STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225503	A. Building B. Wing	06/13/2024

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42742 Based on observation, interview, record review, and policy review, the facility failed for two Residents (#22 and #213), out of a total sample of 17 residents, to maintain and store respiratory equipment in a safe and sanitary manner. Specifically, the facility failed: 1. For Resident #22, to ensure oxygen (O2) equipment was maintained per physician's orders to ensure sanitary conditions to help decrease the risk of potential contamination and infection; and 2. For Resident #213, to store his/her continuous positive airway pressure (CPAP) respiratory tubing and nasal pillow mask in a sanitary way when not in use by the Resident to prevent potential contamination by germs and environmental debris. Findings include: Review of the facility's policy titled Equipment Change/Disinfection, undated, indicated but was not limited to the following: -Thoroughly clean all exterior surfaces of equipment. -All supplies while not in use in patient's room are to be stored in a treatment bag labeled with the patient's name, room number, date of change, and item. Oxygen Concentrators -Rinse and dry the external filter weekly and as needed when visibly dusty. Wipe down concentrator as needed when visibly dusty or soiled. 1. Resident #22 was admitted to the facility in July 2023 and had diagnoses including emphysema, acute and chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), and dependence on supplemental Oxygen (O2). Review of the Minimum Data Set (MDS) assessment, dated 3/27/24, indicated Resident #22 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and required oxygen therapy. Review of current Physician's Orders indicated the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Clean concentrator filter every day shift every Wednesday, 7/5/23 -Clean concentrator filter as needed, 7/3/23 On 6/12/24 at 7:45 A.M. and 3:35 P.M., the surveyor observed Resident #22 lying in bed. An oxygen concentrator (takes air from your surroundings, extracts, and filters it into purified oxygen for you to breathe) was observed on the floor next to the bed delivering oxygen through the attached nasal cannula (NC- device that delivers extra oxygen through a tube and into your nostrils) tubing with the end of the tubing's prongs inserted into the Resident's nostrils. The O2 concentrator and external filter were laden with dust. On 6/13/24 at 7:43 A.M., the surveyor observed Resident #22 lying in bed. An oxygen concentrator was observed on the floor next to the bed delivering oxygen through the attached nasal cannula tubing with the end of the tubing's prongs inserted into the Resident's nostrils. The O2 concentrator and external filter were laden with dust. The external filter was not cleaned the day prior (Wednesday) per physician's orders and the concentrator was not wiped down as needed when visibly dusty per facility policy. During an observation with interview on 6/13/24 at 8:07 A.M., Nurse #3 entered the Resident's room with the surveyor and observed the O2 concentrator and external filter laden with dust. Nurse #3 said she changed the NC tubing the day before and documented that she cleaned the external filter but did not because the respiratory company went around and changed all the filters last Tuesday or Wednesday. Nurse #3 said the order is for nursing to clean the filter every Wednesday and as needed and she should have cleaned it but did not. She said there wasn't an order to wipe down the concentrator, but it should have been done if visibly dusty. During an interview on 6/13/24 at 11:11 A.M., the Director of Nursing (DON) said the respiratory company comes into the facility on ce a week to change out filters, but the order is for nursing to clean and rinse the filters once a week on Wednesdays. She said the expectation is to also clean the concentrator weekly on Wednesdays and as needed per professional standards. She said nursing should follow physician's orders for maintaining the oxygen equipment. 43935 2. Review of the Lippincott Nursing Procedure, eighth edition, indicated but was not limited to the following in regard to the use and storage of CPAP tubing: - When the CPAP therapy has been completed, follow these steps: remove the headgear and appliance from the patient; clean and disinfect the equipment using a facility-approved disinfectant according to the manufacturer's instructions, and store it properly. Resident #213 was admitted to the facility in June 2024 with diagnoses including: cerebral infarct (stroke), sleep apnea, and narcolepsy (chronic neurological disorder that affects the brain's ability to control sleep-wake cycles, resulting in excessive sleepiness during the day and/or falling asleep suddenly during an activity). Review of the Nursing admission evaluation indicated Resident #213 was alert and oriented to person, place, time and situation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 6/11/24 at 8:51 A.M., the surveyor