STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225342	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Adams Commons Nursing & Rehabilitation Cente	175 Franklin Street North Adams, MA 01247

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on interview, record and policy review, the facility failed to ensure that one Resident (#84), out of five residents reviewed for unnecessary medications, out of a total sample of 19 residents, had a care plan developed for the use of an anticoagulant (anticoagulant or blood thinner medication used to prevent or treat blood clots in blood vessels and the heart) medication. Specifically, the facility failed to develop a care plan for Resident #84 for Eliquis (anticoagulant medication) that addressed the risks, potential side effects, and monitoring associated with the use of the medication. Findings include: Review of the facility policy titled Anticoagulant Therapy, revised 7/18/18, indicated the following under nursing considerations: -Observe for signs of bleeding: blood in the urine or stool (black, tarry stools), bleeding gums, nose, small purplish, hemorrhagic spots (collection of small blood pools beneath the skin) on the skin, excessive and easy bruising, bleeding from tumors, ulcers, or lesions (organ or tissue which has suffered damage from injury or disease), confusion or mental status changes, -Administer at the same time daily -Recognize possible food interactions -Recognize possible drug interactions -Be aware of changes in hepatic (liver) and renal (kidney) function Review of the facility policy titled Care Planning, revised 6/21/19, indicated: -a comprehensive person-centered care plan will be developed and implemented for each resident, consistent with the resident rights that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The standardized care plan must be individualized for the resident by adding care needs/preferences, interventions, and resident specific strategies based on the assessment of a resident's needs, strengths, goals, life history, and preferences. Resident #84 was admitted to the facility in March 2024, with diagnoses including Cerebral Vascular Accident (stroke- damage to the brain due to the interruption of blood supply to a part of the brain), difficulty ambulating (walking), and falls. Review of a Social Service Note dated 5/8/24, indicated that Resident #84 was readmitted to the facility after hospitalization for a fall and was found to have a right sided Pulmonary Embolism (sudden blockage of a pulmonary artery by a blood clot which stops blood flow to the lungs). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -Resident #84 had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 1 out of a total score of 15. -Received anticoagulant medication during the assessment period. Review of the June 2024 and July 2024 Physician's orders, indicated the following: -Eliquis 5 milligrams (mg), one tablet twice daily for Pulmonary Embolism, initiated 5/12/24 (changed from two tablets twice daily initiated on 5/6/24) Review of the June 2024 and July 2024 Medication Administration Records (MARs) indicated that Eliquis was administered as ordered from 6/1/24 through 7/18/24. Review of the Care Plan Meeting Form completed on 7/8/24, indicated that all nursing concerns were addressed on the Resident's care plan and that all nursing care plan goals and interventions were reviewed and updated. Review of Resident 84's clinical record indicated no documented evidence that a plan of care was developed for the Eliquis medication which included the risks, potential side effects and monitoring for the medication use. During an interview on 7/19/24 at 4:07 P.M., the Corporate MDS Nurse said resident care plans were reviewed and revised during the MDS assessments which were scheduled quarterly and with significant changes. The Corporate MDS Nurse said a care plan to address the Resident's use of anticoagulant medication should have been developed which would address monitoring and potential side effects of the medication including changes in mentation, bruises, and bleeding. The Corporate MDS Nurse further said that the anticoagulant use and the Resident's history of falling would be important to know due to the increased risk of bleeding with the use of the anticoagulant medication.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on observation, interview, record and policy review, the facility failed to ensure that one Resident (#66) had a complete and accurate medical record, out of a total sample of 19 residents. Specifically, the facility failed to accurately monitor and document Resident #66's total fluid intake during a 24-hour period to ensure that he/she was maintaining the 1500 cubic centimeter (cc- unit of measure) Fluid Restriction ordered by the Physician, putting the Resident at increased risk of dehydration, fluid overload and other medical complications. Findings include: Review of the facility policy titled Monitoring of Intake and Output (I&O), revised 10/30/18, indicated intake and output measurement was instituted based on clinician judgement or Physician's order in order to monitor for fluid deficit/imbalance. The policy included the following: -Intake and output will be monitored for the following residents: >Upon Physician's orders >Residents receiving dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) -Record amounts (in cc's) including amounts taken by mouth -Total shift and daily intake -Notify the Physician if clinical assessment for the resident indicates -Document: intake . in the resident's medical record, Physician notification and responses . Resident #66 was admitted to the facility in June 2024 with diagnoses including Hypertension (high blood pressure), End Stage Renal Disease (ESRD- condition in which the kidneys lose the ability to remove waste and balance fluids) and dependence on dialysis. