include: Review of the facility's policy titled Abuse Prevention Policy and Procedure, dated as reviewed 4/2024, indicated but was not limited to the following: - the purpose of the policy is to promote prevention, protection, prompt reporting and interventions in response to an alleged, suspected or witnessed abuse of any resident - reporting requirements: in general each covered individual shall report to the secretary and 1 or more law enforcement entities in which the facility is located any reasonable suspicion of a crime (as defined by the law) against any individual who is a resident; timing: if the event that caused the suspicion did not result in serious bodily injury, then the suspicion shall be reported not later than 24 hours after forming the suspicion - the procedural and investigational requirement for serious reportable events (procedure #0607), defines facility management responsibilities for conducting comprehensive investigations of allegations of abuse and steps to take to ensure resident safety post-allegation, and state and federal reporting Review of the facility's Investigational Guide for Resident-to-Resident Altercation, form #CN-019, reviewed 12/2024, indicated but was not limited to the following: -SNF's - determination must be made if reasonable suspicion of a crime against a resident of the facility. If there is reasonable suspicion that a crime has been committed against a resident of the facility the staff forming the suspicion must timely report the events to local law enforcement (in cases not involving serious bodily injury to the resident report must be made within 24 hours of forming reasonable suspicion - complete the online report for submission to the required State licensing authority Resident #162 was admitted to the facility in March 2025 with diagnoses including sciatica left sided, Parkinsonism, and bipolar disorder. Review of the Brief Interview for Mental Status, dated 3/22/25, indicated the Resident was moderately cognitively impaired with a score of 11 out of 15. Review of the medical record for Resident #162 indicated the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nursing note: 4/27/25: Resident #162 was involved in a resident to resident altercation on 4/27/25 at approximately 1:30 P.M. which resulted in Resident #162's roommate picking up a small pillow and striking him/her with it in the face and left flank area; Administrator, Director of Nurses (DON), Nurse Practitioner (NP) and Power of attorney (POA) for Resident notified. The note proceeded to say no physical touch was made. Review of the Healthcare Facility Reporting System (HCFRS) on 5/21/25 at 3:08 P.M., failed to indicate the facility had reported the incident to the State Agency as required. During an interview on 5/23/25 at 9:13 A.M., the Administrator said he was made aware of the incident on 4/27/25 and conducted an investigation but did not report the incident involving Resident #162 in HCFRS at that time since he initially thought no physical contact had occurred. He said he realizes now that the incident should have been reported in accordance with the investigation guidance and facility abuse policy. During a follow up interview on 5/23/25 at 10:31 A.M., the Administrator said he had reported the resident to resident incident involving Resident #162 in the HCFRS system today. (26 days after the incident occurred.)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #111 was newly admitted to the facility from home in 5/2025 with diagnoses which included hypertensive heart disease with heart failure, combined systolic and diastolic (congestive) heart failure, atrial fibrillation, and unspecified dementia with other behavioral disturbance. The Resident had been living at home with his/her family and received services from a home Hospice agency. Review of the nursing policy for new admissions, revised in 10/2024, indicated that an admission Checklist (CN-011) was to be completed for each admission. Upon completion of the First Day tasks from the checklist, the nurse was to return the checklist to the Director of Nursing/Executive Director. First Day tasks included, but were not limited to the following: -Physician notification -Physician orders complete, including order to admit for skilled nursing and observation During an observation and interview on 5/22/25 at 11:18 A.M., Resident #111's family member said that they were concerned with the topical, antifungal medications they brought in on the day of admission. The topical medications were ordered by a dermatologist to treat fungal conditions on the Resident's nails and perineum. The family member said staff stored the medications in the Resident's nightstand drawer and no one from nursing had applied them to the Resident. The family member expressed concern that the Resident suffered from advanced dementia, and was not capable of making informed decisions, and would not know to ask for their medication. The family member went on to say that he/she spoke to the Director of Nursing (DON) about their concern that the Resident's oral and topical medications that the Resident was receiving at home were to be continued by the facility, such as Seroquel (antipsychotic) and other cardiac medications. The family member said that the Resident had significant heart failure and was taking a number of medications to treat his/her cardiac disease. Review of the medication list for the Resident's medications from home were as follows: Home Hospice Medication Orders: -Acetaminophen 325 mg 2 tabs by mouth daily/PRN -Acetaminophen 650 mg rectal suppository every 6 hours/PRN -Bisacodyl 10 mg rectal suppository daily/PRN -Donepezil 10 mg by mouth at bedtime -Eliquis 5 mg by mouth 2 times daily (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Entresto 24 mg-26 mg 2 times by mouth daily (cardiovascular therapy) -Furosemide 20 mg by mouth daily (CHF) -Hydromorphone 4 mg/ml, give 0.5mg-1mg by mouth every 4 hours/PRN -Haloperidol Lactate 2 mg/ml oral concentrate 0.5 ml sublingually every 6 hours/PRN -Hyoscyamine 0.125 mg sublingually every 4 hours/PRN (secretions) -Jardiance 10 mg