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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225323 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2025 |
| NAME OF PROVIDER OR SUPPLIER Care One at Peabody | | STREET ADDRESS, CITY, STATE, ZIP CODE 199 Andover Street Peabody, MA 01960 | |

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) |
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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>50338</p> <p>Based on observation, record review and interview, the facility failed to update the care plan for Activities of Daily Living (ADL) for one Resident (#75) out of a total sample of 28 residents.</p> <p>Findings include:</p> <p>Review of the Facility's Policy titled Care Plans Comprehensive Person-Centered, dated 4/25/22, indicated that assessments of the residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.</p> <p>Resident #75 was admitted to the facility in February 2025 with diagnoses including stroke and dysphagia.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 2/27/25, indicated that Resident #75 was rarely/never understood and a staff assessment for Brief Interview for Mental Status (BIMS) indicated severe cognitive impairment. The MDS further indicated Resident #75 required partial/moderate assistance with meals, was holding food in mouth or cheeks or residual food in mouth after meals and had a mechanically altered diet.</p> <p>On 3/25/25 at 8:37 A.M., the surveyor observed Resident #75 sitting up in bed eating breakfast. Resident #75's breakfast tray included a lip plate, but did not have built up utensils. There was no staff present in the room providing assistance and the Resident was not visible from the hallway.</p> <p>On 3/26/25 at 8:12 A.M., the surveyor observed Resident #75 sitting up in bed eating breakfast. Resident #75's breakfast tray included a lip plate, but did not have built up utensils. There was no staff present in the room providing assistance and the Resident was not visible from the hallway.</p> <p>On 3/26/25 at 12:20 P.M., the surveyor observed Resident #75 sitting up in wheelchair in his/her room eating lunch. Resident #75's lunch tray included a lip plate, but did not have built up utensils. Resident #75 said he/she used to have built up utensils but guessed they changed the rules. There was no staff present in the room providing assistance and the Resident was not visible from the hallway.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 3/27/25 at 8:24 A.M., the surveyor observed Resident #75 sitting up in bed eating breakfast. Resident #75's breakfast tray included a lip plate, but did not have built up utensils. There were no staff present in the room providing assistance and the Resident was not visible from the hallway.</p> <p>Review of Resident #75's physician's order, 2/26/25, indicated: built up utensils and lip plate at all meals.</p> <p>Review of Resident #75's physician's order, dated 3/13/25, indicated diet: soft and bite sized texture.</p> <p>Review of Resident #75's plan of care for ADL's, dated 2/21/25, indicated assist with eating as needed.</p> <p>Review of Resident #75's plan of care for diet, dated 3/3/25, indicated uses adaptive equipment: built up utensils, lip plate and 1:1 dependent.</p> <p>Review of Resident #75's Speech Language Pathologist's (SLP) treatment note, dated 3/18/25, indicated patient was noted to be provided with weighted utensils on this date. Patient has order for built up utensils in place. Occupational Therapy (OT) consulted and made aware.</p> <p>During an interview on 3/27/25 at 11:17 A.M., the SLP said that Resident #75 should be seated upright during meals and have his/her food cut up. Resident #75 does not need to be supervised for meals. He said that OT had initiated the built-up utensils but had reassessed the utensils to be too large for Resident #75 to manage so they were discontinued.</p> <p>Review of Resident #75's OT evaluation, dated 2/24/25, indicated Resident required partial/moderate assist for eating.</p> <p>Review of Resident #75's OT treatment note, dated 3/25/25, indicated Resident required set up for eating.</p> <p>Review of Resident #75's Documentation Survey Report (indicates level of assist Resident requires with care), indicated the following: Eating: 1:1 dependent, built-up utensils, lip plate.</p> <p>During an interview on 3/27/25 at 11:22 A.M., Unit Manger #1 and the surveyor reviewed Resident #75's Documentation Survey Report, physician's orders, and plan of care. She said Resident #75 only requires set up for meals and no longer requires built up utensils. She was unaware that the care plan, physician orders, and Documentation Survey Report did not reflect Resident #75's current level of care, but they should.</p> <p>During an interview on 3/27/25 at 1:06 P.M., the Director of Nursing said Resident's care plan should be updated to reflect level of care required for the Resident.</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>50338</p> <p>Based on record review and interview, the facility failed to follow professional standards of practice for one Resident (#494) out of a total sample of 28 residents. Specifically, the facility failed to implement a physician's order to notify provider (physician, nurse practitioner) if Resident #494's daily weight indicated an increase of greater than two pounds.</p> <p>Findings include:</p> <p>Review of facility policy titled 'Weight Assessment and Intervention' dated March 2023, indicated the following but was not limited to:</p> <ul style="list-style-type: none"> - Resident weights are monitored for undesirable or unintended weight loss or gain. <p>Resident #494 was admitted to the facility in March 2025 with diagnoses including heart failure and chronic respiratory failure with hypoxia.</p> <p>Review of Resident #494's most recent Minimum Data Set (MDS) assessment, dated 3/19/25, indicated an entry tracking record and a comprehensive MDS had not been completed.