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -Resident #66 was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15. -Received a therapeutic diet and diuretic medication (used to treat fluid retention or edema) -Was on dialysis while at the facility (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Hydration Care Plan initiated 6/6/24, indicated Resident #66 was at risk for alteration in hydration due to diuretic medication therapy and included the following interventions dated 6/6/24: -Establish fluid plan including meals, medication pass, and nourishments -Assess need to monitor intake Review of the Renal Dialysis Care Plan initiated 6/6/24, included the following intervention dated 6/6/24: -Fluid restriction as ordered with intake monitoring Review of the Nutrition Care Plan initiated 6/13/24, included the following interventions dated 6/13/24: -Monitor intake at all meals . -Encourage 100% consumption of all fluids provided -Document intake regarding solids and fluids consumed Review of the June 2024 and July 2024 Physician's orders included the following: -Torsemide (a diuretic medication), 60 milligrams (mg) daily on Mondays, Wednesdays, Fridays, and Sundays, initiated 6/11/24 -Diet: 2-3 gram Sodium Diet, regular texture and thin liquids, initiated 6/11/24 -Day (7:00 A.M. to 3:00 P.M.) Fluid Restriction 1500 ccs: (Total = 780 cc for Day) >Dietary: breakfast =240 cc, lunch = 240 cc; >Nursing Day =300 cc, add meal intake to total shift intake, initiated 6/11/24 -Evening (3:00 P.M. to 11:00 P.M.) Fluid Restriction 1500 ccs: (Total = 540 cc for Evening) >Dietary: dinner =240 cc; >Nursing Evening = 300 cc, add meal intake to total shift intake, initiated 6/11/24 -Nocturnal (11:00 P.M. to 7:00 A.M.) Fluid Restriction 1500 ccs: (Total = 180 cc for Nights) >Nursing Nocturnal = 180 cc, initiated 6/11/24 -11:00 P.M. to 7:00 A.M. Nurse to total 24-hour fluid restriction, if greater than 1500 cc for 24 hours, the Physician needs to be notified, initiated 6/11/24 (780 cc (Day) + 540 cc (Evening) + 180 cc (Night) = 1500 cc [Daily Total]) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the June and July 2024 Medication Administration Records (MARs) indicated the following: -Torsemide 60 mg was administered as ordered from 6/19/24 through 7/17/24, except on 6/21/24 (indicated the medication was held) -Intake amounts (fluid amount documented each shift on the following dates) that were over the 1500 cc Fluid Restriction despite the 24-intake total fluid amount of 1500 cc being documented: >7/4/24 = 1640 cc >7/10/24 = 2150 cc >7/14/24 = 1920 cc >7/16/24 = 1600 cc Further review of the June and July 2024 MARs indicated: - M (indicating missed/held or not administered) was documented for one or more shifts for fluid intake on: 7/1/24, 7/9/24, 7/12/24, and 7/17/24. -that the 24-hour fluid amount totals for June 2024 and July 2024 did not equal the total intake for fluids documented per shift with the exception of 7/16/24 (where the amounts for each shift equaled the amounts documented on the 24-hour total). During an interview on 7/19/24 at 8:39 A.M., the surveyor observed Resident #66 dressed and lying in bed. Resident #66 said that he/she had been going to dialysis for several years and was on a fluid restriction. On 7/19/24 at 2:57 P.M., the surveyor and the Director of Nursing (DON) reviewed the July 2024 MAR fluid intakes. The DON said for residents on fluid restrictions, the nursing staff were responsible for documenting the total fluids taken by the residents each shift, and that the 11:00 P.M. to 7:00 A.M. Nurse would total the amounts provided each shift and enter the total amount of fluids consumed by the resident under the 24-hour fluid total. The DON reviewed the documentation and said the total fluid amounts documented each shift for Resident #66 did not match the 24-hour fluid intake totals. The DON further said that inaccurate documentation of the total fluid amounts residents consumed could put them at risk for complications. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/19/24 at 3:50 P.M., the surveyor and Nurse #2 reviewed Resident #66's July 2024 MAR. Nurse #2 who worked with Resident #66 and also worked the 11:00 P.M. to 7:00 A.M. (night) shift said when a resident was on Intake and Output monitoring, the night shift Nurse would obtain the fluid intake amount totals from the previous shifts, would total the fluid intake amounts, and document the information under the 24-hour total fluids. Nurse #2 reviewed the July 2024 MAR documentation and said there were some days that fluid amounts were missing for some shifts for Resident #66, and that the total amount of fluids for the 24-hour documentation should equal the totals provided per shift but the totals did not match. Nurse #2 further said that it was important to accurately document fluid intake for Resident #66 because he/she was on dialysis and was at increased risk for fluid status changes, dehydration, and that fluid amounts could affect his/her dialysis prescription (individualized for Resident #66).