STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225485	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Ladys Haven of Fairhaven Inc	71 Center Street Fairhaven, MA 02719

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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 - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50740 Based on observation, interview, and record review, the facility failed to ensure professional standards of care were met for one Resident (#57), out of five residents observed during medication administration and one Resident (#21), out of a total sample of 18 residents. Specifically, the facility failed: 1. For Resident #57, to ensure the Resident had taken all of his/her medications before leaving the Resident's room; and 2. For Resident #21, to ensure nursing performed pain assessments to determine, per physician's orders, which dosage of oxycodone (pain medication used to treat moderate to severe pain; opioid) to administer to the Resident. Findings include: Review of [NAME], Manual of Nursing Practice 11ed, 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: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's 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. 1. Review of the facility's policy titled Oral Medication Administration - Specific Procedures, revised 6/3/13, indicated but was not limited to the following: -Administer medication and remain with resident while medication is swallowed. Resident #57 was admitted to the facility in January 2023 with diagnoses including Parkinson's disease, hypertension, and fluid overload. (continued on next page)

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 - Few	Review of the active Physician's Orders for Resident #57 indicated but were not limited to the following: -Vitamin D3 50 micrograms (mcg) Give one tablet by mouth daily in AM at 8:00 A.M. (1/26/23) (Vitamin D supplement) -Tamsulosin 0.4 milligrams (mg) Give 0.4 mg by mouth daily at 8:00 A.M. (1/26/23) (medication used to relax prostate and bladder muscles in men) -Potassium Chloride Extended Release 20 milliequivalents (meq) once a day at 8:00 A.M. (2/22/23) (potassium supplement) -Metoprolol Succinate Extended Release 25 mg once a day at 8:00 A.M. (4/13/23) (medication used to treat high blood pressure) -Omeprazole Delayed Release 20 mg once a day at 8:00 A.M. (4/19/23) (medication used to reduce excess stomach acid) -Carbidopa-Levodopa 25-100 mg Give one tablet by mouth three times a day at 8:00 A.M., 1:00 P.M., and 7:00 P.M. (5/24/24) (medication used to manage symptoms of Parkinson's disease, such as tremors) -Eliquis 5mg Give 5 mg by mouth twice a day at 8:00 A.M. and 7:00 P.M. (5/24/24) (medication used to prevent blood clotting) -Furosemide 40 mg twice a day at 8:00 A.M. and 1:00 P.M. (5/24/24) (diuretic) -Multiple Vitamins Give one tablet by mouth daily at 8:00 A.M. (5/24/24) -Seroquel 25 mg Give half a tablet (12.5mg) orally every AM at 8:00 A.M. (5/24/24) (antipsychotic medication) On 10/23/24 at 10:52 A.M., the surveyor observed Nurse #6 prepare and administer Vitamin D3, Tamsulosin, Potassium Chloride, Metoprolol Succinate, Omeprazole, Carbidopa-Levodopa, Eliquis, Furosemide, Multiple Vitamins, and Seroquel to Resident #57. On 10/23/24 at 11:09 A.M., the surveyor observed Nurse #6 leave Resident #57's room before the Resident had finished taking all of the medication. Review of Resident #57's medical record failed to indicate that the Resident was able to self-administer medications. During an interview on 10/23/24 at 11:14 A.M., Nurse #6 said she usually administers Resident #57's medications and leaves the room before making sure he/she has taken all of the medications because he/she is cognitively intact. During an interview on 10/23/24 at 4:32 P.M., the Director of Nursing (DON) said that Resident #57 is not able to self-administer medications and that it is her expectation that the nurse stays with the Resident until he/she finishes taking all of their medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49428 2. Resident #21 was admitted to the facility in October 2023 with diagnoses which included unspecified pain, generalized abdominal pain, and polyneuropathy (a nerve disease with symptoms that include pain). Review of Resident #21's Minimum Data Set (MDS) assessment, dated 7/16/24, indicated Resident #21 had frequent pain and was receiving pain medication on an as needed basis. Review of Resident #21's active Physician's Orders indicated but was not limited to the following: -Pain monitoring each shift, notify physician/nurse practitioner if pain is not controlled, every shift 07:00-15:00, 15:00-23:00, 23:00-07:00, active 10/10/23. -oxycodone- schedule II, 5 mg tablet, take 2 tablets (10 mg) by mouth every 4 hours as needed for severe pain, active 10/10/23; -oxycodone- schedule II, 5 mg tablet, take 1 tablet by mouth every 4 hours for moderate pain, as needed, active 10/10/23; -acetaminophen tablet, 325 mg, 2 tablets (650 