| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225398 | A. Building<br>B. Wing | 07/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Devereux Skilled Nursing & Rehabilitation Center | 39 Lafayette Street<br>Marblehead, MA 01945 |

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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>(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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure for one Resident (#1), out of a total sample of 14 residents that a PRN (as needed) psychotropic medication order included a duration for continued use. Findings include: Review of the Facility's policy titled Psychotropic Medication Management, effective date 10/14/2017 indicated the following:Policy:Each resident's drug regimen will be free from unnecessary drugs. Administration of psychoactive medications will focus on the individual needs of the resident and will be prescribed only when necessary and clinically indicated to treat specific conditions and symptoms as diagnoses and documented. Psychoactive medication management will include implementation of behavioral interventions, gradual dose reductions attempts, and adequate monitoring that complies with Federal and State guidelines.Protocol included but was not limited to the following:-PRN (as needed) orders for psychotropic drugs are limited to 14 days (except as noted below) if the prescribing MD (medical doctor) or practitioner believes it is appropriate for the PRN order to extend beyond 14 days. The MD will document his/her rational in the resident's medical record and indicate the duration for the PRN order. Resident #1 was admitted to the facility in September 2023 and has diagnoses that include but are not limited to unspecified dementia, senile degeneration of the brain, unspecified psychosis not due to a substance or known physiological condition, personal history of malignant neoplasm of brain, and other seizures.Review of Resident #1's most recent Minimum Data Set assessment, (MDS) dated [DATE] indicated Resident #1 as having a Brief Interview for Mental Status exam score of 3 out of 15, which indicates severe cognitive impairment, is dependent on staff for daily care including bathing, dressing, and toileting. Further, the MDS at Section N indicated Resident #1 was administered and had indication for use for high-risk drug classes including antipsychotic, and antidepressant medication.On 7/29/2025 at approximately 7:45 A.M., Resident #1 was observed resting in bed. Resident #1 did not respond to the Surveyors greeting. Review of Resident #1 physician's orders indicated the following:-Lorazepam Oral Concentrate 2 MG/ML (a medication classified as an antianxiety medication and used to treat anxiety symptoms) Give 0.25 ml by mouth every four hours as needed for Anxiety/Restlessness/Agitation. Order dated 5/6/2025 Start date 5/6/2025. Review of the order failed to indicate the duration for the use of the PRN Lorazepam. Review of the Medication Administration Record (MAR) dated May 2025, June 2025, and July 2025 indicated Resident #1 was administered the PRN Lorazepam on the following days:5/19/25 1702 (5:02 P.M.)6/19/25 0411 (4:11 A.M.)6/24/25 0447 (4:47 A.M.)7/5/25 0127 (1:27 A.M.)7/8/25 0440 (4:40 A.M. )7/14/25 0035 (12:35 A.M.)7/28/25 0606 (6:06 A.M.)Review of the clinical record indicated the following: -A Physician Progress Note dated 5/10/25 date of service 5/6/25: Patient is status post hospitalization. Medications: Lorazepam Oral concentrate 2mg/ml, Dosage 0.25, Route: by mouth. Frequency: as needed (sic) Continue all current prescription medication and monitor. -A Physician Progress Note dated 5/7/25: Resident was placed on hospice in the hospital. Assessment on hospice, medications: Lorazepam 2 mg/mg oral concentrate 0.5 mg po/sl (by mouth/sublingual) q (every) 4prn agitation. -A Progress note with an encounter date 5/21/25: Chief Compliant: Patient is reported to be on comfort measures. Medications: Lorazepam Oral Concentrate 2 MG/ML, Dosage 0.25, Route by mouth, Frequency: PRN as needed. Assessment/Plans [AGE] year-old resident on hospice with medical issues of aspiration pneumonia, major depression continue comfort measures with morphine, atropine and lorazepam. Disposition: Continue all current prescription medication and monitor. -A Nurse Practitioner Progress note dated 5/21/25: Medications: Lorazepam 2 mg/ml oral concentrate, 0.5 po/sl q4prn (sic) agitation. -A Physician Progress note authored by Nurse Practitioner dated 7/23/25: Medications Lorazepam 2 mg/ml oral concentrate, 0.5 po/sl q4prn (sic) agitation. Review of the Physician