STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225414	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Manor Health Care Inc	215 Thatcher Street Brockton, MA 02302

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure care was provided to one Resident (#5), of 21 sampled residents, in accordance with professional standards of practice. Specifically, the facility failed to follow physician's orders to hold Resident #5's midodrine (prescription medication used to treat low blood pressure) per ordered parameters. Findings include:Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following:-The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following:-Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Resident #5 was admitted to the facility in October 2021 with diagnoses which included end stage renal (kidney) disease (ESRD) and dependence on dialysis (a process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semi-permeable membrane). Review of Resident #5's Minimum Data Set (MDS) Assessment, dated 10/7/25, indicated he/she received dialysis. Review of Resident #5's Physician's Orders indicated but was not limited to:-Midodrine 10 milligrams (mg) by mouth on Mondays, Wednesdays and Fridays, hold for systolic blood pressure (SBP, the top number in a blood pressure reading, representing the pressure in your arteries when your heart contracts (beats) and pushes blood out) above 130, dated 10/19/22 Review of Resident #5's October, November, and December 2025 Medication Administration Record's (MAR) indicated his/her midodrine had been administered when his/her systolic blood pressure exceeded the ordered parameters and was above 130. Further review of Resident #5's October 2025 MAR indicated he/she was administered midodrine with a documented SBP greater than 130 on 11 occasions, as follows:-10/1/25: SBP of 137-10/3/25: SBP of 131-10/10/25: SBP of 149-10/13/25: SBP of 132-10/15/25: SBP of 142-10/17/25: SBP of 142-10/20/25: SBP of 159-10/22/25: SBP of 138-10/24/25: SBP of 140-10/27/25: SBP of 137-10/29/25: SBP of 145 Further review of Resident #5's November 2025 MAR indicated he/she was administered midodrine with a documented SBP greater than 130 on seven occasions, as follows:-11/3/25: SBP of 155-11/5/25: SBP of 139-11/7/25: SBP of 138-11/12/25: SBP of 148-11/19/25: SBP of 141-11/21/25: SBP of 136-11/28/25: SBP of 149 Further review of Resident #5's December 2025 MAR indicated he/she was administered midodrine with a documented SBP greater than 130 on four occasions, as follows:-12/3/25: SBP of 143-12/5/25: SBP of 138-12/8/25: SBP of 142-12/10/25: SBP of 149 During an interview on 12/10/25 at 4:36 P.M., Nurse #5 said Resident #5 was prescribed medication that had order parameters. Nurse # 5 said if Resident #5's systolic blood pressure was above 130, his/her midodrine should not have been administered. During an interview on 12/11/25 at 7:37 A.M., Nurse #2 said Resident #5 was ordered midodrine on days he/she went to dialysis. Nurse #2 said there was a (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	parameter in place to ensure the medication was not administered if his/her systolic blood pressure was above 130. Nurse #2 said in the MAR there is a code to indicate that the medication was not administered because the vital signs exceeded the parameter. During an interview on 12/11/25 at 10:58 A.M., Unit Manager #1 said Resident #5 had an order for midodrine to be administered on days he/she went to dialysis and that it should not be administered if his/her systolic blood pressure was above 130. Unit Manager #1 said the nurse should document in the MAR that the medication was not administered due to the vital sign parameters. Unit Manager #1 reviewed Resident #5's MAR and said there were several dates that the midodrine was documented as administered when his/her systolic blood pressure was above 130. During an interview on 12/11/25 at 12:41 P.M., the Director of Nurses (DON) said she reviewed Resident #5's medical record and found documentation that midodrine was held on 11/24/25 and 11/26/25 but did not see any evidence in the medical record to show that the midodrine was not administered due to ordered parameters on any other dates. During an interview on 12/11/25 at 11:58 A.M., the DON said the expectation was for physician's orders to be followed as prescribed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on records reviewed, document review, and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment. Specifically, the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) while providing care to one Resident (#107), who was on contact precautions, to prevent the potential spread of infection. Findings include:Review of the facility's policy titled Transmission-Based Precautions, last revised March 2025, indicated but was not limited to:-Contact Precautions: Isolation gowns and gloves are required.