STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225266	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Seton	125 Oakland Street Wellesley, MA 02481

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on observation, interview and record review, the facility failed to accurately code the Minimum Data Set (MDS) for two Residents (#63 and #80) out of 18 total sampled residents. Specifically: 1.) For Resident #63, the presence external urinary catheter (a hollow, partially flexible tube that externally collects urine from the bladder and leads to a drainage bag) and ostomy (a surgically created opening from an area inside the body to the outside of the body) was inaccurately coded in the MDS. 2.) For Resident #80, the facility inaccurately coded the MDS to indicate the Resident had come off of skilled services. Findings include: 1.) Resident #63 was admitted to the facility in September 2023 with diagnoses including urinary retention and a history of a stroke. Review of the most recent MDS assessment, dated 6/23/24, indicated Resident #63 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15. This MDS also indicated the presence of bowel/bladder appliances including an indwelling urinary catheter, an external urinary catheter, and an ostomy. On 9/3/24 at 8:34 A.M., the surveyor observed Resident #63 in bed. Resident #63 showed the surveyor a clear tube that was protruding from his/her lower abdomen, which was connected to a urinary drainage bag, attached to his/her bed frame, containing clear yellow urine. Resident #63 was unable to answer additional questions related to this suprapubic urinary catheter (a tube that is surgically inserted into the lower abdomen and bladder, which drains urine directly from the bladder.) Review of Resident #63's physician's order, initiated 2/22/24, indicated: - Cleanse SPT (suprapubic catheter tube) site with n/s (normal saline) then apply DPD (dry protective dressing) daily. Review of Resident #63's medical record for June 2024 failed to indicate the presence of an external urinary catheter or an ostomy. (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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NAME OF PROVIDER OR SUPPLIER Elizabeth Seton		STREET ADDRESS, CITY, STATE, ZIP CODE 125 Oakland Street Wellesley, MA 02481	

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 9/4/24 at 10:43 A.M., Unit Manager #1 said she was the Unit Manager in June 2024, and that Resident #63 only had a suprapubic urinary catheter. Unit Manager #1 said Resident #63 never used an external urinary catheter or had an ostomy since she had known him/her. During an interview on 9/4/24 at 10:50 A.M., the MDS Nurse said Resident #63 only had a suprapubic urinary catheter, which was coded as an indwelling urinary catheter on the MDS. The MDS Nurse said Resident #63 did not use an external urinary catheter or have an ostomy, so those two bowel/bladder appliances had been coded in error. During an interview on 9/4/24 at 11:22 A.M., the Director of Nursing (DON) said the MDS should be coded according to the Resident Assessment Instrument (RAI) guidelines and that the presence of an external urinary catheter and ostomy had been coded in error. 36797 2.) Resident #80 was admitted to the facility in April 2024 with diagnoses including hip fracture, kidney disease and high blood pressure. Review of the MDS assessment dated [DATE] indicated that the assessment was coded as a discharge return not anticipated and also coded as discharged off of skilled services. (When a resident comes off of their medicare benefit, the facility is required to complete an MDS assessment to notify the Centers for Medicare and Medicaid (CMS) that the facility will no longer be billing CMS for the residents stay at the facility). Review of the medical record indicated that Resident #80 was discharged off of skilled services on 5/14/24 not 6/14/24, as the MDS, dated [DATE], inaccurately coded. During an interview on 9/04/24 at 10:55 A.M., the MDS coordinator said that the MDS dated [DATE] was coded incorrectly as Resident #80 came off of skilled services on 5/14/24 and not 6/14/24.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48990 Based on observations, interviews, and record review, the facility failed to ensure staff developed and implemented a comprehensive person-centered care plan for two Residents (#63 and #34), out of a total sample of 18 residents. Specifically: 1.) For Resident #63, the facility failed to ensure nursing implemented a care plan intervention for bilateral floor mats for fall prevention. 2.) For Resident #34, the facility failed to ensure nursing developed and implemented a care plan intervention for bilateral floor mats for fall prevention. Findings include: Review of the facility policy titled 'Falls', undated, indicated, but was not limited to the following: - The licensed nurse, in conjunction with the interdisciplinary team will identify interventions to try to prevent subsequent falls. - Interventions that will be considered include but are not limited to: equipment-related interventions, surrounding environment modifications. - Care plans will be updated to reflect final interventions as necessary. 