STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225275	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Rehab & Skilled Nursing Ctr - Westboro	3 Lyman Street Westborough, MA 01581

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 45429 Based on observation, interview, and record review, the facility failed to ensure that a device utilized for one Resident (#38), was assessed when used as a physical restraint, for one applicable Resident who had nephrostomy tubes (tubes that drain urine from the kidneys into drainage bags), out of a total sample of 27 residents. Specifically, the facility failed to assess Resident #38 for the need of an abdominal binder (wide compression belt that encircles the abdomen) to cover Resident #38's nephrostomy sites to prevent him/her from pulling on the nephrostomy tubes. Findings include: Review of the facility's policy titled Physical Restraints, last revised 10/28/15, indicated: -it is the policy of this facility to use a physical restraint on a resident when alternatives have failed, and it is required by a medical symptom. Every effort will be made to use the least restrictive device with the goal of reducing or eliminating the restraint as soon as possible. -a physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to a resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. -Physical restraints may include but are not limited to the following: siderails, clip belts, seat belts, Velcro belts, soft lap bars, waist restraints, cardiac/geri chair (specialized reclining mobility chair for older adults who need extra support and comfort), lap trays, wrist restraints. -When a resident demonstrates consistent medical symptoms with risk for injury, an assessment will be made and alternatives to restraint use will be discussed and tried, and the resident will be monitored by nursing. -if alternatives have failed and a resident remains at risk because of a specific medical system, an assessment will take place with the members of the team to discuss the least restrictive device that can be used for the least amount of time. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #38 was admitted to the facility in March 2024 with diagnoses including acute kidney failure (a sudden decline in the functioning of the kidneys which might be reversed), hydronephrosis (condition of increased urine in the kidneys that causes swelling) and Dementia. Review of Resident #38's current Physician's orders for December 2024 included: -May use abdominal binder to hold drain tubes in place as a safety precaution, three times a day: 7:00 A.M. to 3:00 P.M., 3:00 P.M. to 11:00 P.M., 11:00 P.M. to 7:00 A.M., start date of 10/8/24. Review of Resident #38's Treatment Administration Record (TAR) from October 2024 to December 2024 indicated that the Resident utilized the abdominal binder on the following days: -daily from 10/8/24 to 10/31/24 -daily from 11/1/24 to 11/23/24, and 11/28/24 to 11/30/24 -daily from 12/1/24 to 12/4/24 Review of Resident #38's Activities of Daily Living (ADL) care plan last revised 10/17/24, indicated that the Resident required assistance of one person for both upper body and lower body dressing. Review of the Minimum Data Set (MDS) Assessment, dated 12/2/24, indicated Resident #38: -was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. -required substantial/maximal assistance (helper does more than half the effort) for both upper body and lower body dressing. Review of Resident #38's clinical record did not provide any documented evidence of assessment of the abdominal binder restraint until 12/4/24, when the surveyor brought it to the facility's attention. On 12/4/24 at 8:57 A.M., the surveyor observed Nurse #2 attempt to fasten the abdominal binder around the Resident's abdomen. Resident #38 was observed with ace bandages wrapped around his/her abdomen and the nephrostomy bags were loose and had fallen on the Resident's mattress. Resident #38 was observed to be unsteady on his/her feet while attempting to use the rolling walker to steady him/herself. The surveyor then observed Nurse #2 request additional assistance from the Certified Nurses Aide (CNA) to place the abdominal binder on safely and successfully. During an interview at the time, Nurse #2 said that Resident #38 removes his/her restraints frequently and the restraints have gotten lost in the past requiring the need for additional binders. During an interview on 12/4/24 at 2:50 P.M., Nurse #3 said that the abdominal binder is used to prevent Resident #38 from touching the nephrostomy entry sites as he/she has dislodged the tubes in the past and required hospitalization . Nurse #3 also said that an assessment had not been completed for the use of the abdominal restraint, and an assessment should have been completed to determine if the Resident could remove it easily. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/24 at 9:10 A.M., the Director of Nursing (DON) said that there was never an assessment for the restraint when the abdominal binder was applied, but there should have been an assessment completed.