observed Resident #213 in his/her room in bed with their CPAP head strap and nasal pillow hanging over the bedrail on the Resident's left side. The Resident said he/she wears the device each night and the staff remove it in the morning but he/she was not sure how the facility was protecting the tubing from germs or environmental debris and said he/she has not ever seen a storage container or bag for the tubing and headgear. Throughout the day on 6/11/24 the surveyor made further observations as follows: - 11:13 A.M., CPAP head strap and nasal pillow were hanging over the left side rail of the Resident's bed open to environmental debris and potential contamination of germs; the device was not in use by the Resident and not stored in a sanitary way. - 3:07 P.M., Resident was out of bed sitting in their room, the CPAP tubing, head strap, and nasal pillow were not in use, and were observed to be hanging over the bed rail open to air and not stored in a manner to protect them from potential germs or environmental debris. During an interview on 6/12/24 at 2:18 P.M., Unit Manager #2 said the best practice and expectation is that the CPAP tubing, headgear, and nasal pillows are to be stored in a respiratory equipment bag when not in use to protect them from potential contamination of germs in the environment. She said Resident #213 is not physically capable of placing the CPAP on or removing it related to their recent stroke and the staff would have to apply and remove the device and then clean and store it properly. She observed the manner in which the surveyor observed Resident #213's CPAP head strap, tubing, and nasal pillow throughout the day on 6/11/23 and said the tubing should never be stored in that manner and it needed to be stored in a way to protect it from potential germs. During an interview on 6/12/24 at 3:51 P.M., the DON said CPAP tubing and the Resident's nasal pillow should always be stored in a respiratory bag when not in use to protect it from potential contaminants. She said the manner in which the surveyor observed the tubing was not an appropriate way for the tubing to be stored and was not in line with the facility practice.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 43935 Based on record review, interviews, and policy review, the facility failed to develop a person-centered plan of care which included post-traumatic stress disorder (PTSD- a mental health condition that is triggered by an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being) identified triggers to avoid potential re-traumatization for one Resident (#37), out of a total sample of 17 residents. Findings include: Review of the facility's policy titled Trauma Assessment and Care Guidelines, dated 6/25/2018, indicated but was not limited to the following: - the facility will ensure trauma survivors receive culturally competent trauma informed care in accordance with professional standards of practice - person-centered care planning will include trauma triggers and interventions to mitigate the risk of re-traumatization - the social service department will develop a person-centered care trauma informed care plan that addresses the assessed emotional or psychosocial needs of the resident, and will identify known triggers that the resident may discuss during interview and assessment. Resident #37 was admitted to the facility in May 2024 with diagnoses including: depression, anxiety, and PTSD. Review of the Brief Interview for Mental Status (BIMS), dated 5/16/24, indicated the Resident was moderately cognitively impaired with a score of 10 out of 15. Review of the medical record indicated the Resident was his/her own person and their healthcare proxy was not activated. Review of the medical record for Resident #37 indicated the Resident had a trauma informed assessment completed on 5/13/24, which indicated but was not limited to the following: - the Resident had experienced an event (trauma) that changed them emotionally physically, spiritually or behaviorally - the Resident indicated the experience still bothers them now - the Resident wished to discuss the experience - the Resident experienced feelings of being jumpy, easily startled and watchful - the PTSD was a result of childhood trauma and the Resident had his/her own community therapist they would continue to have sessions with while in the facility (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the social services progress notes indicated but was not limited to the following: - 5/19/24: trigger for PTSD is a sudden surprise of plans or events with a coping strategy of being informed in advance During an interview on 6/11/24 at 11:11 A.M., the Resident said he/she is unsure if anyone at the facility is aware of what his/her trauma triggers are and was unsure if the staff do anything to prevent him/her from being re-traumatized and said that would be really helpful for them and me to avoid those things as much as possible. During an interview on 6/12/24 at 7:47 A.M., Certified Nurse Assistant #2 said she consistently cares for the Resident