1.) Resident #63 was admitted to the facility in September 2023 with diagnoses including a history of a stroke and right sided hemiparesis (weakness on one side of the body). Review of the most recent Minimum Data Set (MDS) assessment, dated 6/23/24, indicated Resident #63 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15. Review of Resident #63's active physician's order, initiated 7/21/24, indicated: - Bed in low position with fall mats on both sides of the bed while Resident is in bed. Check fall mats placement every shift. Review of Resident #63's active care plan related to falls, dated as reviewed 8/3/24, indicated: - Bed in low position with fall mats on both sides of the bed while Resident is in bed. Check fall mats placement every shift. Further review of Resident #63's care plan failed to indicate any history of refusal of fall mats. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/3/24 at 1:50 P.M., 9/4/24 at 6:48 A.M., 9/4/24 at 7:55 A.M., 9/4/24 at 8:30 A.M., 9/4/24 at 9:28 A.M., and 9/4/24 at 10:10 A.M., the surveyor observed Resident #63 in bed. There was a fall mat in place only on the left side of his/her bed, and there was no fall mat in place on the right side of his/her bed. There was another fall mat stored leaning upright against the wall near the bathroom in the Resident's room. During an interview on 9/4/24 at 10:17 A.M., Certified Nurse Assistant (CNA) #1 said she consistently cares for Resident #63. CNA #1 said Resident #63 should have fall mats on both sides of his/her bed. CNA #1 and the surveyor visualized a fall mat in place on the left side of Resident #63's bed and another fall mat leaning upright against the wall near the bathroom in the Resident's room. CNA #1 said they must have forgotten to put the right fall mat into place, but it should have been in place in addition to the left fall mat. Review of Resident #63's Certified Nurse Assistant (CNA) Documentation Survey Report, dated August 2024, indicated CNA #1 provided care to Resident #63 during nine shifts in August 2024. During an interview on 9/4/24 at 10:25 A.M., Nurse #1 said Resident #63 should have fall mats in place on both sides of the bed, not just on the left side, because he/she has a physician's order and care plan intervention for fall mats on both sides of the bed while the Resident is in bed. During an interview on 9/4/24 at 10:40 A.M., Unit Manager #1 said Resident #63 should have fall mats in place on both sides of the bed, not just on the left side, because he/she has a physician's order and care plan intervention for fall mats on both sides of the bed while the Resident is in bed. Unit Manager #1 said it should have been documented in either the TAR or progress notes if there was any refusal or rationale for only one fall mat being in place instead of two. Unit Manager #1 said Resident #63 should have both fall mats in place whenever he/she is in bed, not just at night. Review of the medical record, including the TAR and progress notes, failed to indicate any refusal or rationale for the right fall mat not being in place on 9/3/24 or 9/4/24. During an interview on 9/4/24 at 11:19 A.M., the Director of Nursing (DON) said Resident #63 should have fall mats in place on both sides of the bed, not just on the left side, because he/she has a physician's order and care plan intervention for fall mats on both sides of the bed while the Resident is in bed. The DON said Resident #63 should have both fall mats in place whenever he/she is in bed, not just at night. 2.) Resident #34 was admitted to the facility in May 2024 with diagnoses including altered mental status and recent history of fall. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/9/24, indicated Resident #34 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 8 out of 15. This MDS also indicated Resident #34 had two falls since he/she was admitted to the facility in May 2024, one fall with injury (except major) and one fall with major injury. Review of Resident #34's active physician's order, initiated 5/9/24, indicated: - Bed in low position with fall mats on both sides of the bed while resident in bed, every shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #34's fall investigation report, dated 8/3/24, indicated Resident #34 was found on the floor after being last seen in bed. This investigation indicated fall interventions utilized for Resident #34 included floor mats. Review of Resident #34's active care plan failed to indicate an intervention for fall mats on both sides of the bed while the Resident is in bed. On 9/3/24 at 8:45 A.M., 9/3/24 at 11:19 A.M., 9/3/24 at 1:55 P.M., and 9/4/24 at 6:53 A.M., the surveyor observed Resident #34 in bed. There was a fall mat in place only on the right side of his/her bed, and there was no fall mat in place on the left side of his/her bed. During an interview on 9/3/24 at 8:45 A.M., the surveyor observed Resident #34 in bed with a large purple bruise-like area on his/her forehead. Resident #34 said he/she sustained the bruise during a fall in his/her room. During an interview on 9/4/24 at 10:17 A.M., Certified