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on interview, record and policy review, the facility failed to ensure that its staff offered the Pneumococcal (infections caused by bacteria called Streptococcus Pneumoniae, or Pneumococcus that can cause Pneumonia and blood stream infections) Vaccination as recommended to four Residents (#25, #46, #84, and #55), out of five applicable residents, out of a total sample of 19 residents. Specifically, the facility failed to ensure that Pneumococcal Vaccinations were offered to, received by, or declined by Residents #25, #46, #84, and #55, at the time of admission or shortly thereafter, putting the Residents at risk for developing facility acquired Pneumonia. Findings include: Review of the facility policy titled Resident Pneumococcal Immunization, effective 9/2011, and revised 9/1/23, indicated: -Residents .will be offered immunization to protect them from Pneumococcal disease unless the vaccine is medically contraindicated, or the resident has already been immunized. -Pneumococcal Immunizations will be provided as recommended by the Center for Disease Control and Prevention (CDC) Advisory Committee for Immunization Practices (ACIP) recommendations. -Immunization status will be reviewed to determine eligibility for immunization. -CDC link Pneumococcal Vaccine Timing for Adults greater than or equal to [AGE] years (cdc.gov) included other adults and indicated that adults age 19-64 with certain underlying medical conditions or other risk factors who have not previously received a Pneumococcal Conjugate Vaccine (PCV - a vaccine that helps protect against diseases caused by pneumococcal bacteria) or whose previous vaccination status is unknown should receive one dose of PCV (either PCV20 or PCV15), adults who have received PPSV23 (Pneumococcal Polysaccharide Vaccine 23) only may receive a Pneumococcal Conjugate Vaccine (either PCV20 or PCV15) equal to or greater than one year after their last PPSV23 dose. -Residents with unknown or uncertain immunization status may be immunized, as the benefit of immunization outweighs any risk related to re-immunization. -If there is no prior evidence of vaccination, vaccine status is unknown or uncertain, the vaccine will be offered in accordance with CDC ACIP recommendations. 1. Resident #25 was admitted to the facility in May 2023, with diagnoses of Diabetes (disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in elevated blood glucose [sugar] levels in the blood), Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment), and Normal Pressure Hydrocephalus (a build-up of spinal fluid and pressure in the brain) and age was greater than 65 at the time of admission. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #25's Immunization History Report printed and provided by the facility on 7/18/24 indicated: -Pneumovax 23 administered on 12/15/05 -Pneumovax 23 administered on 4/12/11 -Prevnar 1 .[sic] administered on 2/12/15 Review of Resident #25's clinical record did not provide any evidence of education or an offer of a Pneumococcal Vaccination upon admission, or at any time since the Resident's admission to the facility. 2. Resident #46 was admitted to the facility in January 2023, with diagnoses of Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), Diabetes, and Schizophrenia (re-occurring episodes of psychosis correlated with a general misperception of reality) and age was greater than 65 at the time of admission. Review of Resident #46's Immunization History Report printed and provided by the facility on 7/18/24 indicated: -Prevnar 1 .[sic] administered on 1/22/11 -Pneumococcal (did not indicate type) on 5/6/15 Review of Resident #25's clinical record did not provide any evidence of education or an offer of a Pneumococcal Vaccination upon admission to the facility. 3. Resident #84 was admitted to the facility in March 2024 with diagnoses of Cerebral Infarction (stroke: damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area) and Supraventricular Tachycardia (a fast heart rate causing palpitations, shortness of breath, and chest pain) and age was greater than 65 at the time of admission. Review of Resident #84's clinical record did not provide any immunization history or evidence of education or an offer of a Pneumococcal Vaccination upon admission to the facility. 47901 4. Resident #55 was admitted to the facility in October 2023, with diagnoses including Dementia, Hypertension (high blood pressure) and Shortness of Breath. Review of Resident #55's medical record indicated the Resident was over [AGE] years of age. Review of Resident #55's Vaccination Administration Record, printed and provided by the facility on 7/18/24, indicated that the Resident received one dose of Prevnar 13 on 7/30/15. Further review of Resident #55's Immunization Report indicated no documented evidence the Resident had received any other dose of Pneumococcal Vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/18/24 at 2:51 P.M., Nurse #3 said that she was the Infection Preventionist (IP) until a few weeks ago. Nurse #3 said that she could not recall why Resident's #25, #46, #84, and #55, were not offered Pneumococcal Vaccinations. Nurse #3 was unable to provide any evidence that education had been offered, and consents obtained for Pneumococcal Vaccination to the Residents upon admission or since admission to the facility. During an interview on 7/19/24 at 1:12 P.M., the Regional Corporate Nurse said Resident's #25, #46, #84, and #55, were overdue for their Pneumococcal Vaccinations. The Regional Corporate Nurse said the facility follows the CDC guidelines and that these Residents should have been offered a Pneumococcal Vaccination upon admission, but they had not been offered.