

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER Cedarwood Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 130 Chestnut Street Franklin, MA 02038	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>40702</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had a been diagnosed with a deep vein thrombosis (DVT), with new orders from the Nurse Practitioner for an anticoagulant medication to be started, the Facility failed to ensure nursing notified Resident #1's Physician, when his/her medication was unavailable to be administered in accordance with his/her Physician orders, as a result Resident #1 did not receive his/her first scheduled dose, he/she was transferred to the Hospital Emergency Department (ED) for evaluation and was admitted .</p> <p>Findings include:</p> <p>The Facility Policy, titled Change in Resident's Condition or Status and Notification, date reviewed June 2022, indicated the following:</p> <ul style="list-style-type: none"> -to ensure that the resident and/or his/her representative, and his/her attending Physician/Physician extender are notified of changes in the resident's medical/mental condition and/or status -the RN Nurse Supervisor/Charge Nurse will notify the resident's attending Physician, Physician extender or on-call Physician when there has been a significant change in the resident's medical/mental conditions and/or status including but not limited to: A need to alter the resident's treatment significantly -the Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical condition or status <p>Resident #1 was admitted to the Facility in February 2024, diagnoses included atrial fibrillation (irregular heartbeat), hypertension, history of transient ischemic attack (TIA, mini stroke), chronic pain syndrome, mild cognitive impairment, muscle weakness, and hyperlipidemia (high cholesterol).</p> <p>Review of Resident #1's Nurse Practitioner Progress Note, dated 3/08/24, indicated that Resident #1's ultrasound report was positive for a DVT of his/her left lower extremity (LLE), and that Eliquis (anticoagulant) will be initiated.</p> <p>Review of Resident #1's Physician orders, dated 3/08/24, indicated there was a new order as follows:</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Eliquis 5 mg by mouth twice a day times one week, then Eliquis 2.5 mg by mouth twice a day times six months</p> <p>Review of Resident #1's Medication Administration Record (MAR), for March 2024, indicated that on 3/09/24 Resident #1's Eliquis 5 milligrams (mg) was not administered at 8:00 A.M. as ordered, and Nurse #1 documented code 9 which indicated see nurses notes.</p> <p>Review of Resident #1's Nurse Progress Notes, on the following dates indicated:</p> <p>-3/09/24 at 06:15 A.M., late entry (by Nurse #3) Pharm delivered medications, but Eliquis was not in delivery</p> <p>-3/09/24 at 13:43 (1:43 P.M.) (written by Nurse #1) (Medication Administration Note) Eliquis oral tablet 5 mg, give 5 mg by mouth two times a day for DVT not available (therefore, was not administered).</p> <p>During an interview on 4/24/24 at 3:40 P.M., Nurse #1 said she worked 7:00 A.M. to 7:00 P.M. on 3/08/24 and 3/09/24 and was assigned to care for Resident #1. Nurse #1 said Resident #1 had an ultrasound of his/her LLE on 3/08/24 which were positive for a DVT. Nurse #1 said the NP was in the Facility, received the results of the ultrasound and she (NP) wrote new orders for Resident #1 to start Eliquis. Nurse #1 said she entered Resident #1's new medication orders into their electronic medical record system (Point Click Care/PCC) and said once the orders are entered they are sent (electronically transmitted) directly to Pharmacy A that the Facility uses.</p> <p>Nurse #1 said on 3/09/24, Resident #1's Eliquis medication was unavailable to administer to him/her at 8:00 A.M. because it had not been delivered from the Pharmacy and said she called the Pharmacy (could not recall who she spoke to) and was told the Eliquis would be delivered on the next scheduled delivery. Nurse #1 said she checked the Facility E-Kit (emergency medication supply) and Eliquis was not one of the medications available. Nurse #1 said she had not notified Resident #1's Physician that his/her Eliquis was not available to administer to him/her at 8:00 A.M. because the Pharmacy said it would be delivered on the next scheduled delivery.</p> <p>Nurse #1 said on 3/09/24 Resident #1's Family Member told her Resident #1 was having a lot of pain in his/her LLE, and when she looked at his/her LLE it was swollen and discolored. Nurse #1 said she then asked the MDS Coordinator to assess Resident #1's LLE and after the MDS Coordinator assessed Resident #1 she told Nurse #1 that Resident #1 needed to be sent to the Hospital ED because the Facility did not have Eliquis to administer to him/her.</p> <p>During an interview on 4/24/24 at 1:21 P.M., the Nurse Practitioner (NP) said she was at the Facility on 3/08/24 when Resident #1's ultrasound was done, and the imaging technician informed her that Resident #1's ultrasound of his/her left lower extremity looked positive for a DVT. The NP said she wrote orders for Resident #1 to start Eliquis for the DVT. The NP said said she was not notified on 3/09/24 by nursing that Resident #1's had not received his/her Eliquis, because it had not been delivered from the Pharmacy. The NP said Resident #1 was transferred to the Hospital ED on 3/09/24 due to increased LLE pain.