STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 42690 Based on record review and interview, the facility failed to ensure the required transfer documentation was completed and that the transfer documentation communicated the appropriate information to the receiving health care institution for one Resident (#16), out of a total sample of 25 residents. Specifically, the facility failed to ensure Resident #16 was transferred to the emergency room with a form that included important information relative to the Resident's medical history and the reason for transfer, putting the Resident at risk for complications and adverse events upon transfer to the hospital. Findings include: Review of the facility's policy titled Transfer and Discharge Policies and Procedures, undated, indicated the following: -Should it become necessary to make an emergency transfer or discharge to a hospital .the facility will implement the following procedures (in part): 4. Prepare a transfer form to send with the resident. Resident #16 was admitted to the facility in August 2018 with diagnoses that included: Anxiety Disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities), COPD (Chronic Obstructive Pulmonary Disease, a chronic lung disorder that causes restricted airflow in the lungs and difficulty breathing) and CHF (Congestive Heart Failure: caused when the heart is unable to pump blood effectively resulting in fluid build-up in the lungs, arms, feet and other organs). Review of the Nurse's Note, dated 3/6/24, indicated that Resident #16 was transferred to the hospital for evaluation after indicating to the staff that he/she could not breathe. Further review of the Resident's medical record indicated no documented evidence of any discharge paperwork that included the Resident's Advanced Directives (legal documents that provide instructions for medical care and only go into effect if you are unable to communicate your own wishes), any specific instructions or precautions for ongoing care, and/or provider information for the hospital transfer on 3/6/24. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/24 at 9:42 A.M., Unit Manager (UM) #2 said when a Resident is sent out to the hospital the following is expected to be completed: transfer form, change in condition and/or a Nurse's note. UM #2 said that a copy of the Resident's Advanced Directives, a face sheet (a form that contains pertinent billing and demographics information relative to the resident), a medication list, the activated Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself) or Guardian (a person appointed by the court to make decisions on behalf of someone else) information if applicable, as well as any recent labs or x-rays. UM #2 said that if the assessments are not completed in the electronic medical record (EMR) then it is assumed that the assessments were not completed and sent with the Resident as required. The surveyor and UM #2 reviewed the transfer form and noted that it had been initiated on 3/6/24 but not completed. The surveyor and UM #2 also reviewed the Nurse's note from 3/6/24 which indicated that Resident #16 was sent out to the emergency room per the Resident's request. UM #2 said that the appropriate documentation should have been sent with the Resident to the hospital but was not as required.

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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. 42690 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services in accordance with professional standards of practice for two Residents (#12 and #54) out of a total sample of 25 residents. Specifically, the facility failed to ensure that: 1. -Resident #12 was administered the appropriate liter per minute (LPM - flow rate of supplemental Oxygen [O2]) of Oxygen as ordered by the Physician. -Resident #12's oxygen equipment was appropriately maintained in a safe and functional manner. 2. Resident #54's nebulizer set/tubing (drug delivery device used to administer medication in the form of a mist inhaled into the lungs) was changed weekly as ordered by the Physician. Findings include: Review of the facility policy titled Nasal Cannula, dated April 2022, indicated the following: -Verify physician orders -Set flow meter by Physician order Review of the facility policy title Transfilling or Portable Liquid Oxygen Units, dated April 2022, indicated the following: -Make sure the connectors are clean and cry [sic] in order to avoid freezing. Review of the facility policy titled Equipment Change/Disinfection, dated 4/2022, included: .nebulizer compressors .Date equipment when changed or cleaned. Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf indicates: -All oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Undesirable results or events may result from noncompliance with Physicians' orders or inadequate instruction for oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There is a potential in some spontaneously breathing hypoxemic patients with hypercapnia [high carbon dioxide levels in the blood) and chronic obstructive pulmonary disease that oxygen administration may lead to an increase in PaCO2. -Equipment maintenance and supervision: All oxygen delivery equipment should be checked at least once daily Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply. 1. Resident #12 was admitted to the facility in May 2024, with diagnoses including Acute Respiratory Failure (ARF-a life-threatening condition where the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body), Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disorder resulting in blocked air flow in the lungs and difficulty breathing). Review of the June 2024 Physician's orders indicated the following: -O2 via Nasal Cannula (flexible tubing that delivers Oxygen through the nostrils) @ (at) 0-4 LPM, initiated on 8/1/23. On 6/11/24 at 11:35 A.M., the surveyor observed Resident #12 seated in a wheelchair in the dining room wearing a nasal cannula that was attached to a portable O2 tank, that was hanging from the back of the Resident's wheelchair. The surveyor observed that there was a buildup of frost on the portable tank, and rising about 12 inches up the tubing from the tank. The surveyor was unable to read the Oxygen liter flow because it was covered by frost. When the surveyor asked Nurse #2 to observe the O2 tank, Nurse #2 said that the tank and the tubing should not have frost on either equipment. Nurse #2 also said that she was unable to see the set liter flow. Nurse #2 then rubbed the frost off the tank and read the liter flow that was set to 6 LPM. The surveyor and Nurse #2 reviewed the Resident's orders and Nurse #2 said per the oxygen order the liter flow should be set between 0-4 LPM. Nurse #2 further said that the liter flow was set too high for the Resident and the portable O2 tank should not have frost build-up on it. 44222 2. Resident #54 was admitted to the facility in January 2023, with a diagnosis of Chronic Obstructive Pulmonary Disease. On 6/11/24 at 9:25 A.M., the surveyor observed the nebulizer device on the windowsill in the Resident's room, with the tubing hanging down and dated 5/27/24. The surveyor further observed that the nebulizer tubing was not stored in a plastic bag. Review of the Resident's June 2024 Physician's orders included: -Change all O2 (oxygen) tubing and neb (nebulizer) tubing weekly on Sundays, start date 2/5/23 -Ipratropium-Albuterol Solution (a combination of medications used to treat COPD) 0.5-2.5 (3) mg (milligrams)/3 ml (milliliters). 1 vial inhale orally (by mouth) via nebulizer four times a day for SOB (shortness of breath) .start date 6/5/24 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident's June 2024 Medication Administration Record (MAR) indicated that the Resident received the Ipratropium-Albuterol Solution medication via nebulizer four times a day as ordered from 6/5/24 through 6/13/24. Review of the Resident's June 2024 Treatment Administration Record (TAR) indicated that the nebulizer set/tubing was changed as ordered on 6/2/24 and 6/9/24. On 6/13/24 at 8:49 A.M., the surveyor and Unit Manager (UM) #1 observed the Resident's nebulizer set tubing dated 5/27/24, and reviewed the TAR which indicated that the nebulizer set tubing had been changed on 6/2/24 and 6/9/24. UM #1 reviewed the Resident's nebulizer set tubing and confirmed that the tubing was dated 5/27/24 and was not stored in a plastic bag. UM #1 said that the nebulizer tubing had not been changed since 5/27/24 according to the labeled tubing, and that the TAR which indicated that the nebulizer tubing had been changed on 6/2/24 and 6/9/24 was inaccurate. UM #1 said that the nebulizer tubing should be changed weekly and placed in a plastic bag when not in use. UM #1 said that the nebulizer tubing was not changed or stored as it should have been and that the TAR which indicated the nebulizer tubing had been changed on 6/2/24 and 6/9/24 was not accurate. Please Refer to F842

