STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225386	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springside Rehabilitation and Skilled Care Center	255 Lebanon Avenue 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain a medication pass error rate of less than five percent (%) for one Resident (#39), of four applicable residents, out of 29 medication pass opportunities. The medication error rate was observed to be 6.9%. Specifically, 1. For Resident #39, the Resident was administered Memantine (a medication used to treat memory loss) capsule and Depakote Sprinkles (a medication used for seizures and various psychiatric symptoms) capsule by opening the capsules and crushing the inside sprinkle capsules placing the Resident at risk of having less efficacy of the prescribed medications. Findings include: Review of the Mayo Clinic's Drug and Supplement information (www.mayoclinic.org/drugs-supplements) for Memantine and Depakote Sprinkles indicated the following: -Memantine >Swallow theˆextended-release capsulesˆwhole. Do not break, crush, or chew them. >If you cannot swallow theˆextended-release capsule, you may open it and pour the medicine into a small amount of soft food such as applesauce. Stir this mixture well and swallow it without chewing. -Depakote Sprinkles >Swallow theˆsprinkle capsulesˆwhole. It may also be opened, and the contents may be sprinkled onto a teaspoonful of soft food, such as applesauce or pudding. This mixture must be swallowed immediately without chewing and followed with a glass of water to ensure complete swallowing of the sprinkles. Review of the facility policy titled Medication Management - General Policies, reviewed September 2024, indicated the following: -Purpose: to identify effective and safe medication management processes to improve resident safety. -Medications may be administered per resident choice consistent with plan of care ie. taken whole, crushed, in accordance with pharmacy standards, or other method. Resident #39 was admitted to the facility in February 2023, with diagnoses including Dementia, Mood Disorder and Psychotic Disturbance. Review of Resident #39's September 2025 Physician's Orders indicated the following: -an active order for Depakote Sprinkles Orla Capsule Delayed Release Sprinkle 125mg (milligrams) capsule, give 2 capsules by mouth two times a day for mood disorder initiated on 9/14/25 -an active order for Namenda XR (Memantine) Oral Capsule Extended Release 24 Hour 28mg capsule, give 1 capsule by mouth one time a day for dementia On 9/26/25 at 8:06 A.M., the surveyor observed Nurse #1 do the following during a Medication Administration Observation for Resident #39: -poured the Resident's morning tablet and capsule medications into a medication cup including Depakote Sprinkles delayed release capsule and Memantine Extended Release -performed hand hygiene, don (put on) gloves and open the Memantine and Depakote capsules into the medication cup with the tablet medications -poured contents of the medication cup into a pill crusher pouch and crush the tablets and opened contents of the Depakote Sprinkles and Memantine capsules -poured the crushed contents of the pill crusher pouch back into the medication cup, added applesauce and administered it to the Resident During an interview on 9/26/25 at 9:31 A.M., the surveyor reviewed the medication administration observation of Resident #39 with Nurse #1. Nurse #1 said she had crushed the contents of the opened Depakote Sprinkles and Memantine capsules. Nurse #1 said that she believed the medications could be crushed once opened but would speak to the Staff Development Coordinator. After a brief conversation with the Staff Development Coordinator, Nurse #1 said that the contents from the Depakote Sprinkles and Memantine should not be crushed. During an interview on 9/26/25 at 9:50 A.M., the Corporate Nurse said that she had spoken with the (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy, and they said the concern with crushing the contents of the Depakote Sprinkles and Memantine capsules was that the duration of effect of the medication would potentially be shorter than intended.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to adhere to infection control standards to prevent the potential transmission of communicable diseases and infections for one Resident (#112), of one applicable Resident reviewed with an intravenous access site, out of a total of 21 sampled Residents. Specifically, for Resident #112, the facility failed to ensure hand hygiene was performed as indicated after removal of gloves to prevent potential cross-contamination during an intravenous (IV) medication administration. Findings include: Review of the facility policy titled Handwashing/Hand Hygiene, reviewed August 2015, indicated the following: -This facility considers hand hygiene the primary means to prevent the spread of infections. -Use an alcohol-based hand rub containing at least 62 percent (%) alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: >before and after direct contact with residents >before and after handling an invasive device (e.g., urinary catheters, IV access sites) >after removing gloves Resident #112 was admitted to the facility in September 2025 with diagnoses including Osteomyelitis (infection of the bone) of the right ankle and foot, Methicillin Resistant Staphylococcus Aureus (MRSA) Infection and Extended Beta Lactamase (ESBL) Resistance. Review of Resident #112's September 2025 Physician's Orders indicated the following: -an active order dated 9/18/25 to maintain enhanced barrier precautions (wear gloves and a gown for the following high contact care activities: dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, or wound care) for wound infection, central venous catheter (proline) [a type of IV access site that is inserted in the chest) and MRSA. On 9/26/25 at 2:30 P.M., the surveyor observed Unit Manager (UM) #1 do the following during a medication administration observation for Resident #112: -performed hand hygiene, donned (put on) a gown and gloves, and entered the room to clean and disinfect the Resident's overbed table -doffed (took off) the gown and gloves and performed hand hygiene before leaving the room -poured oral medication for Resident as ordered, pulled out a pre-packed set of supplies for IV administration from the medication cart -performed hand hygiene, donned a gown and gloves, gathered supplies off the medication cart and entered the Resident's room -set the pre-packaged IV administration supplies on the Resident's dresser, and administered the oral medication -doffed gloves and donned a new pair of gloves without performing hand hygiene -draped the overbed table, took supplies out of package and set them up on the overbed table - doffed gloves and donned a new pair of gloves without performing hand hygiene -prepared the IV medication, primed the IV tubing for administration and set up the IV pump as ordered - doffed gloves and donned a new pair of gloves after performing hand hygiene -cleaned the central venous catheter, flushed the catheter, hooked up the IV medication tubing and began the infusion. -cleaned off table, doffed gown and gloves and performed hand hygiene During an interview on 9/26/25 2:48 P.M., UM #1 said that she should have performed hand hygiene after every glove removal before she donned new gloves but did not. UM #1 further said that the risk of not performing hand hygiene during glove changes was that her hands could be dirty after removing the glove creating the potential that the glove could become contaminated.