STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225451	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Katzman Family Center for Living	17 Lafayette Avenue Chelsea, MA 02150

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 Based on record review and interview, the facility failed to ensure that Minimum Data Set (MDS) assessments were coded accurately for two Residents (#19 and #118) out of a total sample of 26 residents. Specifically, the facility staff failed to ensure that an MDS Assessment: 1.) For Resident #19, was accurately coded relative to a.) oxygen use and b.) use of a non-invasive mechanical ventilator (continuous positive airway pressure, CPAP). 2.) For Resident #118, was accurately coded for discharge location. Findings include: 1.) Resident #19 was admitted to the facility in December 2023 with diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes. Review of Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual, dated October 2023, indicated the following: O0110: Special Treatments, Procedures, and Programs *Steps for Assessment 1. Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the assessment period defined for each column. *Coding Instructions for Column b. While a Resident -Check all treatments, procedures, and programs that the resident received or performed after admission/entry or reentry to the facility and within the last 14 days. If no treatments, procedures or programs were received by, performed on, or participated in by the resident within the last 14 days or since admission/entry or reentry, check Z, none of the above. a.) Review of the Minimum Data Set (MDS) assessment, dated 3/9/24, indicated: (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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	C1. Oxygen Therapy- not checked, left blank. Review of the physician's order, dated 1/25/24, indicated: - Supplemental oxygen 0.5-2 liters per minute (L/min) by nasal cannula (NC) as needed for oxygen saturation (O2 sat) greater than 92% as needed Review of the oxygen saturation summary indicated Resident #19 received oxygen via nasal cannula on the following dates: - 3/2/24, 3/4/24, 3/6/24, 3/7/24, 3/8/24, and 3/9/24 Review of the nursing notes dated, 3/2/24, 3/3/24, 3/4/24, 3/5/24, 3/6/24, 3/7/24, and 3/8/24, indicated Resident #19 received oxygen administration. During an interview on 5/8/24 at 9:49 A.M., Nurse #2 said Resident #19 has been wearing continuous oxygen since his/her most recent hospitalization (December 2023). During an interview on 5/8/24 at 3:45 P.M., Unit Manager #1 said Resident #19 has been utilizing oxygen. b.) Review of the Minimum Data Set (MDS) assessment, dated 3/9/24, indicated: G1. Non-invasive Mechanical Ventilator- not checked, left blank. Review of the physician's order, dated 12/8/23, indicated: -Provide CPAP at night at bedtime related to sleep apnea. Review of the Treatment Administration Record (TAR), dated March 2024, indicated from 3/1/24 to 3/9/24 nursing applied Resident #19's CPAP as ordered by the physician. During an interview on 5/8/24 at 3:52 P.M., Unit Manager #1 said Resident #19 uses a CPAP every night. During an interview on 5/9/24 at 10:33 A.M., the Regional Nurse said the MDS Nurse should code MDS assessments based on the RAI manual. 48671 2. Resident #118 was admitted in March 2024 with a diagnoses that included pneumonitis, multiple fractures of ribs, urinary tract infection, diabetes, and vascular dementia. Review of Resident #118's most recent Minimum Data Set (MDS), dated [DATE], indicated in section A of the MDS that the Resident discharged to a short-term general hospital. Review of Resident #118's social services note, dated 4/1/24, indicated the Resident was discharged home with services. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #118's nursing progress note, dated 4/1/24, indicated, Resident was assessed by Dr. (doctor) and ordered to be discharged home with meds (medications) and services. He/she was picked up today about 11am. Review of Resident #118's nurse practitioner note, dated 4/1/24, indicated, May discharge patient home with meds and services. During an interview on 5/9/24 at 10:34 A.M., the Regional Nurse said Resident #118 was discharged home, he said the MDS should have been coded correctly, following the Resident Assessment Instrument (RAI) manual.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44095 Based on record review, policy review and interviews, the facility failed to meet professional standards of quality for three Residents (#19, #32, and #27) out of a total sample of 26 residents. 