STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225281	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skilled Nursing Facility at North Hill (the)	865 Central Avenue Needham, MA 02492

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews and interviews, the facility failed to ensure one Resident (#10), out of a total sample of 18 residents, was free from unnecessary psychotropic medications. Specifically, the facility failed to ensure an as needed (PRN) dose of Seroquel (antipsychotic) was limited to no more than14 days as required. Findings include:Resident #10 was admitted to the facility in April 2022 and has diagnoses including visual hallucinations.Review of the Minimum Data Set (MDS) assessment, dated 3/13/25, indicated Resident #10 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15, and received antipsychotic medication on a PRN basis only.Review of the medical record indicated but was not limited to the following physician's orders:-Seroquel 25 milligrams (mg) give 2 half tabs for a total dose of 25 mg by mouth twice a day as needed x 30 days and evaluate for hallucinations (7/12/24, stop date: 8/11/24)-Seroquel 25 mg twice a day as needed x 30 days and evaluate for hallucinations/restlessness (9/6/24, stop date: 10/6/24)-Seroquel 25 mg twice a day as needed for 60 days and evaluate (10/11/24, stop date: 11/5/24)-Seroquel 25 mg by mouth twice a day as needed for increased hallucinations (11/7/24, stop date: 12/10/24)During an interview on 7/16/25 at 3:12 P.M., Physician #1 said it is his understanding that the initial orders for all PRN psychotropic medication must be limited to 14 days, and if there is a need, it can be extended for a longer duration. He said he was not aware that antipsychotic medications were limited to 14 days with no exception. During an interview on 7/17/25 at 9:40 A.M., Nurse Practitioner (NP) #1 reviewed Resident #10's PRN Seroquel orders. She said the orders for PRN Seroquel should have been written for no more than 14 days after each evaluation, but were not on 7/12/24, 9/6/24, 10/11/24, and 11/7/24.During an interview on 7/18/25 at 9:05 A.M., the Director of Nursing (DON) reviewed Resident #10's medical record and said Resident #10's PRN orders for Seroquel should not have been written for a duration longer than 14 days but were.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225281	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skilled Nursing Facility at North Hill (the)	865 Central Avenue Needham, MA 02492

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 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. Based on observation, interview, and record review, the facility failed to develop an individualized, person-centered care plan to meet the physical, psychosocial, and functional needs of one Resident (#12), out of a total sample of 18 residents. Specifically, the facility failed to ensure a comprehensive care plan was developed to address the use of psychotropic medication that identified target behaviors and individualized, measurable non-pharmacological interventions and measurable goals of treatment. Findings include:Review of the facility's policy titled Care Planning, last revised April 2014, indicated but was not limited to:-Upon entrance into the Health Center, the Minimum Data Set (MDS) Coordinator and Admitting Nurses begin the assessment process utilizing facility identified, industry standard assessment tools.-The comprehensive care plan is utilized in collaboration with each other to ensure that information related to the care of the individual resident is communicated to all team members.Resident #12 was admitted to the facility in October 2023 with diagnoses including unspecified dementia.Review of the MDS assessment, dated 6/12/25, indicated Resident #12 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15 and received antipsychotic medication on a routine basis.Review of the medical record indicated Resident #12 had been administered Zyprexa (antipsychotic) and Mirtazapine (antidepressant) since admission to the facility.Review of current Physician's Orders indicated but was not limited to:-Zyprexa 2.5 milligrams (mg) every other day for agitation (12/30/24)-Mirtazapine 30 mg every hour of sleep (HS) for depression (10/20/23)Review of March 2025 through July 2025 Medication Administration Records (MAR) indicated Zyprexa 2.5 mg and Mirtazapine 30 mg was administered as ordered by the physician.Review of comprehensive care plans indicated but was not limited to:Problem: Psychotropic Drug Use with Potential Drug Related Complications (initiated 10/20/23).Approaches: Administer/monitor effectiveness and side effects of Remeron and Zyprexa; Assess/record/report to MD drug related cognitive/behavioral impairment of Activity of Daily Living (ADL) functioning; Assess and report to MD gait disturbances, poor balance, dizziness, vertigo, unsteady gait; educate resident/family to potential risks, benefits and alternatives; monitor behaviors and document behavior flowsheet; AIMS test as ordered and as-needed (PRN); follow up with psychiatrist as indicated.Goal: Resident shall remain free from adverse effects of the psychotropic medication usage (no target date identified)The care plan failed to identify specific targeted signs/symptoms, Resident specific interventions, including non-pharmacological approaches, and measurable goals for the use of Mirtazapine and Zyprexa to meet the Resident's needs.During an interview on 7/17/2025 at 2:30 P.M., Nurse #2 said Resident #12 is administered Mirtazapine for depression and Zyprexa for behaviors such as combativeness and agitation. She reviewed the Resident's comprehensive care plan and said it does not identify targeted signs/symptoms or behaviors for the use of Mirtazapine and Zyprexa, and there are no resident-specific non-pharmacological interventions and no measurable goals of treatment. She said it might be on the Care Partners' (nursing assistant) Care Card for Resident #12. Nurse #2 reviewed the care card and said there were no resident-specific behaviors identified on the care card either. She said the Director of Nursing (DON) and Assistant Director of Nursing are responsible for care plan development.During an interview on 7/18/25 at 9:05 A.M., the DON said Resident #12 can become agitated in the afternoon and is prescribed Mirtazapine for depression and Zyprexa for agitation. She reviewed Resident #12's care plan and said the care plan for his/her use of psychotropic medication did not include resident specific signs, symptoms or behaviors for the use of psychotropic medications. She said the care plan should include resident specific symptoms/targeted behaviors such as his/her depression and agitation, resident specific interventions, non-pharmacological approaches, and measurable goals and does not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225281	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skilled Nursing Facility at North Hill (the)	865 Central Avenue Needham, MA 02492