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 42741 Based on interview and record review, the facility failed to obtain Physician's orders prior to obtaining laboratory testing for three Residents (#25, #103, and #112) out of a total sample of three residents. Specifically, the facility failed to: -For Residents #25, #103, and #112, obtain a Physician's order for COVID-19 rapid testing prior to administering a COVID-19 Rapid Test (type of COVID-19 testing which provides rapid test results) for each of the Residents. Findings Include: 1. Resident #25 was admitted to the facility in May 2024. Review of the Nursing Progress Note dated 6/7/24, indicated that Resident #25 was administered a COVID-19 rapid test. Review of Resident #25's June 2024 Physician's orders indicated no documentation that Resident #25 had an order for COVID-19 rapid testing. 2. Resident #103 was admitted to the facility in October 2023. Review of the Nursing Progress Note dated 6/1/24, indicated Resident #103 was administered a COVID-19 rapid test. Review of Resident #103's June 2024 Physician's orders indicated no documentation that Resident #103 had an order for COVID-19 rapid testing. 3. Resident #112 was admitted to the facility in May 2024. Review of the Nursing Progress Note dated 6/1/24, indicated Resident #112 was administered a COVID-19 rapid test. Review of Resident #112's June 2024 Physician's orders indicated no documentation that Resident #112 had an order for COVID-19 rapid testing. During an interview on 6/17/24 at 12:57 P.M., the Infection Preventionist (IP) said all Resident's should have a Physician's order in place for COVID-19 rapid testing. The surveyor and the IP reviewed Residents #25, #103, and #112's medical records and the IP said Resident's #25, #103, and #112 did not have orders in place for COVID-19 rapid testing. The IP said the orders should have been placed into the Residents medical records at the time the Residents were admitted to the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 44222 Based on observation, record review and interview, the facility failed to maintain accurate medical records in accordance with professional standards and practices for one Resident (#54) out of a total sample of 25 residents. Specifically, for Resident #54 the facility staff inaccurately documented that a nebulizer (drug delivery device used to administer medication in the form of a mist inhaled into the lungs) set/tubing was changed as ordered. Findings include: Resident #54 was admitted to the facility in January 2023 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe). Review of the facility policy titled Equipment Change/Disinfection, dated 4/2022, included: .nebulizer compressors .Date equipment when changed or cleaned. On 6/11/24 at 9:25 A.M., the surveyor observed the nebulizer setup on the windowsill in the Resident's room, with the tubing hanging down and dated 5/27/24. Review of the Resident's June 2024 Physician's orders included: -Change all O2 (oxygen) tubing and neb (nebulizer) tubing weekly on Sundays, start date 2/5/23 -Ipratropium-Albuterol Solution (a combination of medications used to treat COPD) 0.5-2.5 (3) MG (milligrams)/3ML (milliliters). 1 vial inhale orally (by mouth) via nebulizer four times a day for SOB (shortness of breath) .start date 6/5/24 Review of the Resident's June 2024 Medication Administration Record (MAR) indicated that the Resident received the Ipratropium-Albuterol Solution medication via nebulizer four times a day as ordered from 6/5/24 through 6/13/24. Review of the Resident's June 2024 Treatment Administration Record (TAR) indicated that the nebulizer set/tubing was changed as ordered on 6/2/24 and 6/9/24. On 6/13/24 at 8:49 A.M., the surveyor and Unit Manager (UM) #1 observed the Resident's nebulizer set/tubing dated 5/27/24, and reviewed the TAR that indicated the nebulizer set/tubing had been changed on 6/2/24 and 6/9/24. UM #1 confirmed that the nebulizer set/tubing was dated 5/27/24, and said that the tubing had not been changed since 5/27/24 according to the label. UM #1 said the TAR documentation that indicated the nebulizer tubing had been changed on 6/2/24 and 6/9/24 was inaccurate. UM #1 said that the nebulizer tubing should be changed weekly but was not changed, and that the TAR which indicated the nebulizer tubing had been changed on 6/2/24 and 6/9/24 was not accurate.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on interview and record review, the facility failed to maintain infection control measures to prevent the development and transmission of communicable diseases and infections for one Resident (#25) and implement procedures for prevention of infection of one Resident (#111), out of nine applicable residents that had an indwelling urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag), out of a total sample of 25 residents. Specifically, the facility failed to: 1. For Resident #25, implement COVID-19 protocol for the Resident on Transmission Based Precautions (infection control precautions taken to prevent the spread of disease), to ensure that COVID-19 testing was done immediately during an outbreak once it was identified Resident #25 had possible signs and symptoms of COVID-19. 