by mouth daily -Lorazepam 0.5 mg by mouth every 6 hours/PRN -Melatonin 3 mg, take 2 tabs by mouth at bedtime -Memantine 10 mg by mouth two times/day -Metformin 500 mg 2 tablets by mouth 2 times daily -Metoprolol Succinate 200 mg, extended release, by mouth once daily in the morning -MiraLAX 17 gm oral powder packet daily/PRN -Oxygen gas 2-4 liters PRN -Prochlorperazine Maleate 10 mg tablet orally every 6 hours for nausea/vomiting PRN -Seroquel 25 mg, give 12.5 mg by mouth daily in the afternoon -Trazodone 50 mg, give 0.5 tablet by mouth at bedtime -Atorvastatin 40 mg by mouth daily Review of the active Physician's Orders and Medication Administration Record (MAR) for medications from the time of Resident #111's admission to the facility to today (5/22/25) indicated the following medications were ordered: 5/21/25 Metformin 500 mg twice a day at 10 A.M. and 4 P.M. (not given on 5/20/25 at 4 P.M. or 5/21/25 at 10 A.M.) 5/21/25 Jardiance 10 mg every day at 10 A.M. (not given on 5/21/25 at 10 A.M.) 5/20/25 Acetaminophen 325 mg, give 2 tabs by mouth every 4 hours/as needed (abbreviated as PRN) 5/21/25 MOM 30 ml every night as needed every bedtime PRN 5/20/25 Bisacodyl 10 mg daily/PRN (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/20/25 Fleet Enema 1 rectally daily PRN for constipation Further review of the Physician's Orders and the Home Hospice Medication orders indicated that as of 5/22/25, 17 medications had not been ordered and/or administered: -Donepezil (used to treat dementia associated with Alzheimer's disease) -Eliquis 5 mg by mouth 2 times daily -Entresto (used to treat chronic heart failure) -Furosemide (used to reduce fluid in the body), -Hydromorphone (a narcotic pain reliever), -Haloperidol (an antipsychotic medication), -Hyoscyamine (used to decrease secretions) -Lorazepam (used to treat anxiety) -Melatonin (used as an adjunct for sleep) -Miralax (used for constipation) -Memantine (used to treat dementia associated with Alzheimer's disease), -Metoprolol Succinate, (used to lower blood pressure and treat heart failure), -Oxygen gas (used to improve respiratory status) -Prochlorperazine (used to treat nausea/vomiting) -Seroquel (an antipsychotic), -Trazodone (an antidepressant often used to treat major depressive disorder), -Atorvastatin, (used to lower cholesterol and triglyceride levels in the blood) Review of a Hospice Nurse Recommendation Form, dated 5/20/25, indicated: -Continue meds from home. Further record review indicated there was no evidence the medications from the home Hospice were reconciled with the physician resulting in many medications not being administered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/25 at 12:04 P.M., the DON said that Nurse #5 admitted Resident #111 and was responsible for completing the Resident's admission Checklist, including reconciling medication/treatment orders from the home Hospice agency, and contacting the physician to complete/approve all the orders. The DON said Nurse #5 did not complete the tasks as required on the admission Checklist. The DON said that there were a number of discrepancies between the medication orders from the list the family member brought in, the orders from the home Hospice agency, and the Resident's current physician's orders and medications on the MAR. During an interview on 5/22/25 at 12:06 P.M., the Hospice Nurse Case Manager (CM) from the facility Hospice, said she reviewed the Resident's previous home Hospice orders with Nurse #5 on 5/20/25 at approximately 3:00 P.M. The Hospice CM said the expectation was that Nurse #5 would contact the physician to reconcile the orders to ensure the Resident's medications were complete and accurate. The Hospice CM said there were a number of discrepancies between the current facility medication orders from the facility physician, and the orders from the Hospice. The Hospice CM said that several cardiac medications, such as Entresto, Furosemide, and Metoprolol, that were not listed on the Resident's MAR upon admission, had not been administered to the Resident. During an interview on 5/22/25 at 3:00 P.M., the DON said she has now reconciled the Resident's current medications from the home Hospice agency with the physician. She said many of the Resident's medications, including cardiac medications, had been omitted since admission as a result of the failure by Nurse #5 to reconcile the Resident's medication orders with the physician, in accordance with the admission Checklist. The DON said Resident #111 had the potential for a decline in his/her medical status due to the omitted doses of multiple medications, including his/her cardiac medications. Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards for three Residents (#52, #111, #262), out of a total sample of 16 residents. Specifically, the facility failed: 1. For Resident #52, to ensure a healthcare proxy (HCP) invocation/activation form was completed in accordance with the standard of practice; 2. For Resident #111, to ensure medication reconciliation and physician notification were completed at the time of admission to ensure the Resident received the required medications timely and without missed doses; and 3. For Resident #262, to implement physician's orders to discontinue Aricept (donepezil, a medication used to treat dementia) and Namenda (memantine, a medication used to treat dementia). Findings include: 1. Review of Massachusetts healthcare proxy act M.G.L C201D, Section 6 indicated, but was not limited to the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The authority of a health care agent shall begin after a determination is made, pursuant to the provisions of this section, that the principal lacks the capacity to make or to communicate health care decisions. Such determination shall be made by the attending physician according to accepted standards of medical judgment. The determination shall be in writing and shall contain the attending physician's opinion regarding the cause and nature of the principal's incapacity as well as its extent and probable duration. This written determination shall be entered into the principal's