</p> <p>Review of Resident #494's physician's orders, dated 3/19/25, indicated daily weights. Notify provider of weight of two pounds or more daily or five pounds in a week in the morning.</p> <p>Review of Resident #494's nursing progress note, dated 3/23/25, indicated notified weight to NP (Nurse Practitioner) Brown, no new order. Continue to monitor the weight.</p> <p>Review of Resident #494's physician notes failed to indicate that the physician was notified of a weight change from 3/24/25 to 3/26/25.</p> <p>Review of Resident #494's daily weights indicated the following:</p> <ul style="list-style-type: none"> -3/22/25 284.6 pounds (lbs.) -3/23/25 290.0 lbs. (gain of 5.4 lbs). -3/24/25 294.8 lbs. (gain of 4.8 lbs). -3/25/25 295.0 lbs. (gain of 0.2 lbs). -3/26/25 296.0 lbs. (gain of 1.0 lbs) (total gain of 11.4 lbs. since 3/22/25). <p>During an interview on 3/27/25 at 11:22 A.M., Unit Manager #1 said she was unaware the physician had not been notified of Resident #494's weight gain, the physician should have been notified, and that the notification should be documented in the nursing notes.</p> <p>(continued on next page)</p> | | |

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| F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | During an interview on 3/27/25 at 1:08 P.M., the Director of Nursing said that physician's orders should be followed, and that Resident #494's weight gain should have been reported to the physician and documented in the nursing notes. | | |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339</p> <p>Based on record review and interviews, the facility failed to provide care and services consistent with professional standards including ongoing communication and collaboration with the dialysis facility for one Resident (#536), who required renal dialysis (a procedure to remove waste products and excess fluid from the body when the kidneys stop working), out of 28 total sampled residents. Specifically, the facility failed to ensure complete and accurate communication with the dialysis facility and failed to implement a Dietitian's recommendation to give phosphate binders (a medication to absorb phosphate from the food you eat to help prevent high phosphorus levels) that was communicated in Resident #536's dialysis communication book.</p> <p>Findings Include:</p> <p>Review of the facility policy titled Hemodialysis Pre and Post Care revised March 2010, indicated the following but not limited to:</p> <ul style="list-style-type: none"> - Document all communications in the hemodialysis communication progress note or dialysis center communication book. - Ensure ongoing communication with dialysis staff. <p>Resident #536 was admitted to the facility in March 2025 with diagnoses including End stage renal disease, Dependence on renal dialysis.</p> <p>Review of Resident #536's most recent Minimum Data Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 10 out of a possible 15, indicating moderate cognitive impairment. Further review of the MDS indicated the Resident received hemodialysis treatment.</p> <p>Review of Resident #536's Dialysis Communication Book document dated March 2025 indicated the following:</p> <ul style="list-style-type: none"> - The Resident's phosphorous range goal was between 3.0 to 5.5 mg/dL (milligrams per deciliter) and that the Residents phosphorus level was 7.6 mg/dL, indicating his/her phosphorus levels were elevated. - Please be sure patient takes 3 Calcium Acetate with meals related to a high phosphorus. <p>Review of the current physician's orders failed to indicate calcium acetate had been ordered for the Resident.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 failed to indicate the Resident was receiving calcium acetate.</p> <p>Review of Resident #536's care plan date initiated 3/10/25: Renal insufficiency related to chronic renal failure; Coordinate dialysis care with the dialysis center.</p> <p>(continued on next page)</p> | | |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 3/7/25 10:57 A.M., Unit Manager # 1 said it is the responsibility of the medication nurse to check the dialysis communication book in her absence when the resident returns to the facility from dialysis. Unit Manager #1 also stated it appeared that no one had checked the dialysis communication book as the Resident did not have an order for the calcium acetate.</p> <p>During an interview on 3/27/25 11:20 A.M., the Director of Nursing said it is the responsibility of the nurse or unit manager to check the dialysis communication book when the resident returns to the facility and they were responsible for updating the physician on any orders or recommendations from the dialysis center.</p> <p>During an interview on 3/28/25 8:00 A.M., the Dialysis Nurse said communication reports are given by the dietitian on the second week of the month, as monthly labs were drawn on the first of the month. The Dialysis Nurse also said Resident #536 had his/her labs drawn between 3/3/25 and 3/4/25 and would have received the communication report on the week of 12th-14th of March with a follow up communication to the facility by the dietitian.</p> <p>52138</p> |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>49880</p> <p>Based on observation and interview the facility failed to store all drugs and biologicals in accordance with currently accepted professional principles on three of three units. Specifically,</p> <ol style="list-style-type: none"> 1. The facility failed to secure drugs and biologicals on three of three units when two treatment carts and one medication room were accessible to the surveyor unsupervised. 2. The facility failed to properly label and store medications in medication carts on two of three units. 