1.) For Resident #19, the facility failed to implement physician's orders to notify the physician of a weight change. 2.) For Resident #32 and #27, the facility failed to ensure nursing implemented physician's orders for urinary catheter changes. Findings include: 1.) For Resident #19, the facility failed to implement physician's orders to notify the physician of a weight change. Review of the facility policy, Physician/ Family Notification, undated, indicated: 1. The Nurse Supervisor or Charge Nurse will notify a resident's Attending Physician or On-Call Physician when there has been: i. Instructions to notify the physician of changes in the resident's condition. Resident #19 was admitted to the facility in December 2023 with diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes. Review of the Minimum Data Set (MDS) assessment, dated 3/9/24, indicated Resident #19 had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 which indicated he/she was cognitively intact. During an interview on 5/7/24 at 4:03 P.M., Resident #19 said his/her weights have been going up and he/she is weighed daily. Review of the plan of care related to congestive heart failure, indicated Resident #19 is at risk for complications due to congestive heart failure, dated 12/8/23, interventions included: -Weigh daily before breakfast. Notify provider (MD/NP) for gain (+) 3 pounds (lbs) in one day or +/-5 lbs in 1 week. Review of the physician's order, dated 1/27/24, indicated: - Weigh daily before breakfast. Notify provider (MD/NP) for gain (+) 3 pounds (lbs) in one day or +/-5 lbs in 1 week. Review of the physician progress note, dated 4/9/24, indicated: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. NYHA class 3 heart failure with borderline preserved ejection fraction (HCC) -Continue daily weights as ordered. Review of the Weight Summary and Medication Administration Record (MAR), dated May 2024, indicated Resident #19 weighed the following: 5/1/24 250.8 lbs 5/2/24 251.0 lbs 5/3/24 253.4 lbs 5/4/24 253.0 lbs 5/5/24 255.0 lbs 5/6/24 no weight obtained. 5/7/24 258.0 lbs, a weight gain of 7.2 pounds in 6 days 5/8/24 259.4 lbs, a weight gain of 8.6 pounds in 7 days During an interview on 5/8/24 at 9:50 A.M., Nurse #2 said that Resident #19 requires daily weights. Nurse #2 said Resident #19 has a diagnosis of CHF and was hospitalized back in December for heart failure. Nurse #2 said Resident #19 became so sick, and he/she could gain 3 pounds over night. Nurse #2 said today's weight is 262 pounds (documented as 259.4, in the medical record). Nurse #2 said that she has not had to notify the physician about Resident #19's weights this week (record review indicated Nurse #2 was Resident #19's assigned Nurse on 5/1/24, 5/6/24, 5/7/24, and 5/8/24). Nurse #2 said the weights have been good this week and she would need to notify the provider for a weight gain of 3 pounds in 1 day or 5 pounds in one week. Nurse #2 said when she puts the weights in the electronic health record, she reviews the weights to ensure that she doesn't need to notify the provider. Nurse #2 reviewed the weights with the surveyor and said Resident #19's weights are good, and she did not need to notify the physician. Review of the nursing note, dated 5/8/24 at 9:05 A.M., indicated: - The resident complained of (C/O) shortness of breath when trying to wean him/her off oxygen. New orders from Nurse Practitioner (NP); Supplemental oxygen 0.5-2L/min via N/C as needed for shortness of breath (SOB). Further review of the note failed to indicate the NP was made aware of the weight gain. Review of the nursing note, dated, 5/8/24 at 1:51 P.M., indicated: - NP called with new orders for supplemental oxygen which override the previous orders; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) Supplemental oxygen 0.5-2 L/min via N/C titrate to maintain 95% and above continuously to ensure Pt is not SOB. every shift Continue with plan of care. Further review of the note failed to indicate the NP was made aware of the weight gain. On 5/8/24 at 3:26 P.M., the surveyor called the Nurse Practitioner and requested a call back. During an interview on 5/8/24 at 3:45 P.M., Unit Manager #1 said that he notified the NP of Resident #19's shortness of breath and obtained new orders for oxygen continuous oxygen use. Unit Manager #1 said he would have the physician review the weights on Friday 5/10/24. During an interview on 5/8/24 at 3:54 P.M., the Triage Nurse, from the Nurse Practitioner's office, called the surveyor and reviewed the