permanent medical record. Resident #52 was admitted to the facility in December 2024 with diagnoses including: Unspecified dementia with severe behavioral disturbance and major depressive disorder. Review of the medical record for Resident #52 indicated a Brief Interview for Mental Status (BIMS) was completed on 2/28/25 with a score of 7 out of 15, indicating severe cognitive deficit. During an interview on 5/23/25 at 12:52 P.M., the HCP said she was making all medical decisions for Resident #52 and had signed all the consents at the facility. During an interview on 5/23/25 at 1:37 P.M., the Social Worker said Resident #52's HCP is activated and the HCP is making all the decisions since admission. During an interview on 5/27/25 at 9:48 A.M., the Director of Nurses (DON) said the process is for a HCP activation/invocation form should be completed once a resident has been deemed incapable of making medical decisions by a Physician. She said the Physician or Nurse Practitioner would complete the form and leave it in the medical record once the decision was made indicating the reason, nature and extent of the incapacitation. Further review of Resident #52's medical record indicated: - an order from the hospital (behind the medical orders for life sustaining treatment (MOLST)) that indicated the HCP was activated prior to admission - a MOLST signed by the HCP - a care plan for the Resident that indicated: decision making skills impaired, HCP activated prior to admission on [DATE] - all consents since the time of admission including consents to treat and consents for medications were signed by the HCP The medical record failed to indicate a HCP invocation form had been completed and was available on file for the Resident. During an interview on 5/27/25 at 10:32 A.M., the Medical Records Coordinator reviewed the medical record and said the Resident should have a HCP invocation form in their record and there is not one that could be located. She said in addition she did not have an invocation form that was to be filed for the Resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225260	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/27/25 at 10:42 A.M., Nurse #2 reviewed Resident #52's medical record and could not locate a HCP activation/invocation form. He said usually when a resident's HCP is activated the activation/invocation form is completed with the cause, nature and expected duration of the activation. He said the Resident's HCP had been activated since prior to admission and the HCP was making all the decisions and couldn't explain why a HCP invocation was not in the medical record. During an interview on 5/27/25 at 11:42 A.M., the DON said Resident #52's HCP was invoked and had been since prior to admission. She reviewed the Resident's medical record and said there was no invocation/activation form on file and there should be and it was possible that it was missed and not completed by the Physician. During an interview on 5/27/25 at 12:17 P.M., Physician #1 said Resident #52 was not capable of making complex medical decisions and their HCP was activated and making all the decisions. He said there should be a HCP invocation form in the record, but he does not recall completing one and said he thinks he likely just missed completing the form. He said the form should absolutely have been completed and in the medical record and it was his error. 3. Review of [NAME], Manual of Nursing Practice 11ed, dated 2019, indicated the following: -The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers 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. -In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. Review of the facility's policy titled Prescriber's Telephone Order, revised 3/2017, indicated, but was not limited to, the following: -Verbal/telephone orders that follow this policy will be considered to be valid orders and will be executed as if the authorized Prescriber wrote them. -It is the Licensed Nurse's responsibility to note (implement) verbal/telephone orders. A nurse who records the order on the telephone order sheet must take whatever steps necessary to ensure that the order is carried out without delay. This includes, but may not be limited to, the following: a) Medication order *entering the order into the EHR (continued on next page)

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	225260	A. Building B. Wing	05/28/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The overnight nurse will conduct a nightly 24-hour chart check to confirm that new orders received in the previous 24 hours have been implemented. In conducting the 24-hour chart check, the nurse should review the telephone order section of each resident to identify any new orders and then validate that all new telephone orders have been implemented. Resident #262 was admitted to the facility in March 2025 with diagnoses including dementia and heart failure. Review of Resident #262's Minimum Data Set (MDS) assessment, dated 4/3/25, indicated Resident #262 was moderately cognitively impaired, as evidenced by a BIMS score of 8 out of 15. Review of Resident #262's Physician's Orders in the electronic health record (EHR) indicated, but was not limited to, the following: -Memantine (Namenda) 5 milligrams (mg) oral every 12 hours (order date: 3/28/25) -Donepezil (Aricept) 10 mg by mouth every night (order date: 3/28/25) Further review of Resident #262's Physician's Orders in the paper record indicated a telephone order was written on 5/16/25 to discontinue Aricept and Namenda. Review of Resident #262's May 2025 Medication Administration Record (MAR) indicated the Resident was administered Donepezil nightly 5/16/25 through 5/27/25 and was administered Memantine 5mg at 9:00 A.M. on 5/16/25 through 5/28/25 and at 9:00 P.M. on 5/16/25 through 5/27/25. During an interview on 5/28/25 at 1:49 P.M., the Director of Nursing (DON) said she had transcribed the telephone order to discontinue Resident #262's Aricept and Namenda on 5/16/25. The DON reviewed the Resident's EHR and said that she did not discontinue the medication in the EHR and that should have been done.