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/25/24 at 1:38 P.M., the Minimum Data Set (MDS) Coordinator said on 3/09/24, Nurse #1 told her that Resident #1 had not received his/her Eliquis medication because she was waiting for the Pharmacy to deliver the medication and that Nurse #1 asked her to look at Resident #1's left leg. The MDS Coordinator said she assessed both of Resident's #1's legs and his/her left foot and ankle were mottled bluish purple in color and cool to touch.</p> <p>Review of Resident #1's Hospital Emergency Department Physician's Note, dated 3/09/24, indicated that Resident #1 was sent to the ED for evaluation of concerns for left foot pain, cyanosis, cool and appearing ischemic. The Note indicated Resident #1 was diagnosed with left popliteal (space behind knee joint) and left calf vein DVT's, was to be started on Eliquis, however he/she was not. The Note indicated that vascular surgery evaluated Resident #1, a Computed tomography angiogram of the abdomen with runoff was performed and showed Resident #1 had an acute arterial thrombosis involving his/her left leg. The Note indicated Resident #1 was admitted and he/she was taken to the operating room for an embolectomy (surgical removal of a blood clot) and emergent fasciotomy (procedure to relieve pressure in the muscle compartment).</p> <p>During an interview on 4/24/24 at 4:51 P.M., the Director of Nurses (DON) said the Nursing Supervisor notified her on 3/09/24 that Resident #1 had not received his/her Eliquis medication because it had not been delivered from the Pharmacy, he/she developed increased pain in his/her LLE with skin color changes and was being transferred to the Hospital ED for evaluation.</p> <p>The DON said she did not know if Nurse #1 had notified Resident #1's Physician when the Eliquis was unavailable to administer to him/her that day. The DON said if a medication is unavailable and has not been delivered from the pharmacy, she expects all nurses to notify the residents Physician.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>40702</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had a been diagnosed with a deep vein thrombosis (blood clot, DVT), with new orders from the Nurse Practitioner for an anticoagulant (blood thinner) medication to be administered, the Facility failed to ensure nursing notified the correct Pharmacy in order to obtain Resident #1's medication in a timely manner, as a result Resident #1 did not receive his/her first scheduled dose as ordered and he/she was transferred to the Hospital for evaluation.</p> <p>Findings include:</p> <p>The Pharmacy Policy, titled Provider Pharmacy Requirements, effective date January 01, 2021, indicated the following:</p> <ul style="list-style-type: none"> -that regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies. -providing routine and timely pharmacy services as contracted, and emergency pharmacy service 24 hours per day, seven days per week -emergency or stat (immediately) medications are available for administration no more than four (4) hour(s) after the order is received by the pharmacy <p>The Pharmacy Policy, titled Medication Ordering and Receiving from Pharmacy: Emergency Pharmacy Service and Emergency Kits, effective date January 01, 2021, indicated the following:</p> <ul style="list-style-type: none"> -emergency pharmacy service is available on a 24-hour basis, emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the provider pharmacy and the provider pharmacy supplies emergency medications including emergency drugs -telephone/fax numbers for emergency pharmacy service are posted at nursing stations -the dispensing pharmacy supplies emergency or stat medications according to the provider pharmacy agreement <p>Resident #1 was admitted to the Facility in February 2024, diagnoses included atrial fibrillation (irregular heartbeat), hypertension, history of transient ischemic attack (TIA, mini stroke), chronic pain syndrome, mild cognitive impairment, muscle weakness, and hyperlipidemia (high cholesterol).</p> <p>Review of Resident #1's Ultrasound Report, dated 3/08/24, indicated that Resident #1 had a deep vein thrombosis involving his/her left popliteal (joint in back of the knee) and upper calf veins.</p> <p>Review of Resident #1's Nurse Practitioner Progress Note, dated 3/08/24, indicated that Resident #1's ultrasound report was positive for a DVT of his/her left lower extremity (LLE), and that Eliquis (anticoagulant) will be initiated.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/24/24 at 1:21 P.M., the Nurse Practitioner (NP) said Resident #1 was having LLE pain with mild swelling, was tender to touch and she ordered an ultrasound of his/her LLE. The NP said she was at the Facility on 3/08/24 when Resident #1's ultrasound was done, and the imaging technician informed her that Resident #1's ultrasound of his/her LLE looked positive for a DVT. The NP said she wrote orders for Resident #1 to start Eliquis for the DVT.</p> <p>Review of Resident #1's Physician orders, dated 3/08/24, indicated he/she had a new order as follows:</p> <p>-Eliquis 5 mg by mouth twice a day times one week, then Eliquis 2.5 mg by mouth twice a day times six months.</p> <p>During an interview on 4/24/24 at 3:40 P.M., Nurse #1 said she worked 7:00 A.M. to 7:00 P.M. on 3/08/24 and 3/09/24 and was assigned to care for Resident #1. Nurse #1 said the NP wrote new orders for Resident #1 to start Eliquis. Nurse #1 said she entered Resident #1's new medication orders into their electronic medical record system (Point Click Care/PCC) and said once the orders are entered, they are sent (electronically transmitted) directly to Pharmacy A that the Facility uses, but said she had also called the Pharmacy with Resident #1's new orders.