NP's note from 5/8/24. The Triage Nurse said that the weight gain was not reported to the NP, but she would notify the NP of the weight gain. During a follow up interview on 5/8/24 at 4:10 P.M., Unit Manager #1 reviewed weights with the surveyor and said nursing should have notified the provider of the 5-pound weight gain on 5/7/24 but they did not. Unit Manager #1 said when nursing notifies providers of weight gains, the notification would be documented in the nurses note. The surveyor and Unit Manager #1 reviewed the nursing notes and there was no documentation to support that nursing made the provider aware of the weight gain. Review of the nursing note dated 5/8/24 at 4:55 P.M., indicated: - NP called back regarding weight gain and elevated blood pressure. Lung sounds clear, denies SOB, no increased edema noted. New orders from NP; 1) STAT (immediately, without a delay) BMP (basic metabolic panel, laboratory test to check for electrolytes) 2) STAT NT-pro BNP (B-type Natriuretic Peptide, laboratory test used diagnose or rule out heart failure) Continue with plan of care. During a follow up interview on 5/9/24 at 10:00 A.M., Unit Manager #1 said that after he had spoken to the surveyor on 5/8/24 the NP called back after the NP became aware of Resident #19's weights and she ordered STAT labs to rule out congestive heart failure. During an interview on 5/9/24 at 1:24 P.M., the Director of Nursing said nursing should monitor Resident #19's daily weights per the physician's order and report changes as ordered. 2.) For Resident #32 and #27 the facility failed to ensure nursing implemented physician's orders for urinary catheter changes, as ordered by the physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.) For Resident #32 the facility failed to implement physician's orders for suprapubic catheter changes (an indwelling urinary catheter placed directly into the bladder through the abdomen) Specifically, the facility staff failed to ensure the correct size indwelling urinary catheter balloon was in place for Resident #32 as indicated in the plan of care (physician's order was not complete). b.) For Resident #27 the facility failed to implement physician's orders for indwelling urinary catheter/Foley (a flexible tube that passes through the urethra and into the bladder to drain urine) changes. Specifically, the facility staff failed to ensure the correct size indwelling urinary catheter was in place for Resident #27 as ordered by the physician. Review of the facility policy, Catheter Care, Urinary, indicated the purpose is prevent catheter associated infections. *Preparation 1. Review the resident's care plan to assess for any special needs of the resident. *General Guidelines -Changing Catheters 2. A physician's order is needed to insert and indwelling catheter including catheter care schedule and size of catheter. a.) Resident #32 was admitted to the facility in June 2013 with diagnoses including diabetes, neuromuscular dysfunction of the bladder, peripheral vascular disease, and benign prostate hyperplasia. Review of the Minimum Data Set (MDS) assessment, dated 4/20/24, indicated Resident #32 had an indwelling urinary catheter. Review of the physician's order, dated 3/5/23, indicated: -change suprapubic every 21 days and as needed. 14 french silicone coated only. Further review of the physician's order failed to include the size of the balloon. Review of the plan of care related to indwelling suprapubic catheter placement indicated: Resident #32 is at risk for complications related to insertion of indwelling suprapubic catheter due to urinary retention, dated as initiated 1/29/16, interventions included: - Change every 3 weeks or as needed - 14 French 10 cc balloon. Review of the Treatment Administration Record (TAR), dated April 2024, indicated on 4/8/24 and 4/29/24, nursing implemented the physician's order and changed the indwelling suprapubic catheter. Review of the nursing note, dated 4/8/24, indicated: - Change Suprapubic every 21 days and as needed. 14 fr silicone coated only. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Suprabic cath changed without any event. Review of the nursing note, by Nurse #1, dated 4/28/24, indicated: - Suprabic cath changed today without any issue. Review of the Urinary/ Straight Catheterization Competency, dated as 1/7/20, indicated Nurse #1 was trained and competent on catheterization including: 1. Verify or obtain the physician's order. 