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	225260	A. Building B. Wing	05/28/2025

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure laboratory results were reported and acted on timely for one Resident (#262), out of a total sample of 16 residents. Specifically, the facility failed to report Resident #262's 4/1/25 critically low hemoglobin (Hgb, a protein in red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide from the tissues back to the lungs) level result to the Resident's provider until 4/3/25. Findings include: Review of the facility's policy titled Consults, Labs and Diagnostic Test Results - Clinical Protocol, dated 4/2024, indicated, but was not limited to, the following: -Nursing staff will review all consults, labs, diagnostic test results, and gather any other pertinent documentation that would be necessary for the provider to recommend the course of treatment. The nurse will notify the physician by calling into the provider's answering service, in which they will then document in the Electronic Health Record (EHR) whom they spoke with and the response. Notation of this information will also be documented on such consult, or diagnostic test results. -The consults and diagnostic test results will then only be placed in the Physician Book for the provider to sign off on during facility rounds. -The Director of Nursing or Designee will then monitor daily that only noted lab, x-rays, and or consults are in the folder, with each document listing the date and time of who specifically they reported the results/details to, and the signature of the reporting nurse. Resident #262 was admitted to the facility in March 2025 with diagnoses including chronic iron deficiency anemia and congestive heart failure. Review of Resident #262's CBC (Complete Blood Count, a blood test used to monitor or diagnose conditions that measures the size and amount of red blood cells, white blood cells, and platelets) laboratory results from 4/1/25 at 11:40 A.M. indicated the following: -Hgb critically low (CL) with results of 7.2 g/dL (grams/deciliter), and a normal range of 13.5-17.5 g/dL per the facility lab -Hematocrit (Hct, the percentage of red blood cells in the blood) low with results of 21.9%, and a normal range of 40-50% per the facility lab Further review of Resident #262's laboratory results indicated that the laboratory made two attempts to call the facility on 4/1/25 at 11:49 A.M. and 12:49 P.M. Review of Resident #262's nursing progress notes indicated, but was not limited to, the following: (continued on next page)

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	225260	A. Building B. Wing	05/28/2025

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 4/3/25, the Resident appeared very lethargic with decreased verbal responsiveness. The nurse practitioner evaluated the Resident and his/her 4/1/25 laboratory results with critically low Hgb and Hct (7.2, 21.9) and ordered the Resident's transfer to the hospital. Further review of Resident #262's nursing progress notes failed to indicate that the Resident's provider was notified of the Resident's critically low Hgb level on 4/1/25 or 4/2/25. Review of Resident #262's provider progress notes indicated, but was not limited to, the following: -On 3/29/25, the Resident was seen by Physician #2. Physician #2's progress note indicated the physician discussed the Resident's case with a Registered Nurse (RN), reviewed the Resident's MAR, and ordered lab work to be done the next week. -On 3/31/25, the Resident was seen by Nurse Practitioner (NP) #1. NP #1's progress note indicated that a CBC was to be drawn the next day (4/1/25). -On 4/3/25, the Resident was seen by NP #1 for decreased alertness, weakness, and poor sleep. NP #1's note indicated that on 4/1/25, the Resident's Hgb was 7.2 and Hct was 21.9. NP #1's note indicated the Resident was seen and examined and was to be transferred to the emergency room due to his/her low Hgb and Hct. Review of Resident #262's hospital Discharge summary, dated [DATE], indicated the Resident presented to the hospital with low Hgb and Hct. While in the hospital, the Resident received a blood transfusion and his/her anticoagulant medication was stopped. During an interview on 5/28/25 at 11:30 A.M., Nurse #3, who was assigned to Resident #262's care on 4/1/25, said she could not recall if she notified the Resident's provider of his/her critically low Hgb lab results. Nurse #3 said when there is a critical lab result, staff at the facility are notified by phone by the lab. Nurse #3 said when a critical result is received, it should be reported to the Resident's provider immediately and documented in the medical record. During a telephonic interview on 5/28/25 at 11:55 A.M., NP #1 said that she was not made aware of Resident #262's 4/1/25 abnormal lab results before she saw the Resident on 4/3/25. NP #1 said she called NP #2 on 4/3/25 to see if she had been notified of the abnormal results by the facility, but NP #2 was not aware of the abnormal lab results either. NP #1 said she had to request for the lab results to be printed so she could review them on 4/3/25 