STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225279	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Path at Duxbury Nursing & Rehabilitation Ctr	308 Kingstown Way Duxbury, MA 02332

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** 46862 Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the Resident's status for two Residents (#44 and #70), out of a sample of 22 residents. Specifically, the facility failed: 1. For Resident #44, to accurately reflect hospice services; and 2. For Resident #70, to accurately reflect Post Traumatic Stress Disorder (PTSD) Findings include: 1. Resident #44 was admitted to the facility in September 2022 with diagnoses including left sided hemiplegia, hypertension and dementia. Review of Resident #44's current physician's orders indicated he/she had an order for Cranberry Hospice, order date 2/14/24. Review of the hospice binder included a Recertification of Terminal Illness form with certification period from 5/28/24 to 7/26/24. Review of the MDS assessment, dated 6/6/24, Section O, failed to indicate he/she had received hospice services. During an interview on 7/9/24 at 8:42 A.M., the surveyor and MDS Nurse #1 reviewed Resident #44's physician's orders and the Recertification of Terminal Illness form. MDS Nurse #1 reviewed the MDS assessment completed 6/6/24, including Section O. MDS Nurse #1 said Resident #44's MDS assessment should have indicated that he/she was receiving hospice services. MDS Nurse #1 said the assessment would need to be modified to correctly reflect Resident #44's hospice status. 2. Resident #70 was admitted to the facility in May 2023 with diagnoses including diabetes, peripheral vascular disease and depression. Review of Resident #70's medical record included a psychiatric assessment dated [DATE]. Diagnoses included depression, unspecified, F32.A (ICD-10) (Active) and Post-traumatic stress disorder (PTSD), chronic, F43.12 (ICD-10) (Active). (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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Recommendations included: -He/she may benefit from 1:1 therapy if he/she would agree to it for PTSD -Start Lexapro 10 milligrams daily for depression/PTSD -Contact Pinnacle with worsening or persistent symptoms Review of nursing progress note, dated 4/16/24, indicated psychiatric recommendations reviewed with Nurse Practitioner #1 who was in agreement. Review of Resident #70's Trauma assessment, dated 6/5/24, indicated he/she had indicators of PTSD. Review of Resident #70's care plan, included but was not limited to: -Resident has a potential for re-traumatization due to history abuse from mother at a younger age, initiated 6/5/24. Review of the MDS assessment, dated 6/6/24, Section I, failed to indicate he/she had an active diagnosis of PTSD. During an interview on 7/9/24 at 9:08 A.M., the surveyor and MDS Nurse #1 reviewed Resident #70's medical record. MDS Nurse #1 reviewed the MDS assessment completed 6/6/24, including Section I. MDS Nurse #1 said she was not sure PTSD should have been checked off as she did not see documentation from the physician. MDS Nurse #1 said she would contact her [NAME] President (VP) of clinical reimbursement for clarification. The MDS Nurse #1 and surveyor placed a call to the VP of clinical reimbursement. The VP of clinical reimbursement said she would get back to MDS Nurse #1 after she had an opportunity to review the resident's medical record. During an interview on 7/9/24 at 10:11 A.M., MDS Nurse #1 said she heard back from the VP of clinical reimbursement. MDS Nurse #1 gave the surveyor an e-mail correspondence indicating: Based on the documentation in the resident record and the RAI (Resident Assessment Instrument) manual instructions I do agree this was and should be added to the MDS. MDS Nurse #1 said Resident #70's MDS assessment should have indicated that he/she had an active diagnosis of PTSD. MDS Nurse #1 said the assessment would need to be modified to correctly reflect Resident #70's active diagnosis.