-Contact Precautions are intended to prevent the transmission of infections that are spread by direct (person to person) or indirect (resident's environment and equipment).-Diseases/microorganisms requiring Contact Precautions include but are not limited to:-Vancomycin-Resistant Enterococci (VRE, Multi-Drug Resistant Organism (MDRO), a species of enterococcus which have developed resistance to the antibiotic, vancomycin.)Resident #107 was admitted to the facility in May 2025 with diagnoses including urinary tract infection (UTI).On 12/8/25 at 1:13 P.M., the surveyor observed a sign for Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of MDROs that employs targeted gown and glove use during high contact resident care activities) and for Contact Precautions outside of Resident #107's room.Review of the EBP sign indicated but was not limited to:- STOP ENHANCED BARRIER PRECAUTIONS- EVERYONE MUST:- Clean their hands, including before entering and when leaving the room.- PROVIDERS AND STAFF MUST ALSO:- Wear gloves and a gown for the following High-Contact Resident Care Activities.- Dressing- Bathing/Showering- Transferring- Changing Linens- Providing Hygiene- Changing briefs or assisting with toileting- Device care or use: central line, urinary catheter, feeding tube, tracheostomy- Wound Care: any skin opening requiring a dressingReview of the Contact Precaution sign indicated but was not limited to:-Contact Precautions (If you have questions go to Nurse Station)-EVERYONE MUST: -Clean hands when entering and leaving room -Follow Standard Precautions -Gown and gloves when entering roomDOCTORS AND STAFF MUST: -Use patient dedication or disposable equipment -Clean and disinfect shared equipmentOn 12/8/25 at 1:47 P.M., the surveyor observed Certified Nursing Assistant (CNA) #1 and CNA #2 enter Resident #107's room. Both CNAs performed hand hygiene and donned (put on) gloves and brought in a mechanical lift. CNA #1 and CNA #2 assisted Resident #107 back to bed using a mechanical lift. CNA #1 exited Resident #107 room doffed (took off) her gloves and took the mechanical lift into another resident's room, she failed to perform hand hygiene or wipe down the mechanical lift before bringing it into another resident's room. CNA #2 exited Resident #107's room doffed her gloves but failed to perform hand hygiene.On 12/9/25 at 3:40 P.M., the surveyor observed:-CNA #3 in Resident #107's room talking to him/her, she was not wearing gloves or a gown.-CNA #3 exited his/her room and failed to perform hand hygiene.On 12/9/25 at 3:57 P.M., the surveyor observed:-Nurse #3 enter Resident #107's room and move his/her bed.-Nurse #3 failed to don gloves and gown prior to entering the room.-Nurse #3 exited the room and failed to perform hand hygiene.-Nurse #3 then went up directly to another resident and touched him/her.On 12/9/25 at 4:00 P.M., the surveyor observed:-CNA #3 go into Resident #107's room she did not perform hand hygiene and did not don PPE prior to entering the room.-CNA #3 exited Resident #107's room did not perform hand hygiene and went directly to the clean linen cart.-CNA #3 re-entered Resident #107's room failing to perform hand hygiene and don PPE, and assisted him/her in bed-CNA #3 failed to perform hand hygiene after exiting the room.On 12/10/25 at 7:55 A.M., the surveyor observed:-CNA #4 bring a breakfast tray into Resident #107's room, failing to don PPE prior to entering room, position him/her in bed and set-up their breakfast tray.