mg) by mouth as needed every 6 hours for pain. Review of Resident #21's 2024 Medication Administration Record (MAR) for the months of August, September, and October indicated the Resident received oxycodone on an as needed basis. Further review of Resident #21's August 2024 MAR indicated but was not limited to the following: -650 mg acetaminophen was administered two times; -5 mg oxycodone was administered two times; -10 mg oxycodone was administered 35 times. -Documentation of pain severity (such as moderate, severe, or utilizing a pain scale) related to administering 10 mg of oxycodone for severe pain included the following: -8/3/24: Pain Comment: 9/10 (pain scale based on a scale of 0-10 with 10 being the worst pain). Further review of the August 2024 MAR indicated but was not limited to the following documentation of reasons for administering 10 mg of oxycodone for severe pain: -8/5/24: per Resident's request; -8/6/24: generalized pain; -8/11/24: abdomen; -8/13/24: per Resident's request; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/27/24: per Resident's request; -8/29/24: complaints of left side pain; -8/30/24: left upper quadrant pain. Review of Resident #21's medical record indicated there were no nursing progress notes in August 2024 that indicated a pain assessment was performed with the administration of 5 mg or 10 mg of oxycodone. Additionally, there were no nursing progress notes that stated the severity of the Resident's pain when any oxycodone was administered. Further review of Resident #21's September 2024 MAR indicated but was not limited to the following: -650 mg acetaminophen was administered five times; -5 mg oxycodone was administered five times; -10 mg oxycodone was administered 18 times. -Documentation of pain severity (such as moderate, severe, or utilizing a pain scale) related to administering 10 mg of oxycodone for severe pain included the following: -9/1/24: Pain Comment: 8/10 -9/17/24: Pain scale 3. Further review of the September 2024 MAR indicated but was not limited to the following documentation of reasons for administering 10 mg oxycodone for severe pain: -9/2/24: complaints of general discomfort; -9/2/24: complaints of left flank pain; -9/10/24: per Resident's request; -9/14/24: per Resident's request; -9/23/24: complaints of generalized discomfort. Review of Resident #21's medical record indicated there were no nursing progress notes in September 2024 that indicated a pain assessment was performed with the administration of 5 mg or 10 mg of oxycodone. Additionally, there were no nursing progress notes that stated the severity of the Resident's pain when any oxycodone was administered. Further review of Resident #21's October 2024 MAR (10/1/24-10/28/24) indicated but was not limited to the following: -650 mg acetaminophen was administered one time; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5 mg oxycodone was administered 12 times; -10 mg oxycodone was administered 20 times. Documentation of pain severity (such as moderate, severe, or utilizing a pain scale) related to administering 10 mg of oxycodone (ordered for severe pain) included the following: -10/24/24: complaints of pain to left side/flank area #8; -10/26/24: abdominal 8/10. Further review of the October 2024 MAR indicated, but was not limited to the following documentation of reasons for administering 10 mg oxycodone for severe pain: -10/1/24: generalized pain; -10/11/24: abdominal; -10/18/24: pain comment: flank; -10/21/24: increase pain left hip/side; -10/24/24: per Resident request; -10/27/24: abdominal pain; -10/27/24: per Resident request. During an interview on 10/28/24 at 2:00 P.M., the surveyor and Unit Manager (UM) #2 reviewed Resident #21's oxycodone orders and MAR. UM #2 said she expects nursing to use an appropriate scale to assess Resident #21's pain. UM #2 said she expects nursing to administer the appropriate oxycodone dosage based on the severity of the Resident's pain and the physician's order. UM #2 said reasons for administering oxycodone, such as generalized pain and per Resident request, are not acceptable. During an interview on 10/29/24 at 12:26 P.M., the Director of Nursing (DON) said the facility's policy is to use a numerical pain scale. The DON acknowledged the Resident's oxycodone orders indicate the terms moderate and severe for pain and do not indicate a numerical pain scale. The DON said nursing should be using a numerical pain scale to assess Resident #21's pain level to determine, per physician's orders, which pain medication or which dose of oxycodone is appropriate for the Resident.