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51466 Based on record review, and interview, the facility failed to ensure that a Minimum Data Set (MDS) assessment was transmitted within the required timeframe after the completion date for one Resident (#46), out of one applicable resident, out of a total sample of 27 residents. Specifically, for Resident #46, a discharge MDS assessment was not transmitted within 14 days of the MDS assessment completion date as required. Findings include: Review of the Centers for Medicare and Medicaid (CMS) MDS 3.0 Resident Assessment Instrument (RAI) Manual, dated [DATE], indicated: -Non-comprehensive MDS assessments (OBRA- required non comprehensive MDS assessments include a select number of MDS items, but not completion of the CAA process [Care Area Assessments- items coded on the MDS to identify problems, needs or strengths] and care planning) must be transmitted to IQIES (Internet Quality Improvement and Evaluation- web based system that is used to transmit data to CMS) no later than 14 calendar days after the MDS completion date. Resident #46 was admitted to the facility in [DATE] with a diagnosis of unspecified Dementia. Review of Resident #46's clinical record indicated: -the Resident expired at the facility on [DATE], while under the care of Hospice services. -a non-comprehensive discharge MDS was completed for Resident #46 on [DATE]. -no evidence was found in the clinical record to indicate that the discharge MDS completed on [DATE] was ever transmitted to IQIES, as required. During an interview on [DATE] at 2:56 P.M., MDS Nurse #1 said the facility followed the RAI Manual to determine when to complete and submit MDS assessments. MDS Nurse #1 further said that Resident #46's discharge MDS assessment was completed on [DATE], and should have been transmitted within 14 days of completion to IQIES, but it had never been transmitted.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on record review, and interview, the facility failed to ensure that a Level II [comprehensive evaluation that identifies the specialized services required] Preadmission Screening and Resident Review (PASARR-evaluation done if it was determined by the Level I [initial pre-screening] screen that a resident had an intellectual or developmental disability and/or serious mental illness [SMI] and if a resident was in need of additional support services at the facility) screen was submitted for one Resident (#36), out of a total sample of 27 residents. Specifically, for Resident #36, the facility staff failed to request a Level II PASARR evaluation when the Resident demonstrated an increase in behavioral, psychiatric, and mood-related symptoms resulting in a change to the Resident's plan of care. Findings include: Resident #36 was admitted to the facility in September 2023 with diagnoses including Bipolar Disorder (chronic mood disorder characterized by manic, hypomanic and depressive episodes, Depression and Anxiety. Review of Resident #36's PASARR Level I screen dated 9/18/23, indicated that he/she had a history of a mood disorder and did not meet criteria for SMI, therefore a Level II PASARR evaluation was not needed. Review of Resident #36's Minimum Data Set (MDS) assessment dated [DATE], indicated that the Resident: -was cognitively intact as evidenced by a Brief interview of Mental Status (BIMS) score of 14 out of a possible score of 15. -had exhibited verbal behavior symptoms directed at others (e.g., threatening others, screaming at others, cursing at others). -the exhibited behaviors were worse when compared to the previous MDS assessment. Review of Resident #36's Psychosocial/Behavioral Care Plan last revised 9/27/24, indicated that the Resident needed monitoring and support for increased Anxiety and depressive symptoms. Review of Resident #36's clinical record indicated: -a Neurological Psychiatric Evaluation note dated 10/30/24, endorsing the Resident's long complex history of Depression, Anxiety, and panic with content related to the death of their child, functional decline and difficulty with loss of independence. The Neurological Psychiatric Evaluation note also references the Resident's somatic anxiety complaints with prominent escalation at night where he/she will often have bad nightmares or wake in panic with his/her heart racing. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-that the Resident had been prescribed Prazosin (a medication used to treat high blood pressure and nightmares caused by PTSD - [Post Traumatic Stress Disorder: a mental and behavioral disorder that develops from having experienced a traumatic event, causing flashbacks, nightmares and severe anxiety]) on 11/1/24. -that the Resident has started a new order for Buspar (anti-anxiety medication) on 11/14/24. -that he/she had received a new diagnosis of PTSD on 11/15/24 due to experiencing nightmares. -the Resident had his/her prescription for Buspar increased from 10 milligrams (mg) twice a day to 10 mg three times a day on 11/22/24. -that the Resident had been prescribed an as needed (PRN) dose of Buspar from 10/26/24 to 11/19/24 for Anxiety. Review of Resident #36's Treatment Administration Record (TAR) for