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and staff interview, the facility failed to ensure that for one Resident (#9), of a total sample of 18 residents, that drugs and biologicals used in the facility were labeled accurately and in accordance with the physician's order. Findings include:Review of the facility's policy titled Administering Medications, revised in April 2019, included but was not limited to the following:2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. 4. Medications are administered in accordance with prescriber orders, including any required time frame.10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. On 7/17/25 at 9:50 A.M., the surveyor observed Nurse #4 enter Resident #9's room to administer their medications. Nurse #4 verified the Resident's medication orders in the electronic Medication Administration Record (eMAR) which included metoprolol (an antihypertensive drug) 37.5 milligrams (mg) twice daily. She then obtained two cards of the drug metoprolol, one containing metoprolol 25 mg and another containing metoprolol 25 mg, 1/2 tabs (12.5 mg). Nurse #4 then proceeded to pour one each of the metoprolol 25 mg and 12.5 mg tablets, respectively, for a total dose of 37.5 mg. She handed the two cards of metoprolol to the surveyor to verify that the correct dose had been poured. Review of the two cards of metoprolol indicated that the pharmacy directions for dosing administration did not match the physician's orders as follows:Card 1: The administration instructions listed on the label for metoprolol 25 mg tablets indicated: Metoprolol Succ (succinate) ER (extended release) 25 mg:Give one half tab with 1 tabTD (total dose)= 75 mg by mouth twice a day for HTN (hypertension), give 1 tab with half tabTD= 75 mg by mouth twice a dayCard 2: The administration instruction listed on the label for metoprolol 25 mg, 1/2 tabs (12.5 mg) indicated: Metoprolol Succ ER 25 mg tab.Give one half tab with 1 tabTD= 75 mg by mouth twice a day for HTNGive 1 tab with half tabTD = 75 mg by mouth twice a day. During an interview on 7/17/25 at 9:55 A.M., Nurse #4 said that the two cards of metoprolol tablets, 25 mg and 12.5 mg, respectively, did not contain the correct labeling/dosing instructions. Nurse #4 said that she routinely administers medications to Resident #9 and had not noticed that the instructions indicated to give a total dose of metoprolol 75 mg twice a day instead of metoprolol 37.5 mg twice a day. Nurse #4 said that the incorrect directions, that amounted to twice the ordered dose of metoprolol, had the potential for a serious medication error. During an interview on 7/17/25 at 11:35 A.M., the Director of Nurses (DON) said that the error in the metoprolol order/administering directions on the medication card had the potential for a serious medication error if followed. She said that Resident #9 would have received twice the amount of metoprolol if the order had been followed (metoprolol 75 mg BID). The DON also said that nurses administering the resident's metoprolol should have identified the error in the order for administration on the medication cards.