

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Care One at Redstone		STREET ADDRESS, CITY, STATE, ZIP CODE  135 Benton Drive East Longmeadow, MA 01028	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>44129</p> <p>Based on records reviewed and interviews for one of three sampled residents (Resident #3), who had a history of Hypokalemia (low potassium levels in the blood) and had a Physician's Order for potassium supplements, the Facility failed to ensure nursing notified the Provider when he/she did not receive the supplement as ordered.</p> <p>Findings include:</p> <p>Review of the Facility's policy titled, Change in a Resident's Condition or Status, revised February 2021 indicated:</p> <ul style="list-style-type: none"> <li>- The nurse will notify the resident's attending physician or physician on call when there has been a(an):</li> <li>- need to alter the resident's medical treatment significantly.</li> <li>- refusal of treatment or medication two (2) or more consecutive times.</li> </ul> <p>Review of Resident #3's Hospital Discharge/Transfer Note, dated 03/12/25, indicated his/her medication orders included (but was not limited to) the following:</p> <ul style="list-style-type: none"> <li>- Potassium Phosphate-Sodium Phosphate 250 milligrams (mg) -280 mg-160 mg oral powder, administer by mouth two times per day for 14 days.</li> </ul> <p>Further review of Resident #3's Hospital Discharge/Transfer note indicated lab work was performed on 03/12/25 and his/her serum (blood) potassium level was 3.6 milliequivalents per liter (mEq/L, a unit of measurement that expresses the chemical equivalence of a substance's concentration in a solution). The normal range for potassium levels in adults is typically between 3.5 and 5.2 mEq/L).</p> <p>Resident #3 was admitted to the Facility in March 2025, diagnoses included Hypokalemia, Metabolic Encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), Influenza, and Respiratory Syncytial Virus (RSV, a virus that causes infections of the respiratory tract).</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #3's Physician's Orders for March 2025 indicated he/she had an order for Potassium and Sodium Phosphate Oral Packet 280-160-250 mg, give one packet by mouth two times per day for low potassium levels with a start date of 03/13/25 and discontinuation date of 03/17/25.</p> <p>Review of Resident #3's Medication Administration Record (MAR), indicated Resident #1 did not receive the ordered Potassium and Sodium Phosphate Oral Packet and that nurses documented code 9 (other, see nursing note) for the following dates and times:</p> <ul style="list-style-type: none"> <li>- 03/13/25: 8:00 A.M., 5:00 P.M.</li> <li>- 03/14/25: 8:00 A.M., 5:00 P.M.</li> <li>- 03/15/25: 8:00 A.M.</li> </ul> <p>On 03/16/25, Resident #3 was transferred to the Hospital Emergency Department (ED) due to new onset mental status changes, and was subsequently admitted to the Hospital for treatment of a urinary tract infection (UTI, a bacterial infection that affects the urinary tract).</p> <p>Review of Resident #3's Hospital Admission Note, dated 03/16/25 indicated his/her potassium level was 2.9 mEq/L (below normal range for an adult) upon arrival to the ED and he/she required 40 mEq of intravenous (through the vein) Potassium Chloride (KCl, a medication used in the management and treatment of Hypokalemia).</p> <p>During an interview on 04/02/25 at 12:00 P.M., (which included review of Resident #3's March 2025 MAR) Nurse #2 said that Resident #3 did not receive any Potassium and Sodium Phosphate on 03/13/25, 03/14/25 and did not receive his/her morning dose on 03/15/25. Nurse #2 said the code 9 corresponding to these dates and times on the MAR indicated the medication was not received from the Pharmacy.</p> <p>Nurse #2 said she did not notify Resident #3's Provider that the Potassium and Sodium Phosphate was unavailable when she went to administer it on 03/15/25, and she said was not aware of a policy or protocol in place as to when to notify the Provider if a medication was not available and/or if a resident missed multiple doses of a prescribed medication.</p> <p>Further review of Resident #3's medical record indicated there was no documentation to support nursing notified the provider on 3/13/25 or 3/14/25, after they were unable to administer the medication because it was unavailable.</p> <p>During an interview on 04/02/25 at 1:00 P.M., Unit Manager #2 said nursing staff should notify the Provider if a resident misses two doses of a medication in order for the Provider to determine what the next steps would be, such as ordering an alternative medication or to obtain a medication from the Facility's emergency supply.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/02/25 at 2:21 P.M., (which included a review of her provider notes and documentation related to Resident #3) the Nurse Practitioner (NP) said she could not see where nursing staff notified her that Resident #3 missed multiple doses of Potassium and Sodium Phosphate due to the medication not being delivered from the Pharmacy. The NP said that she would have liked to have been notified because Resident #3 was known to have repeated instances of Hypokalemia, and the medication was intended to maintain a normal potassium level in his/her blood. The NP said if that particular medication was unavailable from the Pharmacy, she could have prescribed something different, including one that was available in the Facility's emergency medication supply.</p> <p>During a telephone interview on 04/09/25 at 2:03 P.M., the Director of Nursing said that it is their expectation that nursing staff attempt to obtain any prescribed medications from the Pharmacy, and if they are unable to obtain the medication, the expectation is that they notify the resident's Provider.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>44129</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #3), who had a history of Hypokalemia (low potassium levels in the blood) and a Physician's order for Potassium Sodium Sulfate (a supplement that can help maintain a therapeutic potassium level in the body), the facility failed to ensure they obtained and Resident #3 was provided the medication, as ordered by his/her Provider.