16. Document size of catheter inserted, amount of water in the balloon, patients' response to procedure and assessment of urine. On 5/8/24 at 10:29 A.M., the surveyor and the Assistant Director of Nursing (ADON) observed Resident #32 in bed, Resident had a suprapubic indwelling catheter size 14 French and a 30-cc balloon, not a 10-cc balloon as indicated by Resident #32's plan of care. On 5/9/24 at 7:47 A.M., two surveyors and the ADON reviewed the physician's order which did not include a balloon size. The ADON said nursing should have clarified the physician's order before inserting the indwelling catheter. The care plan was reviewed, and the care plan indicated a 14 french and 10-cc balloon. The two surveyors and the ADON observed Resident #32 with a 14 French and a 30-cc balloon. During an interview on 5/9/24 at 1:30 P.M., the Director of Nursing (DON) said nursing should have implemented suprapubic catheter size including the balloon. The DON said if the correct size balloon was unavailable nursing should have notified the provider and obtained a new order for the size available in stock. b.) Resident #27 was admitted to the facility in June 2022 with diagnoses including urinary retention and major depressive disorder. Review of the Minimum Data Set (MDS) assessment, dated 4/6/24, indicated Resident #27 had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 which indicated he/she was cognitively intact. The MDS indicated Resident #27 required an indwelling urinary catheter. During an interview on 5/7/24 at 8:07 A.M., Resident #37 was in his/her bed. Resident #37 said he/she did not like his/her indwelling urinary catheter. On 5/8/24 at 7:55 A.M., at the surveyor observed Certified Nurse Assistant (CNA) #1 providing care to Resident #27, there was a 14 french (fr) 10 cc indwelling urinary catheter. Review of the physician's order, dated 9/21/23, indicated: - Change catheter 12 Fr 10 cc as needed for blockage or leakage. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Foley catheter care every shift. Review of the plan of care related to indwelling foley catheter placement, indicated Resident #27 is at risk for complications related to insertion of an indwelling Foley catheter due to urinary retention, dated as reviewed 4/9/24, interventions included: -May change foley catheter with 12 french 10 cc secondary to blockage as needed. Review of the nursing progress note, dated 3/10/24, indicated: - Change catheter 12 Fr 10 cc as needed for blockage or leakage as needed. Resident complained of pain in his/her bladder. Bladder distended, Foley catheter changed due to blockage. Review of the Treatment Administration Record (TAR), dated March 2024, indicated nursing changed the catheter on 3/9/24. Review of the nursing progress note by Nurse #2, dated 3/27/24, indicated: - Foley catheter blocked. New catheter inserted without difficulty. Resident tolerated well. Catheter now patent. Review of the Treatment Administration Record (TAR), dated March 2024, failed to include nursing inserted a new catheter. Review of the Urinary/ Straight Catheterization Competency, dated as 8/11/20, indicated Nurse #2 was trained and competent on catheterization including: 1. Verify or obtain the physician's order. 16. Document size of catheter inserted, amount of water in the balloon, patients' response to procedure and assessment of urine. During an interview on 5/8/24 at 9:36 A.M., Nurse #2 said prior to changing an indwelling catheter, she would look to see what was currently inserted into Resident #27 and then she would verify the physician's order and care plan prior replacing the catheter. On 5/8/24 at 9:48 A.M., the surveyor and Nurse #2 observed Resident #27 indwelling urinary catheter together and Nurse #2 said the catheter that was inserted into Resident #27 was not the correct size according to the physician's order. During an interview on 5/8/24 at 3:38 P.M., Unit Manager #1 said there was at one point, a back order and the facility only had 14 french catheters. Unit Manager #1 said nursing should implement the correct catheter size based on the physician's order. Unit Manager #1 said that if nursing did not have the correct catheter size the physician should be made aware and a new order should be obtained for the insertion based on the catheter availability. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/24 at 1:29 P.M., the Director of Nursing said that nursing should verify the correct indwelling catheter size prior to implementing the physician's order. The DON said that if the correct size was unavailable nursing should reach out to the provider and obtain a new order with the size that is available.