3. The facility failed to secure medications in a resident room for one (Resident #90) of 28 sampled residents. <p>Findings include:</p> <p>Review of facility policy titled Medication Labeling and Storage, dated as revised February 2023, indicated the following:</p> <ul style="list-style-type: none"> -The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. <p>Medication Storage</p> <ul style="list-style-type: none"> -Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. -The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. -Compartments containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. -Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly. <p>Medication Labeling</p> <ul style="list-style-type: none"> -Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. <p>(continued on next page)</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-Antiseptics, disinfectants and germicides used in any aspect of the resident care must have legible, distinctive labels that identify the contents and the directions for use, and shall be stored separately from regular medications.</p> <p>1. On 3/25/25 at 7:52 A.M., the surveyor observed an unlocked and unattended treatment cart on the first-floor unit. The surveyor was able to gain access to the cart which contained treatment supplies as well medicated creams and ointments. The surveyor observed three staff walk by the unlocked treatment cart without addressing it.</p> <p>During an interview on 3/25/25 on 7:54 A.M., Nurse #1 said that the treatment cart should be locked when unattended.</p> <p>On 3/25/25 at 7:59 A.M., the surveyor observed an unlocked and unattended treatment cart on the second-floor unit. The surveyor was able to gain access to the treatment cart which contained treatment supplies as well as medicated creams and ointments.</p> <p>During an interview on 3/25/25 at 8:00 A.M., Nurse #3 said that the treatment cart should be locked when unattended, but it was not.</p> <p>On 3/25/25 at 10:43 A.M., Nurse #4 unlocked the medication room on the third floor to let the surveyor in the medication room. She left the surveyor alone in the medication room and walked away.</p> <p>During an interview on 3/25/25 at 10:45 A.M., The Infection Preventionist said that the nurse should not have left the surveyor unsupervised in the medication room.</p> <p>During an interview on 3/25/25 at 2:06 P.M., the Director of Nurses said that treatment carts should be locked when they are unattended, and nurses should not leave unauthorized people in the medication room alone.</p> <p>2. On 3/25/25 at 9:03 A.M., the surveyor observed the following in the first floor A side medication cart:</p> <p>-Two unopened vials of Humalog insulin in the medication cart.</p> <p>-One unopened Lantus insulin pen.</p> <p>During an interview on 3/25/25 at 9:06 A.M., Nurse #2 said that unopened insulin should be stored in the fridge until it is opened and not in the medication cart.</p> <p>On 3/25/25 at 10:46 A.M., the surveyor observed the following on the third floor B side medication cart:</p> <p>-A bottle of liquid protein opened, and without an open date. The bottle reads 3-month shelf life from date opened.</p> <p>-Dried and sticky spills from a red liquid in one of the drawers of the medication cart where medications are stored.</p> <p>(continued on next page)</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview on 3/25/25 at 10:49 A.M., Nurse #4 said that the liquid protein should be labeled with an open date, but it was not, and that the medication cart was dirty and needed to be cleaned where leaks or spills from medication had happened.</p> <p>On 3/25/25 at 10:52 A.M., the surveyor made the following observations on the third floor A side medication cart:</p> <ul style="list-style-type: none"> -Cleaning wipes stored in the same compartment as oral medications. -A Lupin inhaler with Tiotropium Bromide inhalation capsules stored in a bag, unlabeled without any resident identification on the bag or inhaler. <p>During an interview on 3/25/25 at 10:58 A.M., Nurse #5 said that the inhaler should be labeled with a resident name to identify who it is for and that the cleaning wipes should not be stored with medications.</p> <p>During an interview on 3/25/25 at 11:05 A.M., the Infection Preventionist said that medication carts should be clean and cleaning products should not be stored with medications. She also said that medications with shortened expiration dates should be labeled when opened and medications should have a resident label on them.</p> <p>During an interview on 3/25/25 at 2:06 P.M., the Director of Nurses said unopened insulin should be stored in the fridge until it is opened. She further said that she would expect that medication carts are clean and without spills. The Director of Nurses also said that medications should be labeled with open dates if they have shortened expiration dates. Further she said that cleaning supplies should not be stored with medications.</p> <p>15016</p> <p>3. Resident #90 was admitted to the facility in June 2021, and has active diagnoses which include diabetes, malnutrition, depression and chronic obstructive pulmonary disorder.</p> <p>Review of Resident #90's Minimum Data Set assessment, dated 1/30/25, indicated that the Resident had intact cognition.</p> <p>Review of Resident #90's Self-Administration of Medications assessment, dated 2/5/25, indicated nursing staff were to pour the medications, and the Resident was allowed to self-administer them.</p> <p>During an interview and observation on 3/25/25 at 10:13 A.M., the surveyor observed approximately eight pills of different colors and shapes on the floor under Resident #90's bed. Resident #90, who was lying in bed, said an unidentified staff member accidentally knocked the pills off his/her meal tray onto the floor. Resident #90 said the staff person told him/her someone would return to the room to remove the pills, but no one did. Resident #90 said the pills may have been under the bed for a couple of days.</p> <p>During an interview on 3/27/25 at 1:00 P.M., the Director of Nurses (DON) said Resident #90 was assessed and determined to be able to self-administer medications. The DON said that all medications should be secured in the bedroom and not left on the floor.</p> | | |