

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Day Brook Village Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 298 Jarvis Avenue Holyoke, MA 01040	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>45435</p> <p>Based on record review and interviews, for one of three sampled residents (Resident #1) who was exhibiting signs and symptoms of Influenza, the facility failed to ensure he/she was provided with quality care and services that meet professional standards of practice, when after an Influenza test had been conducted on 03/06/25, with positive test results on 03/07/25, the test results were not obtained by nursing until 03/12/25, six days after the test was obtained, as a result Resident #1 was unable to receive antiviral medication used to treat Influenza putting him/her at risk for complications from influenza.</p> <p>Findings include:</p> <p>Review of the Facility's policy titled Laboratory and Radiology Services, dated as revised 11/17/16, indicated laboratory and testing will be performed as per medical provider orders and be communicated to the provider and recorded in the patient record in a timely and effective manner. The facility will promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of practitioner or per the ordering physician's order.</p> <p>Review of the Facility's policy titled, Influenza Outbreak Management, dated at revised 01/4/23, indicated residents of long-term care facilities can experience severe and fatal illness during influenza outbreaks. Preventing transmission of Influenza viruses and other infectious agents requires a multi-faceted approach that includes the following .Antiviral Treatment as recommended.</p> <p>Resident #1 was admitted to the facility in July 2020, diagnoses included unspecified dementia and major depressive disorder.</p> <p>Review of the Nurses' Progress Note, dated 03/6/25 indicated the Nurse Practitioner (NP) had been notified by a facility nurse that Resident #1 had a fever, cough and cold symptoms. The Nurses' Progress Note indicated that new Physician's orders for Resident #1 were obtained including a respiratory panel (a group of laboratory tests for the viruses that cause Influenza, COVID, and RSV).</p> <p>Review of Resident #1's Physician's Order, dated 03/06/25, indicated he/she had order for a respiratory panel laboratory test to include Influenza, COVID and RSV.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Laboratory Report, dated as specimen collected on 03/06/25, and resulted on 03/7/25, indicated Resident #1 was positive for Influenza.</p> <p>Review of the Nurse Practitioner's (NP) Progress Note, dated 03/12/25, indicated that no viral panel results for Resident #1 had been found at the facility and that the NP had obtained Resident #1's viral panel results from the offsite laboratory. The NP Progress Note indicated that staff appeared unaware of Resident #1's positive Influenza status, as he/she was not on precautions and there was no note indicating a provider was notified. The NP Progress Note also indicated that it was too late to start Tamiflu.</p> <p>During an interview on 03/27/25 at 7:45 A.M., the Nurse Practitioner (NP) said that the facility had not informed her or any other Provider of Resident #1's positive test result from 03/07/25, for Influenza. The NP said that if she had been made aware that Resident #1 had Influenza on 03/07/25, she would have offered him/her Tamiflu because Resident #1 was symptomatic and was at high risk for complications from influenza. The NP said that Tamiflu is not likely to work if it is started more than a day or two after the start of Influenza symptoms. The NP said that missed lab results have happened at the facility before.</p> <p>During an interview on 03/27/25 at 11:26 A.M., Nurse #1 said she had taken care of Resident #1 on 03/06/25 and that he/she had a fever and cough. Nurse #1 said that she obtained orders from the Nurse Practitioner for lab work, including a respiratory panel, and a chest x-ray. Nurse #1 said that she had taken care of Resident #1 again on 03/07/25 and that the Influenza test results had not been reported during her shift. Nurse #1 said she was not concerned that the respiratory panel results had not been reported because sometimes the respiratory panel takes two days. Nurse #1 said that she could have called the lab for the results.</p> <p>During an interview on 03/26/25 at 2:00 P.M., the Unit Manager said that the facility laboratory results are sent over to the facility and received from the laboratory printer on the nursing unit. The Unit Manager said there might have been a period-of-time when the lab printer was not working, but that the Nurse could have called the lab for the results. The Unit Manager said she was not aware that Resident #1 had Influenza until the NP told her on 03/12/25. The Unit Manager said that each Nurse was responsible for checking the lab printer for results for their assigned residents and following up with the Provider.</p> <p>During an interview on 03/26/25 at 3:30 P.M., the Infection Preventionist (IP) said that her process for monitoring infections in the Facility included listening to clinical reports, reviewing Nurse progress notes, and reviewing laboratory test results. The IP said that she had not been made aware that Resident #1 was positive for Influenza on 03/07/25. The IP said that his/her Nurse was responsible for checking Resident #1's lab results and notifying her of the results.