</p> <p>Nurse #1 said when she entered Resident #1's medications orders into PCC on 3/08/24 there was no drop-down box to choose the Pharmacy (A or B) because the drop-down box does not show up when new orders are entered. Nurse #1 said she never saw Pharmacy B listed when she entered Resident #1's new medication orders.</p> <p>During an interview on 4/24/24 at 2:47 P.M., Nurse #2 said new medication orders for residents are entered into Point Click Care (PCC, the facility's electronic medical record system) under the order medications tab, and that once the medication(s) order is entered into the PCC system it is then sent (electronically transmitted) directly to the Pharmacy.</p> <p>Nurse #2 said there were two Pharmacies listed in the PCC system, Pharmacy A and Pharmacy B and the Facility only deals with Pharmacy A. Nurse #2 said nurses have to click the pharmacy drop- down box, choose Pharmacy A and said that if a nurse chooses Pharmacy B, then Pharmacy A would not receive the medication order.</p> <p>Review of Resident #1's Medication Administration Record (MAR), for March 2024, indicated that on 3/09/24 Resident #1's Eliquis 5 milligrams (mg) per his/her Physician orders was not administered at 8:00 A.M., Nurse #1 documented code 9 which indicated see nurses notes.</p> <p>Review of Resident #1's Progress Notes, on the following dates indicated:</p> <p>-3/09/24 at 06:15 A.M., late entry (written by Nurse #3) Pharm delivered medications but Eliquis was not in delivery</p> <p>-3/09/24 at 13:43 (1:43 P.M.) (written by Nurse #1) (Medication Administration Note) Eliquis oral tablet 5 mg, give 5 mg by mouth two times a day for DVT, not available (and therefore was not administered).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident #1's medical record, indicated there was no documentation to support Nurse #1 called Pharmacy A on 3/09/24 to check on when Resident #1's Eliquis medication was due to be delivered.</p> <p>During an interview on 5/02/24 at 1:24 P.M., the Nursing Supervisor said she worked 11:00 A.M. to 11:00 P. M. on 3/09/24 and she notified the Director of Nursing (DON) that Resident #1 had not received his/her Eliquis because it had not been delivered from the Pharmacy and he/she had increased pain to his/her LLE with skin color changes. The Nursing Supervisor said she told the DON Resident #1 was being transferred to the Hospital Emergency Department for evaluation.</p> <p>Review of email correspondence between the Facility's Chief Nursing Officer and the Director of Clinical Pharmacy Services & Education (Pharmacy A) indicated the following:</p> <p>-On 4/01/24 at 11:11 A.M., Chief Nursing Officer sent an email to the Director of Clinical Pharmacy Services & Education stating that she was doing a chart review and asked if the Director could look into why there was a delay in receiving Resident #1's Eliquis medication.</p> <p>-On 4/01/24 at 11:27 A.M., the Director of Clinical Pharmacy Services & Education responded to the Chief Nursing Officer saying, that it looks as if we received two orders for Eliquis on 3/08/24. One for 2.5 mg twice a day (BID) profile only and one for 5 mg BID profile only. When our pharmacist went into Point Click Care (PCC) to view the orders, it appears whomever entered the orders selected Pharmacy B as the dispensing pharmacy, which automatically makes these orders profile only, so we do not see and/or fill them.</p> <p>During an interview on 4/24/24 at 4:35 P.M., the Chief Nursing Officer (CNO) said she was reviewing Resident #1's medical record because there was a delay in receiving his/her Eliquis medication from the Pharmacy. The CNO said she contacted the Pharmacy A Director via email and was told the orders for Resident #1's Eliquis were profile only, so the Pharmacy had not filled the order.</p> <p>Review of Resident #1's Scheduling/Source Order Details Report, indicated that Nurse #1 entered Resident #1's Eliquis medication orders on 3/08/24 and Pharmacy B was listed not Pharmacy A.</p> <p>During an interview on 4/24/24 at 4:51 P.M., the Director of Nurses (DON) said Resident #1 had an ultrasound of his/her lower left extremity (LLE) on 3/08/24 and the results were positive for a DVT, and the NP ordered Eliquis to be started. The DON said the Nursing Supervisor notified her on 3/09/24 that Resident #1 had not received his/her Eliquis medication because it had not been delivered from the Pharmacy.</p> <p>The DON said on 3/11/24, she reviewed Resident #1's Eliquis medication order in the PCC system and discovered there were two Pharmacies listed in the Pharmacy drop-down box and if Nurse #1 had not clicked the Pharmacy drop-down box to choose Pharmacy A, then the Pharmacy would not have received Resident #1's order for Eliquis. The DON said the Pharmacy that was listed on Resident #1's Eliquis order was Pharmacy B, and not Pharmacy A which was pharmacy the Facility used. The DON said spoke to Nurse #1 and that Nurse #1 told her she (Nurse #1) had not realized there were two Pharmacies listed when she entered Resident #1's order for the Eliquis into the PCC system.</p> <p>The DON said if a medication is unavailable and has not been delivered from the pharmacy, she expects all nurses to call the Pharmacy and notify the residents Physician.</p>		