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 15214 Based on observation, record review, and staff interview, the facility failed to ensure side rails were not implemented per the declination of consent from the Health Care Proxy (HCP) for one Resident (#121), of a total sample of 18 residents. Findings include: Resident #121 was admitted in October 2024 for a respite stay with a diagnosis of dementia. Review of the medical record indicated that upon admission, the Resident's HCP signed that he/she declined the use of side rails for the Resident. On 10/22/24 at 9:10 A.M., the surveyor observed Resident #121's bed to have side rails at the upper left and right sides. Resident #121 was not in the bed. On 10/25/24 at 10:18 A.M., the surveyor observed Resident #121's bed to have side rails at the upper left and right sides. Resident #121 was not in the bed. During an interview on 10/25/24 at 10:25 A.M., Unit Manager #1 said that the side rails that were on the Resident's bed were from the previous resident that occupied the bed. Unit Manager #1 also said that no side rail assessment for use of the side rails had been conducted, and the side rails should have been removed from the bed when Resident #121 was admitted . Unit Manager #1 confirmed that the HCP had signed that he/she declined consent for the use of side rails.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 49428 Based on records reviewed, policy review, and interview for two Residents (#4 and #26), of 18 sampled residents, the facility failed to ensure that each Resident's drug regimen was free from unnecessary psychotropic medications. Specifically, for Residents #4 and #26, the facility failed to ensure an Abnormal Involuntary Movement Scale (AIMS, a clinical outcome checklist completed by a healthcare provider to assess the presence and severity of adverse outcomes, such as abnormal movements of the face, limbs, and body in patients) assessment was completed timely. Findings include: Review of the facility's policy titled Psychotropic Medication Consent, dated as reviewed 2/24, indicated but was not limited to: -In order to meet Section 72BB's requirements for documenting informed consent, prior to the administration of any drug included on Attachment A, long term care facilities must complete the Department's prescribed for (Attachment B), and prior to or upon administration, include the completed form in the resident's medical record. -Written informed consent must be obtained each time a new or renewed prescription falls outside the dosage to which the resident or the resident's legal representative previously consented, or once a year, whichever is shorter. Resident #4 was admitted to the facility in March 2018 with diagnoses which included dementia, paranoid personality disorder, bipolar disorder, personality disorder, and generalized anxiety disorder. Review of Resident #4's Minimum Data Set (MDS) assessments, dated 5/31/24 and 8/3/24, both indicated the Resident was receiving antipsychotic medication on a routine basis. Review of Resident #4's active physician's orders indicated, but was not limited to, the following: -aripiprazole tablet, 5 milligram (mg), One tablet (5mg) by mouth daily, active 10/10/20; -risperidone tablet, 0.5mg, One tablet (0.5mg) by mouth daily at bedtime four times a week, omit Sunday/Wednesday and Thursday, active 6/25/24; -risperidone tablet, 0.25mg, take one tablet by mouth weekly on Sundays/Wednesdays/Thursdays, active 6/25/24. Review of Resident #4's 2024 Medication Administration Record for June through October indicated the Resident was administered their scheduled aripiprazole and risperidone per physician's orders. Review of care plans for Resident #4 indicated but was not limited to the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-AIMS every six months while I am taking antipsychotic medication. Further review of Resident #4's medical record indicated AIMS assessments were completed on 12/18/23 and 8/5/24. Resident #26 was admitted to the facility in June 2021 with diagnoses which included dementia and bipolar disorder. Review of Resident #26's MDS assessments, dated 6/18/24 and 9/18/24, both indicated the Resident was receiving antipsychotic medication on a routine basis. Review of Resident #26's active physician's orders indicated, but was not limited to, the following: -risperidone tablet, 0.5mg, one half tablet (0.25mg) by mouth daily in the morning, active 7/17/23; -risperidone tablet, 0.5mg, once a day on Sunday, active 8/14/24; -risperidone tablet, 0.5mg, twice a day on Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, active 8/14/24. Review of Resident #26's 2024 Medication Administration Record for June through October indicated the Resident was administered their scheduled risperidone per physician's orders. Review of care plans for Resident #26 indicated but was not limited to the following: -AIMS every six months while I am taking antipsychotic medication. Further review of Resident #26's medical record indicated AIMS assessments were completed on 12/18/23 and 8/5/24. During an interview on 10/29/24 at 12:34 P.M., the DON said for residents receiving anti-psychotic medication, an AIMS assessment should be performed every six months. The DON said, for Residents #4 and #26, the 8/5/24 AIMS assessments should have been completed in June 2024, not in August 2024.