2. For Resident #111, appropriately store the urinary drainage bag when not in use, placing Resident #111 at risk for contamination of the drainage bag and infection when the urinary drainage bag was being stored in the Resident's bathroom on a handrail next to the toilet. Findings include: 1. Resident #25 was admitted to the facility in May 2024. Review of the facility policy titled COVID-19 Prevention and Control, revised 11/17/22, indicated the following: -Outbreak Testing >The facility should immediately test any symptomatic resident or staff member. Review of the COVID-19 Outbreak Documentation provided to the surveyors on 6/11/24 at the time of survey entrance, indicated the first cases of an outbreak of COVID-19 were identified on 6/1/24, on the Unit where Resident #25 resided. On 6/17/24 at 9:36 A.M., the Infection Preventionist (IP) said the COVID-19 outbreak on the Unit where Resident #25 resided started on 6/1/24. The IP said staff were to monitor all residents for signs and symptoms of COVID-19 such as changes in respiratory status for example cough, shortness of breath, and also monitor for gastrointestinal (GI)changes for example diarrhea. The IP said if changes in respiratory status or GI changes were noted, then the resident was to be immediately tested for COVID-19. Review of the Nursing Progress Note dated 6/3/24, indicated that Resident #25 had a productive cough (cough that produces mucus), decrease in appetite, nausea, vomiting, and was not feeling well. Review of the Nursing Progress Note dated 6/5/24, indicated that Resident #25 had a productive cough and expiratory wheezing (wheezing that can be heard as someone exhales). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Progress Note dated 6/7/24, indicated that Resident #25 requested to be tested for COVID-19 as he/she was still not feeling well. Further review of the Nursing Progress Note indicated that Resident #25 tested positive for COVID-19 (four days after the initial onset of symptoms that could be COVID-19 symptoms were documented). Review of the Resident's medical record indicated no documentation that Resident #25 was tested for COVID-19 prior to his/her request to be tested on [DATE] or when he/she first began exhibiting possible symptoms of COVID-19. During an interview on 6/17/24 at 11:16 A.M., the IP said Resident #25 should have been tested immediately after showing possible signs and symptoms of COVID-19 on 6/3/24, and he/she was not tested until 6/7/24 when he/she requested to be tested . 50138 2. Resident #111 was admitted to the facility in April 2024, with diagnoses including Urinary Tract Infection (UTI: bacterial infection of the urinary tract). Review of facility policy titled Indwelling Urinary Catheter, dated 7/2022, indicated: -It is the purpose of this policy to protect our residents from both infectious and noninfectious harms associated with the presence of indwelling urinary catheters, our staff members should follow evidenced based infection prevention practices to maintain their [resident] safety when inserting and handling indwelling urinary catheters. -Drainage bags should be placed in a basin, covered with a plastic bag and stored in the lower level of the nightstand when not in use. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #111 was moderately cognitively impaired as indicated by a score of nine out of a total score of 15 on the Brief Interview for Mental Status (BIMS) assessment. Review of Resident #111's Physician's orders for June 2024 indicated the following: -Foley Catheter 14 Fr (French scale or system used to measure catheters - a 4.7 millimeter diameter urinary catheter) with 30 ml balloon (a balloon filled with 30 milliliters of saline to prevent catheter dislodgement from the bladder) to continuous drainage for Obstructive Uropathy (a disorder of the urinary tract that occurs due to obstructed urine flow). -Output only: empty catheter, measure and record every shift. Review of Resident #111's care plan last revised on 5/29/24 indicated: -The Resident had a Foley catheter 14 Fr, 30 ml balloon. On 6/11/24 at 10:42 A.M., the surveyor observed the urinary drainage bag of Resident #111 hanging on the bathroom handrail on the right hand side of the toilet in the in Resident #111's bathroom. The surveyor observed that the urinary drainage bag was not in a basin or covered by a plastic bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 10:11 A.M., the surveyor observed the urinary drainage bag of Resident #111 hanging on the bathroom handrail on the right hand side of the toilet, with the connection