STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225412	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medway Country Manor Skilled Nursing & Rehabilitat	115 Holliston Street Medway, MA 02053

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 37183 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was diagnosed with dementia, had an activated Health Care Proxy, and had physicians orders for the administration of psychotropic medications, the Facility failed to ensure Resident #1's Health Care Agent and/or alternates were provided with necessary information including the risks and benefits of psychotropic medications and failed to ensure they obtained written informed consent for their use, prior to administration of an antidepressant and antipsychotic medication. Findings include: Review of the facility's policy titled, Consent to Treat, undated, indicated the following: -prior to administering any medical treatment or intervention, written or verbal consent must be obtained from the resident or their legal representative; -healthcare providers must assess the resident's capacity to provide informed consent. If a resident is deemed incapable of making decisions regarding their medical care, consent should be obtained from their legal representative as per legal guidelines; -all consent, whether from the resident or their legal representative, must be documented in the resident's medical record. This documentation should include the nature of the treatment, risks and benefits explained (if applicable), and the date and time consent was obtained. Review of the Commonwealth of Massachusetts Circular Letter 17-2-699, Revised Informed Written Consent for the Use of Psychotropic Medications in Long-Term Care Facilities, dated 02/01/17, indicated the following: -Federal law requires that long-term care facilities document informed consent to the extent provided by state law, and Massachusetts long-term care regulations, 105 CMR 150.008 (A)(4), require facilities to comply with all Federal and State laws and regulations relating to the procurement, storage, dispensing, administration, recording and disposal of drugs; - prior to the administration of psychotropic medication, the facility shall obtain the informed written consent of the resident, the resident's health care proxy or guardian; (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the facility is in compliance if the facility has policies and procedures that have documentation of informed consent for psychotropic medications including drugs that treat depression, anxiety disorders and antipsychotic medications; -documentation of informed consent, prior to the administration of any psychotropic drug must be completed and the drugs prescriber must discuss the following with the resident or resident's legal representative: the purpose for administering the psychotropic drug, the prescribed dosage and any known effect or side effect of the psychotropic drug; Resident #1 was admitted to the Facility in May 2022, diagnoses included fracture of unspecified part of neck of left femur, wedge compression fracture of T7-T8 vertebra, pulmonary embolism, Dementia with psychotic disturbance, vascular dementia, mood disturbance and anxiety. Review of Resident #1's Health Care Proxy Invocation, dated 3/18/22, indicated that he/she was unable to make a rational evaluation of the risks and benefits of any proposed treatment. Review of Resident #1's Significant Change Minimum Data Set (MDS) Assessment, dated 05/08/24, indicated Resident #1 had moderate cognitive impairment. Review of Resident #1's Medication Administration Record (MAR), dated 2/17/24 through 05/10/24 indicated Resident #1 had physician's orders for and was administered Amitriptyline HCL as ordered. Review of Resident #1's Medication Administration Record (MAR), dated 2/16/24 through 03/22/24 indicated Resident #1 had physician's orders for and was administered Quetiapine Fumarate as ordered. During a telephone interview on 7/01/24 at 11:59 A.M., Resident #1's Family Member, (who was his/her Health Care Agent), said that at the time of Resident #1's admission she was not provided information about the use of psychotropic medications for Resident #1 and was not asked to provide signed informed consent for the administration of any antipsychotic and antidepressant medications. Further review of Resident #1's Medical Record indicated there was no documentation to support that written informed consents were obtained from Resident #1's Health Care Agent and/or his/her alternates for administration of Amitriptyline HCL and Quetiapine Fumarate, psychotropic medications. During an interview on 07/02/24 at 3:50 P.M., the Administrator said they were unable to locate documentation to support that the Facility had obtained written informed consent for the administration of Resident #1's psychotropic medications Amitriptyline HCL and Quetiapine Fumarate. The Administrator said it was her expectation that a written informed consent be obtained prior to the administration of any psychotropic medications.