STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225306	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Greylock Extended Care Facility	1000 North Street Pittsfield, MA 01201

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on observation, interviews and record reviews, the facility failed to ensure that the Minimum Data Set (MDS) Assessments were accurately coded for four Residents (#46, #78, #24 and #87), out of a total sample of 19 residents and three closed records reviewed. Specifically, the facility failed to: 1. For Resident #46, accurately reflect range of motion (ROM) deficits. 2. For Resident #78, accurately reflect ROM deficits and the use of an antipsychotic medication (used to treat mental health problems whose symptoms include psychosis). 3. For Resident #24, accurately code Insulin (medication used to treat Diabetes) orders. 4. For Resident #87, accurately code the discharge location. Findings include: 1. Resident #46 was admitted to the facility in September 2022, with diagnoses including cerebral infarction (stroke- damage to the tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area) and hemiplegia (paralysis of one side of the body) affecting the left non-dominant side. Review of the Activity of Daily Living (ADL) Care Plan, initiated 9/15/22, indicated Resident #46 had an alteration in his/her ability to provide self care, and was dependent on ADLs due to left sided hemiplegia. Review of the MDS assessment dated [DATE], indicated Resident #46: -was cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15 out of a total 15 -was dependent for upper/lower body dressing -had no ROM impairments (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/24 at 10:27 A.M., the surveyor observed Resident #46 lying in bed. During an interview at the time, the Resident said he/she required assistance from staff with care because the left side of his/her body was paralyzed. During an interview on 4/5/24 at 11:06 A.M., the MDS Nurse said Resident #46's MDS assessment dated [DATE], was coded incorrectly and should have reflected that the Resident had ROM impairments on one side of the body. 2. Resident #78 was admitted to the facility in September 2023, with diagnoses including Cerebral Infarction, hemiplegia, major depressive disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy), Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment) and anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations). Review of the Activity of Daily Living (ADL) Care Plan, dated 10/3/23, indicated Resident #78 had alteration in ability to perform ADLs related to stroke with left sided weakness. Review of the MDS assessment dated [DATE], indicated Resident #78: -had severe cognitive impairment as evidenced by a BIMS score of 3 out of a total 15 -was dependent for ADLs -had no ROM deficits -did not receive antipsychotic medication during the assessment reference period Review of the March 2024 Medication Administration Record (MAR) indicated the Resident was administered Risperdal (antipsychotic medication) 0.25 milligrams twice daily from 3/1/24 through 3/31/24. During an interview on 4/5/24 at 11:06 A.M., the MDS Nurse said Resident #78's MDS assessment dated [DATE], should have indicated ROM deficits for upper and lower body on one side due to his/her hemiplegia and also should have indicated antipsychotic medication had been administered during the reference period. The MDS Nurse said the MDS Assessment was coded incorrectly and would need to be modified. 49422 3. Resident #24 was admitted to the facility in July 2022, with diagnoses of aftercare following joint replacement surgery and Diabetes Type 2 (DM II - chronic condition in which the body does not produce enough insulin and has trouble controlling blood sugar levels). Review of the MDS assessment dated [DATE], indicated Resident #24 received seven days of Insulin injections, and had seven Physician order changes for Insulin during the assessment reference period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the January 2024 MAR indicated that Resident #24 received seven days of Insulin administration during the review period, 1/16/24 through 1/22/24, and had no new Insulin orders during the assessment reference period. During an interview on 4/5/24 at 11:12 A.M., the MDS Nurse said Resident #24's MDS assessment dated [DATE], was coded incorrectly and should have reflected that the Resident had no Insulin Physician order changes during the assessment reference period. 