STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225299	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Redstone	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)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents, (Resident #1) who required laboratory work for a urine culture and sensitivity test (test used to identify bacterial infection and determine the most effective antibiotic), the Facility failed to ensure nursing promptly notified the Physician, Physician Assistant, or Nurse Practitioner of the abnormal laboratory result, when Resident #1's laboratory results were sent to the facility on [DATE], but the provider was not made aware until 01/28/26, five days later resulting in a delay in treatment.Findings include:Review of the Facility policy titled Lab and Diagnostic Test Results- Clinical Protocol, date revised November 2018, indicated the laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. The Policy indicated a Facility nurse will contact the Physician to report abnormal test results and document information about when, how and to whom the information was provided and the response in the Progress Notes section of the of the medical record.Resident #1 was admitted to the Facility in January 2026, diagnoses included metabolic encephalopathy (brain problem caused by a chemical imbalance), atherosclerotic heart disease (plaque buildup in heart artery walls), gastrostomy (G-tube-surgical opening through the skin of the abdomen to the stomach), and urinary retention.Review of Resident #1's Minimum Data Set (MDS) assessment, dated 01/13/26, indicated he/she had intact cognitive functioning, was dependent on staff for activities of daily living (ADL-eating, dressing, bathing, toileting and transfer), had a feeding tube and an indwelling urinary catheter.Review of Resident #1's Nurse Progress Note, dated 01/19/26, indicated an order for urinalysis with culture and sensitivity had been obtained.Review of Resident #1's Nurse Progress Note, dated 01/21/26, indicated urinalysis and preliminary culture results had been obtained and reported to the in-house Provider. The Note indicated the Provider wanted to wait for culture and sensitivity results (usually reported within two to three days).Review of Resident #1's Urine Culture and Sensitivity results, dated 01/23/26 indicated two types of bacteria had been detected in his/her urine and listed antibiotics that would be effective in treating his/her urinary tract infection.Review of Resident #1's Nurse Progress notes, dated 01/21/26 through 01/28/26 indicated there was no documentation to support that the Physician, Physician Assistant or Nurse Practitioner had been notified of his/her urine culture and sensitivity report.Review of Resident #1's Physician Orders for the month of January 2026 indicated his/her new orders included the following:01/28/26-Ciprofloxacin Hydrochloride (antibiotic) oral tablet 500mg, give 500mg via G-tube two times a day for urinary tract infection for seven days.01/28/26-Nitrofurantoin Monohydrate Macro (antibiotic) capsule 100mg, give one capsule via G-tube, two times a day for urinary tract infection for seven days, take with food.Review of Resident #1's Medication Administration Record (MAR) for the month of January 2026 indicated the first dose of Ciprofloxacin Hydrochloride 500mg and Nitrofurantoin Monohydrate Macro 100mg had been administered on 01/28/26 at 5:00 P.M., five days after the abnormal culture and sensitivity result had been available to the facility.During a telephone interview on 04/1/26, at 10:45 A.M., the Physician Assistant (PA) said Facility Nurses are responsible for notifying the Provider of abnormal laboratory results. The PA said she was not notified (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Resident #1's urine culture and sensitivity result.During a telephone interview on 04/01/26, at 2:00 P.M., the Nurse Practitioner (NP) said she had examined Resident #1 on 01/26/26 at the facility and that nursing staff did not notify her of his/her culture and sensitivity result at that time.During an interview on 03/31/26 at 4:15 P.M., the Director of Nurse (DON) said she was aware that that had been a prolonged period between when Resident #1's urine culture results had been available and when treatment for a urinary tract infection had started. The DON said it was the Nurse's responsibility to follow-up with laboratory results but that this had not happened causing a delay in treatment for Resident #1. On 03/31/26, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 02/11/26, which addressed the area(s) of concern as evidenced by:A. Resident #1 no longer resides in the Facility.C. On 02/03/26, the Director of Nurses and/or designee developed a Performance Improvement Plan including audits, re-education of nurses, and reporting to Quality Assurance Performance Improvement Committee.B. On 02/03/26, the Director of Nurses and/or designee initiated a facility wide audit of urine specimen results for the prior 30 days to ensure lab values were received at the facility and reported to the Provider timely.D. On 02/03/26, the Assistant Director of Nurse and/or designee completed an in-service for Nurses regarding their responsibility for obtaining laboratory results, notifying the Provider, and documentation in the medical record.E. The Director of Nursing and Administrator met with the Medical Provider team to address the concern.F. The Concern will be discussed at the facility monthly QAPI meetings, until the facility determines substantial compliance has been achieved.G. The Director of Nursing and/or designee are responsible for compliance.