October 2024 and November 2024 indicated that the Resident utilized the PRN Buspar medication in addition to the standing orders (three times daily) of the Buspar medication on: -10/23/24 at 1:48 A.M. -10/25/24 at 2:19 A.M. -11/8/24 at 7:32 A.M. -11/13/24 at 10:20 A.M. -11/14/24 at 11:13 A.M. Further review of the Resident's medical record failed to indicate that the Level I PASARR was updated and re-submitted for an additional Resident Review when new mental health diagnoses were identified on 11/15/24. During an interview on 12/4/24 at 2:21 P.M., Social Worker (SW) #1 said that the Level I screen should have been re-submitted when the Resident was diagnosed with PTSD, and it had not been. SW #1 also said that the facility did not have a PASARR policy. During an interview on 12/5/24 at 10:19 P.M., Nurse Practitioner (NP) #1 said that she had diagnosed Resident #36 with PTSD and prescribed him/her the Prazosin to help him/her sleep because he/she had been experiencing nightmares.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 45429 Based on interview and record review, the facility failed to develop a comprehensive Trauma Informed Care Plan for one Resident (#36), out of a total sample of 27 residents. Specifically, for Resident #36, the facility failed to complete an assessment and ensure that a comprehensive Trauma Informed Care Plan was developed relative to the Resident's history of Post-Traumatic Stress Disorder (PTSD). Findings include: Review of the facility's policy for Trauma Informed Care, last revised 5/2020, indicated: -acknowledging that trauma is widespread and can affect anyone, and understanding how it can manifest in behaviors and presentations. -care plan will be developed to communicate this history and how it impacts the individualized care of the resident. -all staff members receive comprehensive training in trauma informed care principles and practices. -regularly monitoring the effectiveness of trauma-informed practices and making necessary adjustments. Resident #36 was admitted to the facility in September 2023 with diagnoses including Bipolar Disorder and depressive episodes, Depression, and Anxiety. Review of the Minimum Data Set (MDS) assessment, dated 9/13/24, indicated that Resident #36: -was cognitively intact as evidenced by a Brief interview of Mental Status (BIMS) score of 14 out of a possible score of 15. -exhibited verbal behavior symptoms directed at others (e.g., threatening others, screaming at others, cursing at others). -exhibited behaviors were worse when compared to the previous MDS assessment. Review of a Neurological Psychiatric Evaluation Note dated 10/30/24, for Resident #36 indicated: -long complex history of Depression, Anxiety, and panic. -content related to the death of his/her child, functional decline and difficulty with loss of independence. -somatic anxiety complaints with prominent escalation at night where he/she often had bad nightmares or awakened in panic with his/her heart racing. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #36's clinical record indicated: -that the Resident had been prescribed Prazosin for nightmares caused by PTSD on 11/1/24. -that the Resident received a new diagnosis of PTSD on 11/15/24 due to experiencing nightmares. -no assessment had been completed relative to the Resident's history or triggers of PTSD after he/she had received the new diagnosis. -that the Resident was started on a new order for Buspar (anti-anxiety medication) on 11/14/24. -the Resident had the prescription for Buspar increased from 10 milligrams (mg) twice a day to 10 mg three times a day on 11/22/24. -that the Resident had been prescribed a PRN (as needed) dose of Buspar for Anxiety from 10/26/24 to 11/19/24. Review of Resident #36's Treatment Administration Record (TAR) for October 2024 and November 2024 indicated that the Resident has utilized the PRN Buspar medication in addition to the standing orders of the Buspar medication on the dates: -10/23/24 -10/25/24 -11/8/24 -11/13/24 -11/14/24 Review of the Resident's Comprehensive Care Plan indicated no documentation that a Trauma Informed Care Plan had been developed for Resident #36. During an interview on 12/4/24 at 3:31 P.M., Social Worker (SW) #1 said that a new Trauma assessment should have been completed once the facility had become aware of the PTSD diagnosis and it was not. SW #1 said that the new diagnosis of PTSD had not been communicated to her. SW #1 also said that a Trauma Informed Care Plan should have been developed with interventions for the Resident's diagnosis of PTSD and it was not. During an interview on 12/5/24 at 10:19 P.M., Nurse Practitioner (NP) #1 said that she had diagnosed Resident #36 with PTSD and prescribed him/her the Prazosin medication to help him/her sleep because he/she had been experiencing nightmares. During a follow-up interview on 12/5/24 at 10:09 A.M., SW #1 said that Resident #36's child had passed away because of an accident, which caused the Resident to have difficulty sleeping at night.