and Nurse Practitioner progress notes fail to indicate the duration for the PRN psychotropic medication administration. During an interview on 7/30/2025 at 1:04 P.M., Nurse #3 said Resident #1 can display behaviors and combativeness especially with care and staff attempt to redirect him/her. Nurse #3 said Resident #1 has been on hospice care for a few months. Nurse #3 said Resident #1 does have an order for PRN Lorazepam and that the overnight nurse has given it to him/her to assist with agitation during care. Nurse #3 reviewed the order in the electronic medical record and said there was no duration or end date for the PRN lorazepam and asked if it was needed for a resident on hospice. During an interview on 7/30/2025 at 1:39 P.M., Nurse Practitioner (NP) #1 said Resident #1 is prescribed prn lorazepam for anxiety, seizures and agitation with care, as the main indication for use. NP #1 said Resident |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observations, interviews and record review, the facility failed to provide routine dental services for one Resident (#26) out of a total sample of 14 residents. Specifically, for Resident #26, the facility failed to address and initiate replacement of lost/missing lower dentures timely. Findings include:Review of the facility policy titled 'Lost or Damaged Dentures', dated 10/1/17, indicated:- It is the policy of this facility to ensure that residents found to have lost or damaged dentures while in the facility receive an adequate replacement, along with prompt dental services as outlined below.- Staff/resident/family must notify the charge nurse and the Social Service Director/Designee immediately of any missing or damaged dental appliance. An investigation into how the item/items were lost or damaged will be initiated promptly. - Within 3 days following confirmation of lost or damaged dentures/partials or other removable dental work, the Director of Social Services/Designee must make a referral for appropriate dental services for repair and/or replacement. Resident #26 was admitted to the facility in February 2024 with diagnoses including dysphagia (difficulty swallowing) and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/19/25, indicated Resident #26 was rarely/never understood and had severe cognitive impairment as evidenced by a Staff Assessment for Mental Status. This MDS indicated Resident #26 required substantial/maximal assistance with oral hygiene, including denture management. During a telephone interview on 7/29/25 at 10:10 A.M., Resident #26's Health Care Proxy (HCP) said Resident #26's lower dentures had been missing for many months and would like them replaced. Resident #26's HCP said Resident #26's dentures had been replaced in December 2024 but had been lost again. Resident #26's HCP said she was concerned that staff were not assisting him/her with denture management. Review of Resident #26's plan of care related to activities of daily living (ADLS), revised 1/6/25, failed to indicate the Resident had behaviors of self-removing dentures or any concerns with denture management. The plan of care indicated:- Oral hygiene - maximum assist. Resident #26 has full upper and partial lower dentures. Dentures need to be cleaned at least 2x (two times)/day. Review of Resident #26's nursing progress note, dated 12/16/24, indicated:- Went to dentist today and received full upper denture and partial lower denture. On 7/29/25 at 10:44 A.M., 11:50 A.M., and 12:02 P.M., and on 7/30/25 at 8:47 A.M. and 11:45 A.M., the surveyor observed Resident #26 wearing only upper dentures. There were no lower dentures in Resident #26's oral cavity. During an interview on 7/29/25 at 10:44 A.M., Resident #26 was unable to answer questions regarding his/her dentures and responded with nonsensical speech. During an interview on 7/30/25 at 11:45 A.M., Certified Nurse Assistant (CNA) #2 said she cares for Resident #26 consistently on the day shift. CNA #2 visualized Resident #26's oral cavity with the surveyor and confirmed the Resident was wearing only upper dentures. CNA #2 said she had to check with Nurse #1 because she thought Resident #26 only had upper dentures and was not aware he/she had any lower dentures. CNA #2 said there were no lower dentures in Resident #26's room. During an interview on 7/30/25 at 11:47 A.M., Nurse #1 said Resident #26 used to have lower dentures, but he/she had not worn them in a long time. Nurse #1 said he believed they had been lost for at least a month, maybe longer. Nurse #1 said the missing lower dentures should have been reported to the family and Director of Nursing (DON) but were not. During an