Nurse Assistant (CNA) #1 said she consistently cares for Resident #34. CNA #1 said Resident #34 only has one fall mat that should be in place whenever he/she is in bed. CNA #1 and the surveyor visualized only one fall mat in Resident #34's room. Review of Resident #34's Certified Nurse Assistant (CNA) Documentation Survey Report, dated August 2024, indicated CNA #1 provided care to Resident #34 during nine shifts in August 2024. During an interview on 9/4/24 at 10:25 A.M., Nurse #1 said Resident #34 should have fall mats in place on both sides of the bed, not just on the right side, because he/she has a physician's order for fall mats on both sides of the bed while the Resident is in bed. During an interview on 9/4/24 at 10:40 A.M., Unit Manager #1 said Resident #34 should have fall mats in place on both sides of the bed, not just on the right side, because he/she has a physician's order for fall mats on both sides of the bed while the Resident is in bed. Unit Manager said if only one fall mat was available, the nurses should have clarified the order for fall mats to both sides of the bed or obtained another fall mat instead of signing it off as complete. During an interview on 9/4/24 at 11:19 A.M., the Director of Nursing (DON) said she wrote the interventions for floor mats in Resident #34's fall investigation report, dated 8/3/24, and that the plural meant that two fall mats should be in place. The DON said the intervention for Resident #34 to have fall mats on both sides of the bed, not just the right side, while in bed should have been part of the Resident's plan of care and should have been implemented, but was not. The DON further said that since the physician's order stated fall mats on both sides of the bed, the nurses should have clarified the order or obtained another fall mat if only one fall mat was available instead of signing it off as complete since the physician's order was not implemented as ordered.

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Elizabeth Seton	125 Oakland Street Wellesley, MA 02481

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on observations, interviews, and record review, the facility failed to provide respiratory care services in accordance with professional standards of care and the plan of care for one Resident (#31) out of a total sample of 18 residents. Specifically, the facility failed to ensure nursing implemented a physician's order to change Resident #31's oxygen tubing. Findings include: Review of [NAME], Manual of Nursing Practice 11th edition, dated 2018, 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 the following: - 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. Resident #31 was admitted to the facility in October 2018 with a diagnosis including respiratory failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/5/24, indicated Resident #31 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 2 out of 15. Review of Resident #31's physician's order, initiated 12/26/21, indicated: - Change oxygen tubing every week on Sunday 11-7 (date and initial). Review of Resident #31's Treatment Administration Record (TAR) indicated the following order was documented as implemented on 9/1/24: - Change oxygen tubing every week on Sunday 11-7 (date and initial). On 9/3/24 at 8:39 A.M., 9/3/24 at 1:51 P.M., 9/4/24 at 6:52 A.M., and 9/4/24 at 10:26 A.M., the surveyor observed Resident #31 in bed receiving oxygen through a nasal cannula with tubing dated 8/26. During an interview on 9/3/24 at 8:3:9 A.M., Resident #31 said he/she always wears oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/4/24 at 10:28 A.M., Nurse #1 said oxygen tubing should be changed every seven days. Nurse #1 visualized the label on Resident #31's oxygen tubing dated 8/26 and said that the oxygen tubing change was overdue, and it should have been changed three days ago. Nurse #1 said the order to change oxygen tubing should not have been documented as implemented in the TAR because it was not done. During an interview on 9/4/24 at 10:35 A.M., Unit Manager #1 said oxygen tubing should be changed every seven days. Unit Manager #1 said nurses are supposed to check the oxygen tubing every shift, and if it was overdue, it should be changed immediately. Unit Manager #1 said the order to change oxygen tubing should not have been documented as implemented in the TAR because it was not done. Unit Manager #1 said if there was reason the oxygen tubing was not changed it should have been documented in the TAR or progress notes. Review of Resident #31's medical record, including the TAR and progress notes, failed to indicate any rationale for oxygen tubing not being changed as ordered by the physician on 9/1/24. During an interview on 9/4/24 at 11:17 A.M., the Director of Nursing (DON) said oxygen tubing should be changed every seven days and/or as ordered by the physician if it is being used. The DON said nurses are supposed to check the oxygen tubing every shift, and if it was overdue, it should be changed immediately. The DON said the order to change oxygen tubing should not have been documented as implemented in the TAR because it was not done.