-CNA #4 exited his/her room and failed to perform hand hygiene.On 12/10/25 at 9:26 A.M., the surveyor observed:-CNA #2 don gloves and enter Resident #107's room, failing to perform hand hygiene prior to donning gloves and failed to don a gown.During an interview on 12/8/25 at 11:32 A.M., Unit Manager #2 said Resident #107 was on contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precautions for VRE in his/her urine. During an interview on 12/8/25 at 1:53 P.M, CNA #2 said Resident #107 had an infection in his/her urine and was on contact precautions. She said staff needed to wear gloves in Resident #107's room but needed a gown only when helping him/her with care that involved changing his/her brief. She said her and CNA #1 only helped Resident #107 into bed.During an interview on 12/8/25 at 1:57 P.M., CNA #1 said Resident #107 was on Contact Precautions for a UTI.During an interview on 12/9/25 at 3:44 P.M., CNA #3 reviewed the EBP and Contact Precaution signs outside of Resident #107's room and said Resident #107 was not on precautions.During an interview on 12/9/25 at 4:02 P.M., Nurse #3 reviewed the EBP and Contact Precaution signs outside of Resident #107's room and said he/she required contact precautions for VRE in their urine. She said CNA #3 should not have gone in and out of Resident #107's room without performing hand hygiene and donning PPE. She said CNA #3 should not have gone over to the linen cart without performing hand hygiene. She said that she did not have to don PPE because she had not done care for Resident #107 but had only moved his/her bed.During an interview on 12/10/25 at 9:26 A.M., CNA #2 said Resident #107 was on contact precautions and she needed to wear a gown and gloves when providing care for him/her and should have worn PPE but she did not.During an interview on 12/10/25 at 3:41 P.M., the Infection Perfectionist said Resident #107 was on Contact Precautions for VRE in his/her urine but is on EBP at baseline. She said all staff that entered Resident #107's room should have followed the more stringent precautions which, in his/her case, were contact precautions. She said all staff must perform hand hygiene and don and doff gloves and a gown upon entering and exiting Resident #107's room. She said all equipment must be wiped down when going from one resident's room to another's especially if they were on precautions.During an interview on 12/11/25 at 1:11 P.M., the Director of Nursing (DON) said all staff should follow the more stringent signs for precautions and must wear appropriate PPE.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure the physician or nurse practitioner (NP) was notified timely of critical urinalysis culture & sensitivity (C&S) report for one Resident (#69), out of a total sample of 21 residents. Specifically, for Resident #69, their urinalysis C&S final report was reviewed with the NP on 12/1/25, four days after it was received in the facility on 11/27/25, resulting in Resident #69 receiving six doses of Macrobid (antibiotic) 100 milligrams (mg) before it was discontinued for a more effective antibiotic. Findings include: Review of the facility's policy titled Antibiotic Stewardship-Orders for Antibiotics, revised December 2016, indicated but was not limited to the following:1. Appropriate indications for use of antibiotics include:-Pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending).2. When a culture and sensitivity (C&S) Is ordered, it will be completed, and:-Lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. Resident #69 was admitted to the facility in October 2025 with diagnoses which included severe chronic obstructive pulmonary disease (COPD) oxygen dependent, coronary artery disease, and atrial fibrillation. Review of the Minimum Data Set (MDS) assessment, dated 10/21/25, indicated Resident #69 scored 12 out of 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #65 had moderate cognitive deficits. Review of Resident #69's Physician's Orders indicated:-May go on leave of absence (LOA) 11/26/25 Return 11/28/2025, May Take Medications.-Macrobid (antibiotic) Oral Capsule 100 mg (Nitrofurantoin Macro) Give 100 mg by mouth two times a day for positive urinary tract infection (UTI) for 5 days, order date 11/26/25 with start date 11/28/25 and discontinued 12/01/25.-Ertapenem (antibiotic) Sodium Injection Solution Reconstituted 1 gram (gm), inject 1 gm intramuscularly one time only for UTI Klebsiella (bacteria) for 10 days reconstitute with 3.2 milliliters (ml) 1% lidocaine, order date 12/1/25. Review of the November 2025 Medication Administration Record (MAR) indicated Resident #69 received Macrobid 100 mg on 11/28/25 at 10:00 P.M., 11/29/25 at 10:00 A.M. and 10:00 P.M., and 11/30/25 at 10:00 A.M. and 10:00 P.M. Review of the December 2025 MAR indicated Resident #69 received Macrobid 100 mg on12/1/25 at 10:00 A.M. Review of a Nursing Note, dated 11/24/25 at 12:47 P.M., indicated at 12:30 P.M. a urine sample was obtained for a repeat urinalysis (U/A) and C&S. Urine Dark Yellow. Specs Dated, Timed, Labeled, Lab made aware for pick up.Review of Lab/X-ray note, dated 12/1/25 at 1:56 P.M., indicated