because she did not have access to the EHR system. NP #1 said when she evaluated Resident #262 and reviewed the 4/1/25 lab results on 4/3/25, she was concerned that the Resident's Hgb level had decreased further and ordered his/her transfer to the emergency room. NP #1 said if she had been notified of the Resident's critically low Hgb level on 4/1/25, she would have at least ordered follow-up lab work be done. During a telephonic interview on 5/28/25 at 12:28 P.M., NP #2 said she was not notified of Resident #262's critically low Hgb level until NP #1 called her on 4/3/25. NP #2 said if she had been notified of the critically low Hgb result on 4/1/25, she would have ordered the Resident's transfer to the emergency room for further evaluation at that time. NP #2 said she did not have access to the facility's EHR system and was unable to view lab results unless provided to her by facility staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225260	A. Building B. Wing	05/28/2025

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/25 at 1:49 P.M., the Director of Nursing (DON) said it is her expectation that critical lab results are called in to the provider immediately. During a telephonic interview on 5/28/25 at 1:56 P.M., Physician #2 said that she was overseeing the care of Resident #262 for his/her attending physician (Physician #1) on 4/1/25 through 4/3/25. Physician #2 said that she was not notified of Resident #262's 4/1/25 critically low Hgb results.

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	225260	A. Building B. Wing	05/28/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to ensure food items were properly labeled and dated in three of three kitchenettes. Findings include: Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when packaging food using a reduced oxygen packaging method as specified under § 3-502.12, and except as specified in paragraphs (E) and (F) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41°Fahrenheit (F) or less for a maximum of 7 days. The day of preparation shall be counted as Day One. Review of the facility's policy titled Resident Personal Food Storage Policy and Procedure, dated February 2025, indicated but was not limited to the following: -Resident food and beverage items stored in the unit kitchenettes must be clearly marked with the resident's name and the date the item was placed in the kitchenette. Review of the facility's policy titled Foods Brought in From an Outside Source Policy and Procedure, dated January 2024, indicated but was not limited to the following: -Food or beverages brought in from the outside will be labeled with the resident's name, and dated by staff with the date the item(s) are brought into the facility for storage. On 5/21/25 at 3:30 P.M., the surveyor observed the following in the East Unit kitchenette refrigerator: -one open container of thickened liquid, undated with a manufacturer's instruction to use within 7 days of opening; -eight single-serve yogurt cups with a manufacturer's expiration date of 5/20/25. On 5/21/25 at 3:40 P.M., the surveyor observed in the [NAME] Unit Kitchenette refrigerator: -one opened can of soda in the freezer, with no cover and no label or date; -one opened container of thickened liquid, undated with a manufacturer's instruction to use within 7 days of opening; (continued on next page)

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	225260	A. Building B. Wing	05/28/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-one plastic bag containing Tupperware with food and a can of soda, no label or date; -one bowl of mandarin oranges labeled with the contents and a first name, no date. On 5/27/25 at 8:45 A.M., the surveyor observed eight single-serve yogurt cups with a manufacturer's expiration date of 5/20/25 in the East Unit kitchenette refrigerator. On 5/28/25 at 8:08 A.M., the surveyor observed the following in the main dining room kitchenette: -two single-serve yogurt cups with a manufacturer's expiration date of 5/9/25; -four pre-poured containers of salad dressing, no label or date; -one bowl of garden salad wrapped with plastic, no label or date; -four plates of cake, no label or date. On 5/28/25 at 3:30 P.M., the surveyor observed the following in the East Unit kitchenette: -one pre-poured container of salad dressing with no label or date; -one opened bottle of water with no label or date; -four single-serve yogurt cups with manufacturer's expiration date of 5/20/25. During an interview on 5/28/25 at 3:30 P.M., the Food Service Director (FSD) said all food items in the kitchenettes should be labeled and/or dated to ensure proper storage. The FSD said there were signs posted in each kitchenette to remind staff to label and date food, but it doesn't always happen. The FSD said thickened liquids should be dated with the date it was opened; any resident food items should be labeled and dated and stored in the refrigerator for three days; any opened food items should be labeled and dated with the day it was opened. The FSD said there should be no food stored in the unit refrigerators that are beyond their expiration or storage date.