</p> <p>During an interview on 03/26/25 at 4:15 P.M., the Director of Nurses (DON) said that the Nurse that swabbed Resident #1 on 03/06/25 should have looked for the Influenza test result the following day, and if the results were not available, she should have passed the information on in report for the next shift nurse to look for the results. The DON said if the Influenza test results had not been reported to the facility within a reasonable period of time the Nurse should have called the laboratory for the results. The DON said the facility did not obtain or act upon Resident #1's positive influenza test results timely.</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45435</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was exhibiting signs and symptoms of Influenza, and for whom nursing received a new order on 3/06/25 for an Influenza test, the Facility failed to ensure Nursing promptly notified the ordering physician, physician assistant, or nurse practitioner of the laboratory results, when he/she tested positive for Influenza on 03/07/25, but the provider was not made aware until 03/12/25, six days later.</p> <p>Findings Include:</p> <p>Review of the policy titled Laboratory and Radiology Services, dated as revised 11/17/16, indicated laboratory and testing will be performed as per medical provider orders and be communicated to the provider and recorded in the patient record in a timely and effective manner. The facility will promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of practitioner or per the ordering physician's order.</p> <p>Review of the Nurses' Progress Note, dated 03/06/25 indicated the Nurse Practitioner (NP) had been notified by a facility nurse that Resident #1 had a fever, cough and cold symptoms. The Nurses' Progress Note further indicated that new Physician's orders for Resident #1 were obtained including a respiratory panel (a group of tests for the viruses that cause Influenza, COVID, and RSV).</p> <p>Review of Resident #1's Physician's Order, dated 03/06/25, indicated he/she had an order for a respiratory panel laboratory test to include Influenza, COVID and RSV.</p> <p>Review of Resident #1's Laboratory Report, dated as specimen collected on 03/06/25, and resulted on 03/07/25, indicated Resident #1 was positive for Influenza.</p> <p>Review of the Nurse Practitioner's (NP) Progress Note, dated 03/12/25, indicated that no viral panel laboratory test result for Resident #1 had been found at the facility, and that the NP had obtained Resident #1's viral panel results from the offsite laboratory. The NP Progress Note indicated that staff appear unaware of Resident #1's positive Influenza status, as he/she was not on precautions and there was no note indicating a provider had been notified.</p> <p>During an interview on 03/28/25 at 7:25 A.M., the Senior Medical Technician from the offsite laboratory said Resident #1's positive Influenza test result had been sent to the facility on [DATE] at 1:52 P.M.</p> <p>(continued on next page)</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/27/25 at 11:26 A.M., Nurse #1 said that she had been assigned to take care of Resident #1 on 03/06/25, on the day shift, and that Resident #1 had a fever and cough. Nurse #1 said that she obtained orders from the Nurse Practitioner (NP) for lab work, including a respiratory panel, and a chest x-ray. Nurse #1 said a nurse that was helping her had obtained the nasal swab from Resident #1 for the Influenza test. Nurse #1 said she also worked on 03/07/25, on the day shift, and that she was not concerned when the respiratory panel results had not been reported because sometimes the respiratory panel takes two days. Nurse #1 said that she could have called the lab for the results.</p> <p>During an interview on 03/26/25 at 2:00 P.M., the Unit Manager said that the facility receives laboratory results from the lab printer at the Nurses' station. The Unit Manager said there might have been a period-of-time when the lab printer was not working, but that the Nurse could have called the lab for the results. The Unit Manager said she was not aware that Resident #1 had Influenza until the Nurse Practitioner told her on 03/12/25. The Unit Manager said that each Nurse was responsible for checking the lab printer for results for their assigned residents and following up with the Provider.</p> <p>During an interview on 03/26/25 at 4:15 P.M., the Director of Nurses (DON) said that the Nurse that swabbed Resident #1 on 03/06/25 should have looked for the influenza test results the following day, and if the results were not available, she should have passed the information on in report for the next shift nurse to look for the results. The DON said if the Influenza test results had not been reported to the facility in a reasonable period of time the Nurse should have called the laboratory for the results. The DON said the facility did not obtain or act upon, [which included notification to the Provider], Resident #1's positive Influenza test timely.