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37183 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), after facility staff were made aware on 05/06/24 by a Family Member of an allegation that he/she was sexually abused by a staff member, the Facility failed to ensure staff implemented and followed their abuse policy when 1) Certified Nurse Aide (CNA) #1 and CNA #2 (who fit the description of the accused staff member) were not immediately suspended pending an investigation, and 2) failed to conduct Massachusetts Nurse Aide Registry (NAR) check and Criminal Offender Record Information (CORI) checks prior to CNA #1 and CNA #2's date of employment at the Facility, in accordance with their Abuse Policy. Both of these issues placed their resident's at risk for potential abuse. Findings include: Review of the Facility Policy titled, Abuse Prevention Program, dated as revised 01/21/20, indicated the Facility assured an environment free of abuse, neglect, mistreatment and would do the following: -upon receiving an allegation of abuse, staff members implicated in a potential abuse incident will be removed immediately from all resident areas and will be suspended from work pending the results of the investigation. The Policy also indicated that the Facility would assure sound hiring practices through screening procedures which included the following: - all potential employees will be screened to rule out a history of abuse, neglect, or mistreatment of residents; - the Facility does not knowingly hire individuals who have been found guilty of abusing residents by a court of law, had a finding entered into the state nurse aid registry concerning abuse and/or had disciplinary action taken in regard to their profession license in regard to resident abuse; - check state nurse aide registries for all prospective employees; - use the CORI system to make inquiries on nation-wide criminal background information prior to hiring and orientation of direct care staff. -conduct a search of the Office of Inspector General exclusion database upon hire and monthly; -checks all professional licenses with appropriate licensing boards; -obtain a minimum of two employment references as part of the hiring process. 1) Resident #1 was admitted to the Facility in May 2022, diagnoses included fracture of unspecified part of neck of left femur, wedge compression fracture of T7-T8 vertebra, pulmonary embolism, Dementia with psychotic disturbance, vascular dementia, mood disturbance and anxiety. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS) dated as submitted on 05/07/24 at 11:01 A.M., indicated that on 05/06/24 at 1:00 P.M., Resident #1's Family Member called the Facility and spoke with the Director of Nurses (DON) and Assistant Director of Nurses (ADON) regarding concerns that Resident #1 had been sexually abused by a male staff member. The Report indicated that Resident #1 was unable to identify the male staff member [exact name unknown] but stated he was an African American male. The Report indicated that an investigation was begun, and CNA #1 and CNA #2 [who fit the description of the accused] were interviewed, and both denied the allegations. Review of the Police Department Report, dated 05/07/24, indicated a Police Officer responded to the facility on [DATE], at approximately 1:54 P.M. in response to the Assistant Director of Nursing's (ADON) report of an alleged past sexual assault of Resident #1 by a staff member. The Report indicated that the ADON stated that the Facility completed an internal investigation into the incident and closed it due to the fact that they believed that the complaint was not true. The Report indicated that the Police Officer attempted to speak to Resident #1 but he/she did not remember the incident or what happened. The Report indicated that the Police officer spoke to Resident #1's Family Member over the phone regarding the sexual assault allegation and that the Family Member stated that Resident #1 told her that a male sexually assaulted him/her but was unable to say which male. The Report indicated that someone would follow up with the allegation. Review of the Facility's Nursing Staff Schedule, dated 05/04/24, 05/06/24 and 05/07/24, indicated that CNA #1 and CNA #2 worked during the day shift (7:00 A.M. to 3:00 P.M.) and/or the evening shift (3:00 P.M. to 11:00 P.M.) and worked on Resident #1's unit providing care to the residents. Review of CNA #1's timecard indicated he worked the following dates/hours: -05/04/24, 07:09 A.M. until 03:03 P.M. -05/06/24, 07:22 A.M. until 11:00 P.M. -05/07/24, 07:15 A.M. until 10:57 P.M. Review of CNA #2's timecard indicated he worked the following dates/hours: -05/04/24, 07:09 A.M. until 10:57 P.M. -05/06/24, 07:08 A.M. until 11:00 P.M. -05/07/24, 07:08 A.M. until 10:57 P.M. During an interview on 07/02/24 at 1:50 P.M., CNA #2 said he was not suspended during the Internal Investigation and said he worked double shifts on 5/06/24 and 5/07/24. During an interview on 07/02/24 at 2:20 P.M., CNA #1 said he was not suspended during the Internal Investigation and said he worked double shifts on 5/06/24 and 5/07/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 07/03/24 at 10:05 A.M., the Director of Nurses (DON) said that on 05/06/24 at approximately 1:00 P.M. Resident #1's Family Member called her to report an allegation of sexual abuse that occurred to Resident #1 during the past weekend [exact date unknown, weekend dates were 5/04/24 and 5/05/24]. The DON said that on 05/06/24 after the phone call, she asked the Assistant Director of Nurses (ADON) to begin an investigation into the allegation of sexual abuse. The DON said that she thought the ADON was investigating the allegation of sexual abuse and said she did not ask the ADON what the disposition of the investigation was before she went home on 5/06/24. The DON said that the next day, she was informed by the ADON that she had not investigated the allegation of sexual abuse and said the ADON thought she (the DON) was investigating the allegation. The DON said it was a miscommunication between the ADON and herself. The DON said that CNA #1 and CNA #2 were not suspended during the investigation and said that both CNA #1 and CNA #2 should have been suspended during the investigation per Facility policy. During a telephone interview on 07/03/24 at 10:30 A.M., the Assistant Director of Nurses (ADON) said that on 05/06/24 Resident #1's Family Member called to report an allegation of sexual abuse that occurred to Resident #1 over the weekend. The ADON said that she thought the DON was going to investigate the allegation of sexual abuse. The ADON said she did not investigate the allegation of sexual