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	225260	A. Building B. Wing	05/28/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, document review, and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment. Specifically, the facility failed to: 1. Maintain an accurate surveillance system that reflected potential illnesses and infections in the facility in accordance with the most up to date pre-defined McGeer criteria; and 2. Ensure hand hygiene was performed by staff and residents during meals and tray pass. Findings include: Review of the facility's policy titled Infection Prevention and Control Policy, dated last revised 10/2024, included but was not limited to: - Purpose: to maintain an infection control and prevention program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. - A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to 483.70(e) and following accepted national standards. - A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. 1. Review of the facility's policy titled Surveillance for Infections, dated as revised September 2017, indicated but was not limited to the following: - the purpose of surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections (HAIs), to guide appropriate interventions, and to prevent future infections - the criteria for such infections is based on the current standard definitions of infections - infections that will be included in routine surveillance include: those with evidence of transmittability, available processes to prevent or reduce the spread of infections, clinically significant morbidity or mortality associated with infection (e.g., pneumonia, urinary tract infections (UTIs)) and pathogens associated with serious outbreaks - infections that may be considered in surveillance are those with limited transmittability in a healthcare environment and/or limited prevention strategies - nursing staff will monitor residents for signs and symptoms (s/s) that may suggest infection, according to current criteria, and will document and report suspected infections (continued on next page)

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	225260	A. Building B. Wing	05/28/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Gathering Surveillance Data: - the Infection Preventionist (IP) is responsible for gathering and interpreting surveillance data - the surveillance should include any or all of the following information to help identify possible indicators of infection: lab results, skin care sheets, infection control rounds/interviews, verbal reports, infection documentation record, temperature logs, pharmacy records, antibiotic review, transfer logs/summaries Data Collection and Recording: - for residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: identifying information, diagnoses, date of onset of infection, infection site (be as specific as possible, e.g., cutaneous infection should be listed as pressure ulcer left foot, pneumonia as right upper lobe, etc.), pathogens, risk factors, pertinent remarks (i.e., temperature, other symptoms of specific infection, etc.), treatment measures and precautions - using the current suggested criteria for HAIs determine if the resident has a HAI During an interview on 5/21/25 at 10:34 A.M., the Director of Nurses (DON) said she is the IP in the facility and the facility uses McGeer criteria to determine if an illness rises to the level of an infection. Review of the most recent McGeer criteria, last revised May 2021, indicated but was not limited to the following: Syndrome: Cellulitis, soft tissue, or wound infection (Skin) Criteria: Must fulfill at least 1 of the criteria. 1. Pus at wound, skin, or soft tissue site 2. At least four of the following: - New or increasing sign or symptom - Heat (warmth) at affected site - Redness (erythema) at affected site - Swelling at affected site - Tenderness or pain at affected site - Serous drainage at the affected site 2A. At least one of the following (can be counted as part of the four in criteria #2) (continued on next page)

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	225260	A. Building B. Wing	05/28/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Fever - Leukocytosis - Acute change in mental status - Acute functional decline Syndrome: Pneumonia Criteria: Must fulfill 1,2 and 3 1. Chest x-ray (CXR) with pneumonia or new infiltrate 2. At least one of the following criteria: -new or increased cough -new or increased sputum production -oxygen saturation (O2 sat) less than (<) 94% or greater than (>) 3% decrease from baseline O2 sat -new or change in lung exam abnormalities -pleuritic chest pain -respiratory rate >25 breaths per minute 3. At least one of the following: -fever -leukocytosis -acute mental status change -acute functional decline Laboratory Surveillance Sheet Key: (in use by the facility) Categories: Skin and soft tissue = S; Pneumonia = PNU Symptoms: cough = C Count: Yes = Y (continued on next page)