42761 4. Resident #87 was admitted to the facility in February 2024, with a diagnosis of Cerebral Infarction. Review of Resident #87's Nursing Progress Note dated 3/9/24, indicated that the Resident was discharged to home from the facility on 3/9/24. Review of Resident #87's MDS assessment dated [DATE], indicated the Resident was discharged to the hospital. During an interview on 4/5/24 at 11:05 A.M., the MDS Nurse said she reviewed Resident #87's MDS Assessment, dated 3/9/24, and that the MDS Assessment was coded inaccurately relative to the Resident's discharge status. The MDS Nurse further said Resident #87 was not discharged to the hospital, but was discharged to home.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on interview and record review, the facility failed to administer medication as ordered by the Physician for one Resident (#52) out of a total sample of 19 residents. Specifically, the facility staff failed to ensure that Midodrine (medication to treat low blood pressure [hypotension] by increasing the blood pressure) was administered according to the parameters ordered by the Physician. Findings include: Review of the facility policy titled Administration Procedure for All Medications, effective 9/20/13, included the following: -Purpose: to administer medications in a safe and effective manner. -Check the Medication Administration Record (MAR) for order. -Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. Resident #52 was admitted to the facility in December 2023, with diagnoses including Acute Cerebrovascular Insufficiency (obstruction of one or more arteries that supply blood to the brain), Nonrheumatic Mitral Valve Insufficiency (form of heart disease where the mitral valve does not close properly and can leak or flow in the wrong direction), Hypertension (high blood pressure) and Occlusion and Stenosis of the Carotid Artery (blockage of the large artery on either side of the neck). Review of Resident #52's Cardiac Care Plan, initiated 12/12/23, indicated the Resident had a potential for alteration in cardiac function/status related to . hypertension, hypotension. The plan of care included the following interventions: -monitor and document vital signs as indicated. -administer medications as ordered and assess for effectiveness and adverse side effects. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #52 was severely cognitively impaired as evidenced by staff interview. Review of the January 2024 Physician's orders included the following: -Midodrine HCL 5 milligram (mg), 2 tablets (for total dose of 10 mg) orally three times daily for hypotension. -Hold (do not administer) for a Systolic Blood Pressure (SBP = pressure in the arteries when the heart beats) > (greater than) 110 [mm Hg] (measurement - millimeters of mercury), initiated 1/2/24 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the January 2024 MAR indicated that the Midodrine medication was administered to Resident #52, outside of the Physician's ordered parameters (SBP > 110 mm Hg) on the following dates/times: -1/2/24: SBP was 126 mm Hg at 8:00 P.M. -1/6/24 and 1/21/24: SBP was 118 mm Hg at 8:00 P.M. -1/7/24: SBP was 128 mm Hg at 8:00 P.M. -1/9/24: SBP was 111 mm Hg at 8:00 A.M. -1/20/24: SBP was 114 mm Hg at 8:00 P.M. -1/22/24: SBP was 112 mm Hg at 2:00 P.M. -1/23/24: SBP was 124 mm Hg at 8:00 P.M. Review of the February 2024 Physician's orders included the following: -Midodrine HCL 10 mg, 1 tablet orally three times daily for hypotension. Hold for a SBP > 110 [mm Hg], initiated 2/1/24 Review of the February 2024 MAR indicated Midodrine medication was administered to Resident #52, outside of the Physician's ordered parameters on the following dates/times: -2/1/24: SBP was 116 mm Hg at 8:00 P.M. -2/15/24: SBP was 118 mm Hg at 8:00 P.M. -2/20/24: SBP was 118 mm Hg at 8:00 A.M. -2/22/24: SBP was 125 mm Hg at 8:00 A.M. -2/23/24: SBP was 120 mm Hg at 8:00 P.M. -2/27/24: SBP was 113 mm Hg at 2:00 P.M. Review of the March 2024 MAR indicated Midodrine medication was administered to Resident #52, outside of the Physician's ordered parameters on the following dates/times: -3/4/24 and 3/6/24: SBP was 118 mm Hg at 8:00 P.M. -3/6/24: SBP was 118 mm Hg at 8:00 A.M. -3/9/24: SBP was 122 mm Hg at 8:00 P.M. -3/10/24: SBP was 116 mm Hg at 8:00 P.M. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/11/24: and 3/23/24: SBP was 118 mm Hg at 8:00 P.M. -3/13/24: SBP was 111 mm Hg at 8:00 A.M. -3/19/24: SBP was 112 mm Hg at 2:00 P.M. -3/24/24: SBP was 123 mm Hg at 2:00 P.M. -3/26/24: SBP was 117 mm Hg at 8:00 A.M. On 4/3/24 at 3:23 P.M., the surveyor reviewed Resident #52's MARs with Unit Manager (UM) #1 relative to the Midodrine medication. When the surveyor UM #1 asked to define what the > symbol within the order meant, UM #1 said it meant greater than or less than. After further prompting from the surveyor, UM #1 said the > symbol meant to hold the medication if the SBP was greater than 110 mm Hg. The surveyor and UM #1 reviewed when the Midodrine was administered to Resident #52 and the documented SBP associated with the administration times, and UM #1 said she would have to look into this matter because it appeared that some of the Nurses might not understand what the > symbol within the Physician order means. During a follow-up interview on 4/3/24 at 3:59 P.M., UM #1 said that she spoke with one of the Nurses who had administered the Midodrine outside of the Physician ordered parameters, and asked what the > symbol meant. UM #1 said the Nurse indicated that the > symbol meant greater than. UM #1 further said that it appears that the Nurses may not be paying attention and/or may not understand the Physician ordered parameters of when to administer or hold the Midodrine medication. UM #1 said the Physician will have to be notified that the Midodrine medication was administered outside of the ordered parameters.

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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. 49422 Based on observation, interview, record and policy review, the facility failed to ensure that Enhanced Barrier Precautions (EBP- targeted gown and glove use during high contact resident care activities, designed to reduce transmission of infection) were implemented in order to prevent the potential spread of infection for one Resident (#47), of one applicable resident on EBP, out of a total sample of 19 residents. Specifically, the facility staff failed to ensure that the required personal protective equipment (PPE) was worn when providing high-contact feeding tube care for Resident #47 when he/she was identified as being on EBP. Findings include: Review of the facility policy titled Enhanced Barrier Precautions, January 2023, indicated EBP: -Will be used on all residents on the unit with indwelling medical devices (e.g., . feeding tube). -Require gowns and gloves for all high contact care: .Device care or use: feeding tube. Resident #47 was admitted to the facility in September 2019, with Intracerebral hemorrhage (a type of stroke, with damage to the brain from bleeding within the brain), Apraxia (the inability to execute learned motor tasks due to brain damage or degeneration) and recurrent aspiration (frequently inhaling food and/or liquids into the airway and lungs accidentally which may cause serious health problems such as Pneumonia). On 4/3/24 at 10:30 A.M., the surveyor observed the following: -Signage posted outside the Resident's room indicating: -Stop. Enhanced Barrier Precautions: Everyone must: >Clean their hands, including before entering and when leaving the room. >Providers and Staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities .Device Care or use: feeding tube. -A cart with PPE (gown, gloves) was located outside the Resident's room. On 4/3/24 at 10:45 A.M., the surveyor observed the medication and tube feeding administration process with Nurse #3 and Nurse #1 that was being provided for Resident #47. The surveyor observed that Nurse #1 entered the room wearing gloves, but no gown, and assisted Nurse #3 to turn and reposition Resident #47 in bed. The surveyor observed that Nurse #3 wore gloves to check the feeding tube placement, administer medications and provide liquid nutrition through the feeding tube. Nurse #3 did not don (put on) a gown before or during the high-contact feeding tube care as required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/5/24 at 1:00 P.M., Nurse #1 said that the facility's EBP protocol included for staff to wear a gown and gloves when providing high-contact care for any resident with a feeding tube. When the surveyor asked Nurse #1 if they used EBP during the feeding tube care and medication/feeding administration with Nurse #3 on 4/3/24 at 10:45 A.M., Nurse #1 said they did not wear a gown as required.