tip uncovered and touching the bathroom wall. The surveyor observed that the urinary drainage bag was not in a basin or covered by a plastic bag. During an interview on 6/12/24 at 10:38 A.M., Certified Nurses Aide (CNA) #1 said Resident #111 required assistance with all care including catheter care. CNA #1 further said that Resident #111 had a large urinary drainage bag which was worn at night and then Resident #111 was changed by staff to a small urinary drainage leg bag for day time comfort. CNA #1 said she rinsed the large urinary drainage bag with water and put the large urinary drainage bag on the bathroom handrail so that staff would know where the urinary drainage bag was. CNA #1 said the large urinary drainage bag should be stored in a plastic bag to keep the urinary drainage bag from getting dirty and getting the bathroom area dirty. CNA #1 said the urinary drainage bag was uncovered and there was no plastic storage bag available in the Resident's room. CNA #1 said germs could get on the large urinary drainage bag if it was not kept clean in the plastic storage bag. During an interview on 6/13/24 at 10:30 A.M., with CNA #2 who was familiar with Resident #111, CNA #2 said urinary drainage bags should be stored in a plastic bag and then hung on the bathroom handrail when not in use. During an interview on 6/13/24 at 10:40 A.M., Unit Manager (UM) #1 said urinary drainage bags should be placed in a plastic bag in the Residents' bathroom, when not in use. During an interview on 6/13/24 at 10:53 A.M., The IP Nurse said staff were expected to follow the policy for storing urinary drainage bags. The IP Nurse said when urinary drainage bags are not in use, the urinary drainage bags should to be stored in a clean plastic bag to prevent bacteria from contacting the equipment. The IP Nurse also said storing drainage bags on the bathroom handrail, uncovered, puts the resident at risk for urinary infection.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on interview, record and policy review, the facility failed to ensure that the Pneumococcal (any infection caused by bacteria called Streptococcus pneumoniae, or pneumococcus that can range from ear and sinus infections to pneumonia and blood stream infections) Vaccination was administered to two Residents (#16 and #23) for five applicable residents, out of a total sample of 25 residents, increasing the Resident's risk for facility acquired Pneumococcal infections. Specifically, the facility failed to: 1. offer and administer the Pneumococcal Vaccine to Resident #16 when he/she became eligible. 2. ensure that staff offered and administered an updated Pneumococcal Vaccination to Resident #23 within the appropriate timeframe as indicated by CDC (Centers for Disease Control) guidelines. Findings include: Review of the facility's policy, titled Immunizations and Vaccines-Residents, revised February 2024, indicated the following: -It is the policy of the facility that all residents receive immunizations and vaccinations that assist in preventing infectious diseases, unless medically contraindicated, or otherwise ordered by the resident's attending physician, or refused by the resident or residents activated HCP (Health Care Proxy - the person chosen as the healthcare decision maker when the individual is unable to do so for themself). -Vaccine information statements and consent for Pneumococcal, Influenza, and Covid-19 will be a part of the resident's admission packet. Consent for these vaccinations will be obtained from the resident or resident representative at the time of admission. -For adults who have received the PCV13 at any age and the PPSV23 (Pneumovax 23: vaccine used to help protect against serious infections caused by 23 types of pneumococcal bacteria) after age [AGE] years: used shared clinical decision making to decide whether to administer PCV20. Review of CDC (Center for Disease Control and Prevention) guidelines titled Pneumococcal Vaccination Timeline for Adults, dated 3/15/23, indicated the following for adults aged [AGE] years and older: -If the following vaccines series has been completed: PCV (Pneumococcal Conjugate Vaccine) 13 at any age & PPSV (Pneumococcal Polysaccharide Vaccine) 23 at [AGE] years of age or older, then together with the patient, vaccine Providers may choose to administer PCV20 to adults [AGE] years of age or older, who already received PCV13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of [AGE] years old. (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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #16 was admitted to the facility in August 2018, with diagnoses including COPD (Chronic Obstructive Pulmonary Disease, a