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on observation and interview, the facility failed to accurately and safely provide pharmaceutical services pertaining to the administration of routine medications for one Resident (#40), out of a total of five resident medication administration observations. Specifically, the facility failed to ensure that Resident #40's Furosemide (medication used to treat high blood pressure, heart failure and build-up of fluid in the body) medication: -was dispensed from the pharmacy. -was administered in the correct dose to the Resident when the facility staff used a higher dose medication tablet and broke the higher dose tablet to obtain the ordered dose. Findings include: Review of the facility's policy titled, General Guidelines for Medication Administration, revised August 2020, indicated: -At a minimum, the 5 Rights - right resident, right drug, right dose, right route and the right time should be applied to all medication administration and reviewed at three steps in the process of preparation. -Select the medication, check the label, container, and contents for integrity, and compare the medication against the Medication Administration Record (MAR) by reviewing the five rights. -Prepare the dose by removing the dose from the container and verifying it against the label and the MAR by reviewing the five rights. -Prior to the administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. If the label and MAR are different and the container has not already been flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. -Splitting of tablets should be avoided and every attempt should be made to obtain an alternate dosage form, medication, or dosing schedule to avoid splitting. -Since unscored tablets may not be accurately broken, their use is discouraged. -Medications supplied for one resident are never administered to another resident. Resident #40 was admitted to the facility in August 2024 with diagnoses of Heart Failure and Hypertension. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #40: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of Resident #40's December 2024 Physician's orders indicated: -9:00 A.M., Aspirin 81 mg, 1 tablet once a day, started 8/28/24. -8:00 A.M., D- Mannose 2000 mg, 4 tablets once a day, started 11/13/24. -8:00 A.M., Multivitamin tablet, 1 tablet, once a day, started 7/22/24. -8:00 A.M., Vitamin D3, 25 mg, 2 tablets once a day, started 7/22/24. -8:00 A.M., Folate 1 mg, 1 tablet once a day, started 10/23/24. -8:00 A.M., Eliquis 5 mg tablet, 1 tablet twice a day, started 7/22/24. -8:00 A.M., Thera Cran 1 capsule, once a day, started 11/13/24. -8:00 A.M., Furosemide 10 mg tablet, 1 tablet once a day, started 11/20/24. -9:00 A.M., Spironolactone 25 mg tablet, 1 tablet once a day, started 9/4/24. On 12/4/24 at 9:56 A.M., the surveyor observed Nurse #1 prepare and administer the following medications to Resident #40: -Aspirin 81 milligrams (mg), 1 tablet -D-Mannose 2000 mg (4 tablets) -Multivitamins with Minerals, 1 tablet -Vitamin D3 25 microgram (mcg) 2 tablets -Folic Acid 1 mg, 1 tablet -Eliquis 5 mg, 1 tablet -Thera Cran, 1 capsule -Spironolactone 25 mg, 1 tablet Nurse #1 handed the medications to Resident #40, and the Resident asked Nurse #1 where the Furosemide medication was. Nurse #1 said that she would have to locate a dose since the Furosemide medication had not been delivered from the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/24 at 10:14 A.M., Nurse #1 said the Furosemide medication was a new order from 11/20/24. Nurse #1 said she was unsure how the medication had been administered to Resident #40, because the Furosemide medication was not available in the medication cart for the Resident. During an interview on 12/4/24 at 10:31 A.M., the Director of Nursing (DON) said there was no indication the Furosemide medication had been removed from the facility Pyxis (automated medication dispensing system). The DON said that the Furosemide medication had not been delivered from the pharmacy since it was ordered on 11/20/24. During an interview on 12/4/24 at 10:38 A.M., Resident #40 said the facility staff would bring a Furosemide 20 mg tablet and break the medication tablet in his/her presence and then administer the Furosemide medication to him/her. During a follow-up interview on 12/4/24 at 10:39 A.M., Nurse #1 said she worked the previous day on 12/3/24, and borrowed the Furosemide 20 mg medication from another resident. Nurse #1 said she had broken the 20 mg tablet of Furosemide medication to administer 10 mg to Resident #40. During an interview on 12/4/24 at 11:03 A.M., the DON said the facility staff should not borrow medication from one resident to administer to another resident. The DON further said the facility staff should not break the Furosemide medication in half to administer to Resident #40, because the Resident could receive an inaccurate amount of the medication. During a follow-up interview on 12/5/24 at 9:32 A.M., the DON showed the surveyor the Resident's Medication Delivery Manifest which indicated that the 20 mg tabs of the Furosemide medication was delivered to the Resident on 12/5/24 at 3:03 A.M. The DON said the order for the 10 mg Furosemide medication never got to the pharmacy.