interview on 7/30/25 at 11:51 A.M., Nurse #2 said that Unit Manager #1 and the DON should have been notified of the missing dentures so an investigation could have been completed and a dental appointment arranged. During an interview on 7/30/25 at 12:56 P.M., Unit Manager #1 said if any CNA or nurse noted that Resident #26's dentures were missing it should have been reported to him and the DON, but it was not. Unit Manager #1 said whenever a resident's dentures are noted to be missing, they need to complete a missing dentures report, complete a thorough search for missing dentures, and if they are unable to be found then a dental consult needs to be arranged to replace them. Unit Manager #1 said this was not done for Resident #26 because he and the DON were not notified that the lower dentures were missing. Unit Manager #1 further said if Resident #26 had any behaviors or concerns with self-removing dentures he would have expected those concerns to be addressed by either implementing denture storage in the medication cart, more frequent denture checks, or putting in specific physician orders or care plan interventions to address those concerns. Unit Manager #1 said further interventions were not implemented because he was not aware of any concerns with his/her denture management. Review of Resident #26's medical record, including nursing notes, physician's orders, and care plan, dated from when the new dentures were received on 12/16/24 through 7/20/25, failed to indicate any dentures concerns, such as being refused, self-removed or lost. During an interview on 7/30/25 at 2:55 P.M., CNA #3 said CNAs get patient |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to implement enhanced barrier precautions for one Resident (#2), out of a total of 14 sampled residents.Findings include:Review of the Enhanced Barrier Precautions policy dated March 2024 indicated:-Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug resistant organisms (MDRO).- Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.-An order for EBP will be obtained for any residents with any of the following: wounds, and/or indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with an MDRO. Review of United States Centers for Disease Control and Prevention's (CDC) guidance titled 'Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs)', updated July 12, 2022, indicated:- Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.- Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing.Resident #2 was admitted to the facility in June 2025 with diagnoses including toxic encephalopathy and urinary retention.Review of the Minimum Data Set assessment dated [DATE] indicated Resident #2 had severe cognitive impairment evidenced by a score of three out of a possible 15 on the Brief Interview for Mental Status exam. The MDS further indicated he/she utilized an indwelling catheter. On 7/29/2025 at 8:17 A.M., the surveyor observed Resident #2 resting in bed. A catheter in a privacy bag was visible hanging on the side of the bed. The doorway outside of Resident #2's room did not have a sign indicating EBP and there was no precautions cart containing personal protective equipment (PPE). Review of Resident #2's catheter care plan dated 6/10/2025, and current physician's orders failed to indicate Resident #2 was on EBP. On 7/29/25 at 11:09 A.M. the surveyor observed staff in Resident #2's room providing care and wearing gloves but no gown while Resident #2 was in bed. There was no sign or precaution cart outside the room indicating Resident #2 was on EBP. On 7/30/2025 at 7:59 A.M. the surveyor observed Resident #2's room had no signs or precaution carts to indicate Resident #2 was on EBP. During an interview on 7/30/2025 at 9:53 A.M. , Certified Nursing Assistant (CNA) #1 said that he is assigned to take care of Resident #2. CNA #1 said he only has to wear gloves while providing care to Resident #2. CNA #1 did not say that Resident #2 was on precautions.On 7/30/2025 at 10:25 A.M., the surveyor observed CNA #1 providing care to Resident #2 in his/her bathroom while wearing gloves. CNA #1 was not wearing a gown as required. On 7/30/2025 at 12:15 P.M., Nurse #2 said residents who have wounds and catheters should be on EBP. Nurse #2 said that Resident #2 should be on EBP.During an interview on 7/30/25 at 12:30 P.M., the Director of Nursing (DON) said every resident with a catheter should have an order and a care plan to be on EBP. The DON said that EBP help protect the residents and staff to prevent possible infectious transmission. The DON said that she was not aware Resident #2 was not on EBP and he/she should have been. |