</p> <p>Findings include:</p> <p>Review of the Facility's policy titled, Pharmacy Services Overview, revised April 2019, indicated but was not limited to:</p> <ul style="list-style-type: none"> <li>- Residents have a sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner.</li> <li>- Nursing staff communicate Prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration.</li> </ul> <p>Resident #3 was admitted to the Facility in March 2025, diagnoses included Hypokalemia, Metabolic Encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), Influenza, and Respiratory Syncytial Virus (RSV, a virus that causes infections of the respiratory tract).</p> <p>Review of Resident #3's Physician's Orders for March 2025, indicated it included an order for (but was not limited to) the following:</p> <ul style="list-style-type: none"> <li>- Potassium and Sodium Phosphate Oral Packet 280-160-250 milligrams (mg), give one packet two times per day for low potassium levels, initiated 3/13/25.</li> </ul> <p>Review of Resident #3's Medication Administration Record (MAR), indicated Resident #1 did not receive the ordered Potassium and Sodium Phosphate Oral Packet and that nurses documented code 9 (other, see nursing note) for the following dates and times:.</p> <ul style="list-style-type: none"> <li>- 03/13/25: 8:00 A.M., 5:00 P.M.</li> <li>- 03/14/25: 8:00 A.M., 5:00 P.M.</li> <li>- 03/15/25: 8:00 A.M.</li> </ul> <p>Review of Resident #3's Nurse Progress Notes, indicated it included notes titled, Administration Note (for Potassium and Sodium Phosphate) with nursing documenting:</p> <ul style="list-style-type: none"> <li>- 03/13/25 8:59 A.M., Medication not available, on order.</li> <li>- 03/13/25 4:34 P.M , Medication not available, pharmacy called.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 03/14/25 9:11 A.M., Medication not available, pharmacy contacted.</p> <p>- 03/14/25 4:15 P.M., No reason given as to why the medication was not given or what steps nursing took after they were unable to administer the medication.</p> <p>- 03/15/25 8:53 A.M., No reason given as to why the medication was not given or what steps nursing took after they were unable to administer the medication.</p> <p>During an interview on 04/02/25 at 12:00 P.M., Nurse #2 said the particular potassium supplement that was prescribed to Resident #3 was not available in the Facility's emergency medication supply. Nurse #2 said the Facility has had a lot of issues with their Pharmacy related to the medications taking a long time to be delivered, medications being out of stock, and medications being on backorder.</p> <p>Nurse #2 said they make a list of medications that were not available at the end of the day shift (the shift she primarily works) and call the Pharmacy to find out the status of the missing medication(s). Nurse #2 said the Facility had not received Potassium and Sodium Phosphate timely from the Pharmacy and that it should have been delivered to the Facility before Resident #3 was due to be administered his/her 5:00 P.M. dose on 03/15/25.</p> <p>During an interview on 04/02/25 at 1:00 P.M., Unit Manager #1 said they often have trouble obtaining medications from the Pharmacy and when they call, the Pharmacy gives them various reasons for why the medications were not delivered. Unit Manager #1 said the Pharmacy will give reasons such as, the medication is on backorder, they (the Pharmacy) need to obtain the medication from another pharmacy, or the medication will be on the next delivery.</p> <p>Unit Manager #1 said she has sent emails to the Pharmacy about medications that are not delivered and sometimes she receives no reply at all or other times she will receive a reply with the previously stated reasons. Unit Manager #1 said the Pharmacy email address the Facility utilizes is a generic customer service email address and the responses, when they receive them, are from various Pharmacy staff and they do not have a consistent customer service person to contact. Unit Manager #1 said that Resident #3 should have received his/her Potassium and Sodium Sulfate prior to 03/15/25.</p> <p>Review of Resident #3's Medical Record indicated there was no documentation to support Nursing communicated with the Pharmacy on 03/13/25 and 03/14/25 to inquire about when the medication would be delivered.</p> <p>During a telephone interview on 04/09/25 at 1:08 P.M., the Pharmacy Manager said he reviewed Resident #3's prescriptions, that the Potassium and Sodium Phosphate was considered an over the counter (OTC) medication and said the Facility should be aware the Pharmacy does not send OTC medications unless they get a signed OTC form from the Facility. The Pharmacy Manager said they never received a signed OTC form from the Facility, and according to their records, the medication order was never sent to the Facility. The Pharmacy Manager said he did not know if the Facility contacted anyone directly (via telephone) at the Pharmacy regarding the medication not being delivered.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 04/09/25 at 2:03 P.M., the Director of Nursing (DON) said Potassium and Sodium Phosphate packets are not a medication the Facility stocks in the emergency medication supply. The DON said the Pharmacy has sent OTC medications to the Facility without needing an OTC form in the past. The DON said the Pharmacy has been inconsistent with their communication. The DON said that their current Pharmacy has had ongoing problems and are in the process of being acquired by another Pharmacy.</p> <p>During a follow up telephone interview on 04/10/25 at 2:45 P.M., the DON said other than the Administration Notes on 03/13/25 and 03/14/25 which indicated that nursing staff contacted the Pharmacy, there was no further documentation of the details of the conversation with the Pharmacy that indicated a reason as to why there was no Potassium and Sodium Phosphate available for the nursing staff to administer to Resident #3.</p>