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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. 44095 Based on observation, record review, policy review, and interviews, for one Resident (#19), out of 26 sampled residents, the facility failed to maintain an accurate medical record in accordance with accepted professional standards and practice. Specifically, for Resident #19, the facility failed to ensure nursing documented oxygen administration on the treatment administration record. Findings include: Review of the facility policy, Oxygen Administration, undated, indicated the purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify there is a physician's order for the procedure. 2. Review the resident's care plan to assess for any special needs of the resident. Steps in the Procedure 4. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. Reporting 1. Report information in accordance with facility policy and professional standards of practice. Resident #19 was admitted to the facility in December 2023 with diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes. Review of the Minimum Data Set (MDS) assessment, dated 3/9/24, indicated Resident #19 had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 which indicated he/she was cognitively intact. On 5/7/24 at 8:37 A.M., and on 5/7/24 at 12:01 P.M., the surveyor observed Resident #19 being administered continuous oxygen via nasal cannula at 1 liter per minute. During an interview on 5/7/24 at 4:03 P.M., Resident #19 was in his/her bedroom being administered oxygen at 3 liters per minute. Resident #19 said he/she needs nurses to help with oxygen administration and he/she cannot see the settings. Resident #19 said he/she has been wearing oxygen continuously for a few months. Review of the physician's order, dated 1/25/24, indicated: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Supplemental oxygen 0.5-2 liters/minute via nasal cannula (NC) as needed for oxygen saturation (O2 sat) greater than 92%, as needed. Review of the plan of care related to COPD: Resident #19 is at risk for complications due to COPD, dated 12/8/23, indicated: - Apply O2 via NC as needed. Review of the oxygen saturation summary indicated facility staff recorded Resident #19's oxygen saturations on the following dates and times: 5/1/24 12:57 P.M., 98.0% Oxygen via Nasal Cannula 5/2/24 9:08 A.M., 99.0% Oxygen via Nasal Cannula 5/3/24 8:36 A.M., 98.0% Oxygen via Nasal Cannula 5/4/24 1:09 P.M., 99.0% Oxygen via Nasal Cannula 5/5/24 9:33 A.M., 99.0% Oxygen via Nasal Cannula 5/7/24 1:09 P.M., 98.0% Oxygen via Nasal Cannula Review of the Treatment Administration Record, dated May 2024, failed to include documentation to support that nursing administered the as needed oxygen from 5/1/24 to 5/7/24. Further review of the nurses notes from 5/1/24 to 5/7/24, failed to include the flow rate of oxygen that nursing was administering to Resident #19. During an interview on 5/8/24 at 9:49 A.M., Nurse #2 said Resident #19 has been wearing continuous oxygen since his/her most recent hospitalization (December 2023). Nurse #2 said that oxygen administration is documented on the treatment administration record (TAR). Nurse #2 said she works the medication cart that Resident #19 is on 4 days a week and that she has not documented on the TAR as required but should have. Nurse #2 continued to say Resident #19 should have had an order for continuous oxygen but did not. Review of the nursing note, dated, 5/8/24 at 1:51 P.M., indicated: - new orders for supplemental oxygen which override the previous orders; During an interview on 5/8/24 at 3:45 P.M., Unit Manager #1 said Resident #19 has been on and off oxygen and since his/her most recent hospitalization he/she has been wearing the oxygen continuously. Unit Manager #1 and the surveyor reviewed the medical record, and he said that nursing should be documenting the oxygen administration on the TAR. Unit Manager #1 said that oxygen flow rate should be documented in the medical record. During an interview on 5/9/24 at 1:23 P.M., the Director of Nursing said that nursing should document the administration of oxygen on the treatment administration record.