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	225485	A. Building B. Wing	10/29/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 50740 Based on observation, interview, and record review, the facility failed to ensure it was free from a medication error rate of greater than five percent when one of two nurses made four errors out of 30 opportunities, totaling a medication error rate of 13.33%. These errors impacted two Residents (#38, #57), out of five residents observed. Specifically, 1. For Resident #38, Repaglinide (an oral antihyperglycemic medication used to help control high blood sugar), and Metformin (an oral antihyperglycemic medication used to help control high blood sugar) were not administered as ordered by the physician during the medication pass; and 2. For Resident #57, Carbidopa-Levodopa (a medication used to treat symptoms of Parkinson's disease) and Furosemide (a diuretic medication used to aid the body in removing excess fluid) were not administered as ordered by the physician during the medication pass. Findings include: Review of Lippincott Nursing Procedures, Ninth Edition, Safe Medication Administration Practices, General, indicated that nurses must adhere to the five rights of medication administration: identify the right patient by using at least two patient-specific identifiers; select the right medication; administer the right dose; administer the medication at the right time; and administer the medication by the right route. Review of the facility's policy titled Administration of Medications - General Guidelines - Specific Procedures, revised 1/15/15, indicated but was not limited to the following: -Medications are administered in accordance with written orders of the physician or other authorized prescriber. -Medications ordered to be given before meals must be administered at least one hour before meals. 1. Review of the active Physician's Orders for Resident #38 indicated but were not limited to the following: -Repaglinide 2 milligrams (mg) One tablet by mouth daily at 11:30 A.M. (6/1/21) -Metformin 500 mg Take two 500 mg tablets (1000 mg) by mouth daily before breakfast and dinner at 8:30 A. M., 5:30 P.M. (5/31/24) On 10/23/24 at 10:18 A.M., the surveyor observed Nurse #6 prepare and administer Repaglinide and Metformin to Resident #38. Nurse #6 failed to administer the Repaglinide within one hour before or after the scheduled administration time indicated in the physician's order. Nurse #6 failed to administer the Metformin before breakfast as ordered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 10:14 A.M., Nurse #6 said that Resident #38 likes to take her medications together. During an interview on 10/23/24 at 4:32 P.M., the Director of Nursing (DON) said that it is her expectation that medications are administered within a one hour window before or after the medication's scheduled time. 2. Review of the active Physician's Orders for Resident #57 indicated but were not limited to the following: -Carbidopa-Levodopa 25-100 mg Give one tablet by mouth three times a day at 8:00 A.M., 1:00 P.M., and 7:00 P.M. (5/24/24) -Furosemide 40 mg twice a day at 8:00 A.M. and 1:00 P.M. (5/24/24) On 10/23/24 at 10:52 A.M., the surveyor observed Nurse #6 prepare and administer medications, including Carbidopa-Levodopa and Furosemide, to Resident #57. Nurse #6 failed to administer the Carbidopa-Levodopa and Furosemide within one hour before or after the scheduled administration times as ordered by the physician. Review of Resident #57's electronic Medication Administration Record indicated that on 10/23/24, the scheduled 8:00 A.M. doses of Carbidopa-Levodopa and Furosemide were charted late. Nurse #6 entered in the comments for the late administration on time. During an interview on 10/23/24 at 4:32 P.M., the DON said that it was her expectation that medications are administered within a one-hour window before or after the medication's scheduled time.

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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. 46562 Based on record review and interview, the facility failed to maintain medical records that are complete, accurate, and systemically organized within accepted professional standards of practice for one Resident (#15) of 18 sampled residents. Specifically, the facility failed to document two administered doses of glucagon (an anti-hypoglycemic (low blood sugar) agent that increases blood glucose) on the Medication Administration Record (MAR). Findings include: Review of the facility's policy titled Administration of Medications - General Guidelines, Specific Procedures, dated as revised 1/15/15, indicated but was not limited to: -Medication administration is documented on the resident's Medication Administration Record at the time the medication is given by the person who administered the medication. -When as needed medications are administered, the following documentation is provided (date, time, dose, and route of administration). -The person administering medication reviews the Medication Administration Records to ascertain that all necessary doses were documented. Resident #15 was admitted to the facility in October 2023 with diagnoses which included diabetes mellitus and peripheral vascular disease (PVD). Review of the Minimum Data Set (MDS) assessment, dated 7/22/24, indicated Resident #15 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of Resident #15's Physician's Orders indicated but was not limited to: -glucagon solution 1 milligram (mg)/milliliter (mL); inject 1 mg intramuscularly (into muscle) as needed for severe hypoglycemia and if resident is unresponsive or unable to swallow anything by mouth, may repeat dose after 15 minutes if no response, dated 10/2/23 Review of Resident #15's nursing progress note, dated 10/26/24, indicated Resident #15 was diaphoretic and unresponsive with blood glucose reading indicating an abnormally low blood sugar. Further review of the nursing progress note indicated facility staff administered two doses of glucagon to Resident #15. Review of Resident #15's October 2024 MAR failed to indicate the glucagon had been administered. During a telephonic interview on 10/29/24 at 8:56 A.M., Nurse # 2 said on 10/26/24 Resident #15 had received two doses of glucagon and she wrote a progress not indicating that but did not ensure the medication administration had been documented on the MAR. (continued on next page)