abuse on 05/06/24. The ADON said the next day, 05/07/24, she realized that CNA #1 and CNA #2 were on the schedule to work, and that she was unaware of the disposition of the investigation as to whether or not CNA #1 and CNA #2 were suspended. The ADON said that the DON was not working at the Facility on 05/07/24, so she called the DON and asked her what the disposition of the investigation was and that she was directed by the DON to obtain a statement from both CNA #1 and CNA #2 and begin an investigation. The ADON said she obtained statements from CNA #1 and CNA #2 on 05/07/24. The ADON said that the DON told her that both CNA #1 and CNA #2 could continue to work on 5/07/24 and therefore they were not suspended. During a telephone interview on 07/08/24 at 11:11 A.M., the Administrator said that it was her expectation that CNA #1 and CNA #2 be suspended during the investigation of the allegation of sexual abuse, as per Facility policy. 2) Review of CNA #1's Employee File indicated his first date of employment at the Facility was 09/07/21. Further review of his Employee File indicated there was no documentation to support that Nurse Aide Registry (NAR) and Criminal Offender Record Information (CORI) checks were conducted prior to his first day of employment, or at any time during employment at the Facility prior to the investigation of this complaint. Review of CNA #2's Employee File indicated his first date of employment at the Facility was 09/24/23. Further review of his Employee File indicated there was no documentation to support that Nurse Aide Registry (NAR) and Criminal Offender Record Information (CORI) checks were conducted prior to his first day of employment, or at any time during employment at the Facility prior to the investigation of this complaint. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/02/24 at 3:50 P.M., the Administrator said they were unable to locate documentation to support that the Facility had conducted NAR and CORI checks on CNA #1 and CNA #2 prior to their hire date. The Administrator said it was her expectation that NAR and CORI checks be obtained prior to staff being hired at the Facility. The Facility was unable to provide any documentation to support that NAR and CORI checks had been conducted on CNA #1 and CNA # 2 prior to being hired.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37183 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure that after an administrative staff member (Director of Nurses) was made aware on 05/06/24 of an allegation of sexual abuse, that it was reported to the Department of Public Health (DPH) within two hours as required, when it was not reported to the DPH until 05/07/24, the following day. Findings include: Review of the Facility Policy titled Abuse Prevention Program, dated as revised 01/21/20, indicated the Facility assured an environment free of abuse, neglect, mistreatment and misappropriation of resident property. The Policy indicated that a thorough investigation will be completed under the direction of the Director of Nurses (DON) and Administrator and that the Administrator will provide proper notification to the state agency. The Policy further indicated that a report is to be made within two hours to the Department of Public Health immediately for suspected abuse, neglect, and misappropriation of property. Resident #1 was admitted to the Facility in May 2022, diagnoses included fracture of unspecified part of neck of left femur, wedge compression fracture of T7-T8 vertebra, pulmonary embolism, Dementia with psychotic disturbance, vascular dementia, mood disturbance and anxiety. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS) dated as submitted on 05/07/24 at 11:01 A.M., indicated that on 05/06/24 at 1:00 P.M., Resident #1's Family Member called the Facility and spoke with the Director of Nurses (DON) and Assistant Director of Nurses (ADON) regarding concerns that Resident #1 had been sexually abused by a male staff member. The Report indicated that Resident #1 was unable to identify the male staff member [exact name unknown] but stated he was an African American male. The Report indicated that an investigation was begun, and CNA #1 and CNA #2 were interviewed, and both denied the allegations. During a telephone interview on 07/03/24 at 10:05 A.M., the Director of Nurses (DON) said that on 05/06/24 at approximately 1:00 P.M. Resident #1's Family Member called her to report an allegation of sexual abuse that occurred to Resident #1 during the past weekend (dates were 5/04/24 and 5/05/24). The DON said that on 05/06/24 after the phone call, she asked the Assistant Director of Nurses (ADON) to begin an investigation into the allegation of sexual abuse. The DON said that she thought the ADON was investigating the allegation of sexual abuse and said she did not ask the ADON what the disposition of the investigation was before she went home on 5/06/24. The DON said that the next day, she was informed by the ADON that she had not investigated the allegation of sexual abuse and said the ADON thought she (the DON) was investigating the allegation of sexual abuse and said it was a miscommunication between the ADON and herself. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said that she reported the allegation of sexual abuse to the Department of Public Health (DPH) via the HCFRS system on 5/07/24, the next day. The DON said that the allegation of sexual abuse should have been reported to DPH on 5/06/24 within two hours of being notified of the allegation of sexual abuse. During an interview on 07/02/24 at 3:50 P.M., the Administrator said that the allegation of sexual abuse was reported to the DON on 5/06/24 and was not reported to the DPH until 5/07/24, the next day. The Administrator said it was her expectation that any allegation of abuse be reported to the DPH within two hours of the allegation being made.