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>45435</p> <p>Based on records reviewed and interviews, for three of three sampled residents, (Resident #1, Resident #2 and Resident #3), the Facility failed to ensure they maintained complete and accurate medical records, when 1) for Residents #1, #2 and #3, who all tested positive for Influenza, there were no Physician's orders obtained and therefore no documentation related to the need for Droplet precautions to be initiated and 2) for Resident #1, his/her Certified Nurse Aide (CNA) Activities of Daily Living (ADL) Flow Sheets were incomplete.</p> <p>Findings include:</p> <p>Review of the Facility's Policy, titled Documentation-Clinical, dated revised 10/31/23 indicated the following:</p> <ul style="list-style-type: none"> -This Facility meets DPH requirements for weekly summary of resident condition by ensuring documentation of medication and treatment administration every shift, interdisciplinary progress notes as needed, skin evaluations weekly and Functional Performance point of care documentation every shift. Resident status, including change in condition, nursing or other services provided and resident response or progress will be documented as warranted. -Purpose-to ensure accuracy and completeness of clinical documentation. -Change of condition/Incidents: complete documentation for change in resident condition or incidents, interventions, and resident response. Continue documentation as often as the resident condition warrants and at a minimum every shift for 72 hours or until the condition stabilizes or resolves. <p>Review of the Facility's Policy titled, Influenza Outbreak Management, dated as revised 01/4/23 indicated in addition to Standard Precautions, Droplet Precautions will be implemented for all residents with suspected or confirmed influenza.</p> <p>1. Resident #1 was admitted to the facility in July 2020, diagnoses included unspecified dementia and major depressive disorder.</p> <p>Review of Resident #1 Laboratory Report, dated 03/07/25, indicated he/she tested positive for Influenza.</p> <p>Review of Resident #1's Physician's Orders, dated March 2025, indicated there was no documentation to support that nursing obtained a Physician's order to implement Droplet Precautions when Resident #1 tested positive for Influenza.</p> <p>Review of Resident #1's Treatment Administration Record (TAR) for March 2025, indicated there was no documentation to support that Droplet precautions had been implemented.</p> <p>Resident #2 was admitted to the Facility in March 2025, diagnoses included acute kidney failure.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's Nursing Progress Note, dated 03/24/25, indicated Resident #2 tested positive for Influenza.</p> <p>On 03/26/25 at 10:07 A.M., Surveyor #2 observed a Droplet Precaution sign posted on Resident #2's door.</p> <p>Although Resident #2 was observed to be on Droplet Precautions, review of Resident #2's Physician's Orders for the month of March 2025, indicated there was no documentation to support that nursing obtained a Physician's Order to include the implementation and duration for Droplet Precautions.</p> <p>Resident #3 was admitted to the facility in January 2023 with diagnoses including unspecified dementia and respiratory failure.</p> <p>Review of the Facility Line List for Influenza, provided by the facility, indicated Resident #3 tested positive for Influenza on 03/9/25.</p> <p>Review of Resident #3's Physician's Orders, dated March 2025, indicated there was no documentation to support that nursing obtained a Physician's order to implement Droplet Precautions when Resident #3 tested positive for Influenza.</p> <p>Review of Resident #3's Treatment Administration Record (TAR) for the month of March 2025, indicated there was no documentation to support that Droplet precautions had been implemented.</p> <p>During an interview on 03/26/25 at 2:00 P.M., the Unit Manager said that when a resident tests positive for Influenza it is the Nurses' responsibility to obtain a Physician's order to put the resident on droplet precautions.</p> <p>During an interview on 03/26/25 at 3:30 P.M., the Infection Preventionist (IP) said that when a resident tests positive for Influenza it is the Unit Manager's responsibility to obtain a Physician's order to put the resident on droplet precautions.</p> <p>2. Resident #1 was admitted to the facility in July 2020 with diagnoses including unspecified dementia and major depressive disorder.</p> <p>Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 12/19/24, indicated he/she required various levels of staff assistance with his/her Activities of Daily Living (ADLs) including but not limited to bathing, dressing, grooming, transfer, toileting and personal hygiene.</p> <p>Review of Resident #1's ADL Flow Sheets (CNA documentation) dated 03/01/25 through 03/25/25 indicated that for the following shifts, documentation on the flow sheets was incomplete:</p> <p>-7:00 A.M. to 3:00 P.M. 9 days (out of 25) all ADL care areas were left blank.</p> <p>-3:00 P.M. to 11:00 P.M. 12 days (out of 25) all ADL care areas were left blank.</p> <p>-11:00 P.M. to 7:00 A.M. 7 days (out of 25) all ADL care areas were left blank.</p> <p>(continued on next page)</p>		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/26/25 at 1:45 P.M., the Director of Nursing said the CNAs are responsible for completing their documentation by the end of their shift.