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	225260	A. Building B. Wing	05/28/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility provided infection surveillance from February through April 2025, indicated but was not limited to the following: February 2025: -Resident #32: Category: PNU, date of onset (DOO): 2/22, s/s: C, the sections for culture site and result were all blank, final status: HAI, count: Y -Resident #163: Category: S, DOO: 2/25, s/s: C, the sections for culture site and result were all blank, final status: HAI, count: Y Resident #32 did not have enough signs and symptoms documented or a chest x-ray with results documented on the surveillance sheets to meet surveillance criteria but was counted as an HAI infection indicating the surveillance was incomplete or inaccurate. Review of the medical record for Resident #32 failed to indicate any documentation of signs and symptoms of pneumonia, indicating the Feb surveillance was inaccurate. Resident #163 did not have any symptoms associated with a Skin infection documented on the surveillance sheet but was counted as a HAI infection indicating the surveillance was inaccurate. April 2025: Resident #22: Category: S, DOO: 4/12, s/s: abscess, the sections for culture site and result were all blank, final status: HAI, count: Y Resident #22 did not have any signs and symptoms of skin infection documented on the surveillance in accordance with McGeer criteria, indicating the surveillance was incomplete. Review of the medical record for Resident #22 indicated signs and symptoms of redness and serosanguinous drainage, but not enough documentation to indicate the area had the signs and symptoms necessary to meet McGeer criteria, indicating the surveillance was inaccurate. During an interview on 5/27/25 at 9:12 A.M., the IP said the facility also used infection control report sheets to ensure an illness rose to the level of an infection using McGeer criteria. On review of the sheets, it was identified that the facility was using an outdated version of McGeer criteria with the report sheets last revised 1/2013, making any of their content inaccurate for the Residents on surveillance. Review of the Infection Control Report Sheet for February and April 2025, indicated the following: - Resident #32's form failed to indicate a chest x-ray was completed or the required amount of signs and symptoms were identified for the Resident to have met McGeer criteria. - Resident #163's form was incomplete and provided no documentation or symptoms of any potential infection in any category. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225260	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Milford	20 Claflin Street Milford, MA 01757

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #22's form was incomplete and failed to provide any additional documentation of any potential infection. During an interview on 5/27/25 at 9:23 A.M., the IP reviewed the surveillance and all supporting documentation with the surveyor. She said the only available x-ray for Resident #32 indicated a humerus fracture and there was not an x-ray to support the surveillance for meeting criteria of pneumonia in February 2025. She said the documentation on the surveillance for Resident #163 was an error and the surveillance for February 2025 was inaccurate for these two Residents. She said in review of the information for Resident #22 that the documented signs and symptoms on surveillance and in the record did not support the Resident meeting criteria for a skin infection and the April surveillance for this Resident was inaccurate. She said she was not aware there was a new version of McGeer criteria making the criteria in use outdated. 2. Review of the Centers for Disease Control and Prevention guidance titled Infection Prevention and Long-term Care Facility Residents, dated 3/26/24, indicated but was not limited to: If you live in a nursing home, assisted living facility or other long-term care facility, you have a higher risk of getting an infection. There are steps you can take to reduce your risk: -Keep your hands clean. Remind staff and visitors to keep their hands clean. On 5/27/25, the surveyor observed the following: 11:50 A.M. - two Certified Nursing Assistants (CNAs) passing meals to resident rooms on the [NAME] Unit. The surveyor observed the CNAs did not clean or sanitize their hands when entering or exiting resident rooms, nor did they clean or sanitize their hands between trays. 11:50 A.M. to 12:10 P.M. - five residents in the main dining room, unsupervised at most times, waiting for lunch. One Resident was observed building blocks, another Resident was observed manipulating a sensory quilt (an object to provide sensory stimulation), and a third Resident was observed with a sensory quilt in front of them but was not seen touching it. 12:10 P.M. - CNA #1 and CNA #2 completed meal pass and went directly to the main dining room to pass and assist with meals. The surveyor did not observe either CNA perform hand hygiene between the unit meal pass and the main dining room meal pass. 12:10 P.M. - CNA #3 was observed seated between two residents, feeding them by alternating between each resident, and wiping the mouths of both residents. CNA #3 did not perform hand hygiene as she alternated between the two residents. On 5/28/25 the surveyor observed the following: 7:48 A.M. - two CNAs passing meals on the [NAME] Unit. The CNAs did not perform hand hygiene prior to entering or exiting five resident rooms. The CNAs were observed clearing items including remote controls from residents' tray tables and using their hands to brush items aside on the tray tables, their hand contacting the table. The surveyor observed the CNAs did not perform hand hygiene after these tasks and continued to serve trays to other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7:55 A.M. - During meal pass, CNA #2 and another CNA grab a Resident's bed sheet to boost the Resident into an upright position for their meal. Neither CNA was wearing gloves. CNA #2 exited the room without performing hand hygiene and continued to pass meals to other residents. 7:56 A.M. - the surveyor observed five residents, unsupervised at most times, in the main dining room waiting for breakfast. One Resident was building blocks. 8:12 A.M. - a block fell on the floor in the main dining room. CNA #4 picked the block up off the floor and placed the block on the table in front of the Resident. The Resident touched the block with both hands. 