urine culture critical final report, dated 11/27/25 at 12:42 P.M., was positive for Klebsiella pneumonia urine greater than 100,000 colony-forming unit (cfu)/ml. NP Reviewed. New order to discontinue macrodantin, start ertapenem 1 gm with 3.2 ml lidocaine 1% intramuscular once daily for 10 days.Review of NP #1's progress note, dated 12/1/25, indicated Resident #69 recently started on antibiotics for UTI, was being treated with Macrobid however sensitivities revealed Klebsiella and more sensitive to ertapenem. During an interview on 12/11/25 at 10:55 A.M., Nurse Manager #3 said Resident #69 was symptomatic with UTI symptoms. She said the facility had received a call from the lab telling them the first urinalysis sample was not picked up in time, and they had to repeat the urinalysis on 11/24/25. She said she had notified the Physician who wanted to start Resident #69 on Macrobid when the Resident returned from their medical LOA on 11/28/25. Nurse Manager #3 reviewed the electronic medical urinalysis results which included the C&S, which indicated the collection date of 11/24/25 and the final results were reported 11/27/25. The report further indicated that it was accessed by the facility for the first time on 12/1/25. Nurse Manager #3 said the lab would have faxed and/or called over the C&S results on 11/27/25 and the C&S should have been reported to the on-call physician or NP, but it was not until 12/1/25. On 12/11/25 at 11:05 A.M., Resident #69's urinalysis C&S faxed results were in a wall folder at the nurses' station. The lab results had a fax time stamp of 11/27/25 at 10:46 A.M., and there was no written notation on the lab report indicating the results were read. During an interview on 12/11/25 at 11:17 A.M., Nurse Manager #3 said that when she returned to work on 12/1/25, the C&S was reviewed (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with NP #1. She said NP #1 then changed the antibiotics from the prescribed Macrobid to the more sensitive Ertapenem antibiotic. During an interview on 12/11/25 at 11:45 A.M., Nurse #7 said she was here on 11/27/25 and said she did not see the fax of the urinalysis and C&S. She said if she had, she would have called the Physician or NP and informed them of the sensitivity report and she would have written a note on their response. On 12/11/25 at 11:12 A.M., the surveyor left a voicemail message on NP #1's phone and did not get a return phone call.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure all medications were stored and labeled in accordance with currently accepted professional standards. Specifically, the facility failed to ensure staff properly labeled and stored all medications in one of three medication carts reviewed.Findings include: Review of the facility's policy titled Medication Labeling and Storage, undated, indicated but was not limited to the following:-Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. -Medications are kept in the packaging in which they were dispensed by the pharmacy-Controlled substances and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detectedDuring an observation with interview on 12/10/25 at 11:30 A.M., the surveyor completed a review of the medication cart on the Applewood Unit with Nurse #3, and made the following observations:-In the top drawer there was one small, clear plastic medication cup, uncovered and not labeled, which contained seven loose pills.Nurse #3 said the medication cup with the loose pills was for Resident #76. She said she had prepared the morning medications and then realized the Resident was attending activities and had been keeping the medications in the top drawer until the Resident returned. She said she had not discarded the medications because there was a controlled substance in the cup. She said the standard practice was to discard the medications, as indicated, if the Resident was not available and she had not done this.Review of the Medication Administration Record (MAR) for Resident #76 indicated the following medications were scheduled for 9:00 A.M.:Aspirin 81 milligrams (mg)Losartan potassium tablet 50 mgMetformin HCl ER (extended release) 500 mg, give two tabletsMetoprolol succinate ER 25 mgMultivitaminPregabalin 100 mg (a controlled substance)During an interview on 12/11/25 at 11:57 A.M., the Director of Nurses said the nurse should not store medications in an unlabeled medication cup in the medication cart and the nurse should have followed the appropriate procedures to discard the medications.