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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. 41106 Based on observation, interview, and record review, the facility failed to adhere to infection control procedures during a wound dressing change for one Resident (#26) of a sample size of 22 residents. Findings include: The surveyor was provided as the facility policy the form titled Competency Assessment Dressing, Dry/Clean, dated 2018, which indicated but was not limited to the following: -The purpose of this procedure is to provide guidelines for the application of dry, clean dressings. -Verify that there is a physician's order for this procedure. -Assemble the equipment and supplies needed. Date and initial all bottles and jars upon opening (unless product is single use). Wipe nozzles of wound cleanser with alcohol wipe or facility disinfected wipe. -Explain procedure to resident and provide privacy. -Clean bedside stand. Establish a clean field. -Place the clean equipment on the clean field. -Wash and dry your hands thoroughly. -Put on a clean gloves. Loosen tape and remove soil dressing. -Pull glove over dressing and discard into plastic or biohazard bag. -Wash and dry your hands thoroughly. -Open dry, clean dressing by pulling corners of exterior wrapping outward, touching only the exterior surface. -Using clean technique, open other products (i.e., prescribe dressing; dry, clean gauze.) -Wash and dry your hands thoroughly. -Put on clean gloves. -Cleanse the wound with the ordered cleanser. If using gauze use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually from the center outward). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Use dry gauze to pat the wound dry. -Apply the ordered dressing and secure with tape or boarded dressing per order. -Discard disposable items into designated container. Resident #26 was admitted to the facility April 2024 with diagnoses which included: Left heel pressure wound and diabetes. Review of the Minimum Data Set (MDS) assessment, dated 4/8/24, indicated Resident #26 had a Brief Interview for Mental Status (BIMS) score of 12 of 15, which indicated he/she had moderate cognitive impairment. Further review of Section M: Skin Conditions of the MDS assessment indicated the Resident had a Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcers/injuries on admission and was receiving care and treatment for the areas. Review of current physician orders indicated but was not limited to the following: -Left heel: cleanse with wound wash, pat dry followed by (f/b) calcium alginate, f/b abdominal gauze (ABD) pad, and stretch wrap daily for wound care, effective 5/2/24. On 7/3/24 at 1:20 P.M., the surveyor observed Nurse #3 perform a dressing change on Resident #26's left heel and made the following observations: -Nurse #3 transferred Resident #26 into bed. -Nurse #3 washed hands and donned a pair of gloves. -Nurse #3 set up the following supplies on the over bed tray table, which she did not clean the table or and/or establish a clean barrier: a. Opened the ABD pad and placed it on the outside of the package, with a portion of it in contact with overbed tray table. b. Removed a small stack of gauze pads from the package and placed directly on the over bed tray table. c. Calcium alginate which remained on the inside of the package, uncut. d. Placed a pair of scissors on the over bed tray table. e. Placed a bottle of wound cleanser, not labeled, or dated. -Nurse #3 pulled the bedside curtain partially closed leaving the Resident's feet and affected heel visible from the hallway and the door to the room was open. -Nurse #3 was then observed using the scissors to cut off the old dressing that was on the Resident's left heel and then placed the scissors on the bed side table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse #3 sprayed the gauze with wound cleaner and cleaned the wound. -Nurse #3 changed her gloves but did perform hand hygiene. -Nurse #3 used the same scissors which were used to cut off the dirty dressing to cut a small piece of the calcium alginate to size without cleaning them. Nurse #3 then placed the trimmed piece of calcium alginate on the wound, applied the ABD pad, wrapped the ankle, and applied a dated piece of tape. During an interview on 7/3/24 at 2:20 P.M., the Director of Nurses (DON) said her expectations are the nurse would wear the appropriate personnel protective equipment (PPE), prepare the supplies, and have a clean barrier or sanitize the surface, and provide full privacy to the resident during the dressing change. She said the nurse is expected to wash her hands and change gloves before starting the dressing change, and after removing dirty dressing, and before cleaning the wound and applying the new dressing. The DON said she would also expect the nurse to clean the scissors after being used to remove the old dressing, before cutting the calcium alginate to size. The DON said the nurse did not follow protocol.