8:19 A.M. - CNAs pass meals to residents in the main dining room. The surveyor did not observe hand hygiene offered to the residents. 8:19 A.M. - CNA #4 touch the handles and breaks of one Resident's wheelchair before assisting the Resident with his/her meal. CNA #4 was not observed performing hand hygiene prior to meal assistance. 8:19 A.M. - one Resident ate cereal pieces with his/her bare hands. CNA #3 held the Resident's toast with her bare hand to butter it. During an interview on 5/28/25 at 2:12 P.M., CNA #2 said residents should be encouraged to clean their hands before meals, and the facility has hand wipes they use for this purpose. The surveyor said she had not seen the hand wipes used during the survey. CNA #2 said they ran out of the hand wipes recently and currently used regular napkins to clean hands which was not as effective as the special hand wipes. CNA #2 said staff did not clean the hands of the residents in the main dining room prior to breakfast this morning but should have. During an interview on 5/28/25 at 2:26 P.M., Nurse #3 said staff should perform hand hygiene when they enter and exit rooms and residents' hands should be cleaned before meals. Nurse #3 said the facility had hand wipes to clean the residents' hands but could not find any when she looked around the unit. During an interview on 5/28/25 at 3:40 P.M., the Director of Nursing (DON) said she expected staff to practice hand hygiene when entering and exiting resident rooms. The DON said staff should perform hand hygiene before and after providing care, which included boosting residents in bed and feeding or assisting with meals, and after touching residents' items, such as moving items on tray tables. The DON said the facility had hand wipes to clean residents' hands prior to meals and was unaware that they were not currently being used. The DON said staff should offer and encourage residents to clean their hands prior to meals, especially residents who were cognitively impaired. The facility was unable to provide a policy that addressed hand hygiene protocol for staff during meal pass and meal assistance and hand hygiene for residents prior to meals.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure two Residents (#14 and #28), out of a total sample of five residents reviewed for immunizations, were screened for eligibility to receive the recommended PCV20 or PCV21 pneumococcal vaccination, the residents/residents' representatives were educated on the benefits and potential side effects of the vaccine, and were offered and administered (if applicable) the vaccine in a timely manner. Specifically, the facility failed: to identify that the Residents were eligible for the PCV20 or PCV21 pneumococcal vaccinations and were offered the opportunity through shared decision making to receive the vaccination if warranted and desired in accordance with Centers for Disease Control and Prevention (CDC) guidance. Findings include: Review of the facility's policy titled Facility Vaccine Procedure, last reviewed 12/2024, indicated but was not limited to the following: - Purpose: to offer residents the recommended immunizations against influenza and pneumonia - Schedule of administration: any additional vaccine administration for residents, i.e. pneumonia vaccine will follow the procedure of obtaining informed consent prior, obtaining a physician order, providing education and administering the vaccine and completing the documentation of the vaccine administration in [Name of facility's electronic medical record] Review of the CDC guidance titled Pneumococcal Vaccine Timing for Adults, dated October 2024, indicated but was not limited to the following: Adults 50 years or older: Shared clinical decision-making for those who already completed the series with PCV13 and PPSV23. Prior vaccines Shared clinical decision-making option for adults [AGE] years old or older Complete series: previously received PCV13 at any age & PPSV23 at or older than 65 yrs and it has been more than five years since the series was completed. Together, with the patient, vaccine providers may choose to administer PCV20 or PCV21 to adults that are [AGE] years old or older who have already received PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of [AGE] years old. Review of the medical record for Resident #14 indicated the Resident was currently [AGE] years old and had received their PCV13 pneumococcal vaccination in 2015 and their PPSV23 pneumococcal vaccination in 2017 (approximately 8 years ago at the approximate age of 83). The record failed to indicate that the Resident or his/her responsible party was offered the PCV20 or PCV21 pneumococcal vaccination, even though they were eligible. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #28 indicated the Resident was currently [AGE] years old and had received their PCV13 pneumococcal vaccination in 2014 and their PPSV23 pneumococcal vaccination in 2012 (approximately 13 years ago at the approximate age of 66). The record failed to indicate that the Resident or his/her responsible party was offered the PCV20 or PCV21 pneumococcal vaccination, even though they were eligible. During an interview on 5/22/25 at 3:54 P.M., the Infection Preventionist said the facility is working off a Pneumococcal timing decision tree from February 2015 and was unaware of the recommendation to determine eligibility and offer the PCV20 or PCV21 pneumococcal vaccination to residents who have previously received both the PCV13 and PPSV23 vaccines. She reviewed the medical records for both Resident #14 and #28 and said there was no documentation that the Residents or their responsible parties were offered the PCV20 or PCV21 vaccinations.