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	225485	A. Building B. Wing	10/29/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/28/24 at 2:53 P.M., Nurse #5 said anytime a medication is administered it should be documented on the MAR with the date and time of administration. During an interview on 10/29/24 at 11:29 A.M., Nurse #9 said the administration of any medication, including as needed medications, should be documented in the Resident's MAR. During an interview on 10/29/24 at 10:04 A.M., Unit Manager #3 said Resident #15 was hypoglycemic on 10/26/24 and was administered two doses of glucagon. Unit Manager #3 reviewed Resident #15's October 2024 MAR and said the glucagon administration had not been recorded but it should have been signed off. During an interview on 10/29/24 at 11:54 A.M., the Director of Nurses said the administration of any medication should be documented in the Resident's MAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225485	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Ladys Haven of Fairhaven Inc	71 Center Street Fairhaven, MA 02719

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50740 Based on observation, interview, and policy review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to ensure: 1. For Resident #20, who has an indwelling urinary catheter, that staff implemented Enhanced Barrier Precautions (EBP-an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities); and 2. For Resident #32, who has an open wound, that staff implemented EBP. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) guidance titled Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, indicated but was not limited to: - Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. - EBP are used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing - EBP are indicated for residents with any of the following: a. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO - EBP should be used for any residents who meet the above criteria, wherever they reside in the Facility Review of the Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precautions sign, undated, indicated but was not limited to: -Everyone must: clean their hands, including before entering and when leaving the room. (continued on next page)

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	225485	A. Building B. Wing	10/29/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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), and wound care. Review of the facility's policy titled Enhanced Barrier Precautions, dated 3/2024, indicated but was not limited to: -EBP are to be initiated for residents who have an infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply. -Residents with wounds/ or [sic] indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. -Wounds include chronic wounds, such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. -Indwelling medical device examples include central lines, urinary catheters, feeding tubes, tracheostomies. Procedure -The use of gown and gloves for high-contact resident care activities is indicated with EBP. -High-contact care includes: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care. 1. Resident #20 was admitted to the facility in December 2020 with diagnoses including benign prostatic hyperplasia, bladder cancer, and urinary retention. Review of the Minimum Data Set (MDS) assessment, dated 8/28/24, indicated Resident #20 had an indwelling urinary catheter. On 10/28/24 at 9:32 A.M., the surveyor observed Resident #20 in his wheelchair with the urinary catheter drainage bag with privacy shield hanging from the wheelchair frame. CNA #2 was assisting Resident #20 to the bathroom for morning hygiene and dressing. The surveyor observed an EBP sign posted at the door of Resident #20's room indicating the Resident was on EBP. During an interview on 10/29/24 at 9:44 A.M., CNA #2 said that she assisted the Resident with morning activities of daily living (ADLs) in the bathroom and that Resident #20 does not require precautions when performing care. CNA #2 said that the EBP sign is posted on the door because he/she has a catheter but that she does not have to take any special precautions when going into the room or performing care. During an interview on 10/29/24 at 11:57 A.M., the Director of Nursing (DON) said that it is her expectation that staff follow EBP when indicated while providing care to residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #32 was admitted to the facility in September 2024 with a diagnosis of lung cancer with metastasis to the bone. Review of the MDS assessment, dated 9/24/24, indicated that the Resident had an unhealed pressure ulcer requiring pressure ulcer care. During an observation of Resident #32's wound care on 10/28/24 at 1:27 P.M., Unit Manager #2 performed hand hygiene and donned (put on) gloves, but failed to don a gown. The surveyor observed Unit Manager #2 reposition the Resident and perform wound care as ordered with no gown on. The surveyor observed an EBP sign posted outside of the Resident's room and gowns available in a hanging organizer mounted to the Resident's room door. During an interview on 10/28/24 at 1:37 P.M., Unit Manager #2 said that the Resident requires EBP due to his/her open wound and that she should have worn a gown while performing wound care. During an interview on 10/29/24 at 11:57 A.M., the DON said that it is her expectation that staff follow EBP when indicated while performing wound care.