chronic lung disorder resulting in blocked air flow in the lungs and difficulty breathing). Review of Resident #16's medical record indicated that he/she received a Pneumococcal Vaccination on 3/31/09 and the PCV23 Vaccine on 9/6/18. During an interview on 6/13/24 at 1:01 P.M., the Infection Preventionist (IP) said that the Resident received the first two Pneumococcal Vaccinations and that according to the CDC guidelines, the Provider was to review the Resident record and have a conversation with the Resident/Representative to determine if it was appropriate to administer another Pneumococcal Vaccination. The IP said that the Provider had been in the facility within the past few weeks, had reviewed the Resident record and determined that Resident #16 was eligible to receive the next appropriate dose. The IP said that the Resident became eligible in September 2023 and should have been offered and administered the Pneumococcal Vaccination at that time. During a follow-up interview on 6/17/24 at 10:27 A.M., the surveyor and the IP reviewed the Pneumococcal Vaccination Consent Form, signed in 2018 by the activated HCP indicating the Resident Representative consented for Resident #16 to receive the Pneumococcal Vaccine. The IP said that when the Resident became eligible the Pneumococcal Vaccine should have been offered and was not. 50138 2. Resident #23 was admitted to the facility in September 2021 with diagnoses including Emphysema (a chronic lung condition where air is abnormally present in the lungs causing shortness of breath) and Chronic Kidney Disease (CKD - when the kidneys are damaged and cannot filter waste and fluids from the blood) and was over the age of 65. Review of the Minimum Data Set (MDS) dated [DATE], indicated that Resident #23 was severely cognitively impaired. as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of a total score of 15. Review of the Medical Record for Resident #23 indicated that the HCP was activated on 9/7/21. Further Review of the Medical Record for Resident #23 indicated that the PPSV23 had been received by Resident #23 on 9/27/15, and PCV13 had been received on 11/27/17. Review of the Adult Vaccine Consent Form, signed by Resident #23's HCP on 9/7/21, indicated consent for Pneumococcal Vaccine administration per CDC guidelines in the facility. During an interview on 6/12/24 at 11:48 A.M., the IP Nurse said the facility follows CDC guidelines for vaccination of the residents in the facility. The IP Nurse said Resident #23's Physician had directed the IP Nurse to bring Resident #23 current for all vaccinations when due. The IP Nurse said Resident #23 was eligible on 11/27/22 to receive the PCV20. The IP Nurse also said that Resident #23 had not been offered or administered the PCV20 as yet and so was at risk for Pneumococcal infections due to living in a high risk environment, age and comorbid diagnoses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 50138 Based on observation, interview, and document review, the facility failed to ensure 15 resident bedrooms measured the required square footage of 80 square feet per resident in a multi-bed bedroom. Specifically, Rooms 101 - 105, 107, 118 - 122, 124 - 126, and 128, were found to measure 75 square feet per resident, and not the required 80 square feet. Findings include: On 6/17/24 at 1:24 P.M., the surveyor observed the following rooms: 101 - 105, 107, 118 - 122, 124 - 126, and 128 which measured 75 square feet per resident, instead of the required 80 square feet. Observations made by the surveyor throughout the survey period from 4/11/24 through 4/14/24, and on 4/17/24 revealed that the size of the impacted rooms did not compromise the health and safety of the residents residing in the rooms. The surveyor reviewed a photocopied, certified letter signed by the Administrator to the Department of Public Health dated 5/30/24, regarding waiver requests for Rooms 101 - 105, 107, 118 - 122, 124 - 126, and 128. The Administrator provided the surveyor a photocopy of the original request dated 8/25/2006. During an interview and document review on 6/17/24 at 1:30 P.M., the Administrator said that he sent a letter to the Department of Public Health (DPH) on 5/30/24 to request a waiver due to low square footage in Rooms 101 - 105, 107, 118 - 122, 124 - 126, and 128 which stated the rooms were located in the 1958 construction of the facility and any attempts to enlarge them would be cost prohibitive, and/or result in the loss of available resident beds. The Administrator said that he has not yet received return correspondence from DPH. The Administrator further said the room sizes did not affect the health and safety of the residents who reside in them.