and is aware of the anxiety the Resident has, but was not aware the Resident had PTSD. She said she does not know of any potential triggers to avoid to help lessen the likelihood of or alleviate the Resident's anxiety and reports any episodes of anxiety to the nurse. During an interview on 6/12/24 at 8:26 A.M., the Resident said he/she was being discharged from the facility on this day and felt it was a surprise since they attempted to appeal their discharge. He/She said they do not think the facility is trying to help them avoid triggering situations. During an interview on 6/12/24 at 8:35 A.M., Nurse #1 said she is caring for Resident #37 today and is aware the Resident suffers from PTSD and has anxiety. She said she is not aware of what the PTSD stems from or what potential triggers should be avoided or could potentially exacerbate the Resident's PTSD or anxiety. During an interview on 6/12/24 at 9:21 A.M., Nurse #2 said she knows Resident #37 well and is aware the Resident suffers from PTSD and anxiety but is unaware of any potential triggers that should be avoided or could potentially increase the Resident's anxiety. She said the Resident is followed by his/her own personal therapist for management of their PTSD on an outpatient basis. Review of the current active care plans for Resident #37 indicated but were not limited to the following: FOCUS: Resident demonstrates periods of depression and anxiety related to a history of trauma. INTERVENTIONS: Encourage to attend activities of interest; review activity schedule and discuss areas of interest; encourage deep breathing exercises and relaxation techniques; help facilitate continued established sessions with community therapist during their stay; provide one to one (1:1) brief supportive visits; refer to psych as needed. FOCUS: Resident uses anti-anxiety medications related to anxiety and PTSD. INTERVENTIONS: Administer medications as ordered and monitor for effectiveness and side effects; Monitor and report any adverse reactions. FOCUS: Feelings of depression and anxiety characterized by flat affect, difficulty concentrating, lack of energy, lack of interest or pleasure in doing things, difficulty sleeping, and restlessness related to recent hospitalization and medical concerns, disruption in the home routine and diagnosis of major depressive disorder and anxiety. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTERVENTIONS: Acknowledge resident's mood in 1:1 interactions; assist with moving to a quiet room as needed; provide support and reassurance; assist with facilitating ongoing appointments with counselor as needed; encourage resident to participate in activities he/she finds appealing; involve resident in making their own schedule and sequencing activities; observe and report for mental status; provide 1:1 brief supportive visits as needed; refer to psych as needed. The care plans failed to indicate what the Resident's triggers were to prevent potential re-traumatization. During an interview on 6/12/24 at 10:23 A.M., the Director of Social Services said the process for trauma informed care included a record review, an initial meeting and interview with the residents, a trauma informed assessment if applicable, and then care plans for the residents. She said Resident #37 was willing to share his/her trauma and triggers and she documented that information in her note along with the Resident's desire to maintain weekly visits with his/her community therapist. She reviewed the care plans for Resident #37 and said although the triggers are not indicated on the care plan she felt the interventions would prevent the triggers from occurring. She said the care plan should have been more clear and specific to the Resident's trigger and can see how it is not clear for the staff to understand the potential triggers for the Resident.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 48362 Based on interview, record review, and policy review, the facility failed to ensure monthly medication regimen reviews were maintained as part of the permanent medical record and failed to ensure recommendations made by the pharmacy consultant were addressed timely for one Resident (#9), out of a total sample of 17 residents. Findings include: Review of the facility's policy titled Medication Regimen Review (MRR), dated as last revised 6/1/24, indicated but was not limited to the following: - The consultant pharmacist will provide required recipients of residents' MRR on the MRR report to the Director of Nursing (DON) and/or the attending physician, and to the Medical Director. - Facility staff should ensure that the attending physician, medical director and director of nursing are provided with copies of the MRRs. - Facility should encourage physician/prescriber or other responsible parties receiving the MRR and the DON to act upon the recommendations contained in the MRR. - Facility should alert the medical director where MRRs are not addressed by the attending physician in a timely manner. - If an irregularity is not time sensitive but should be addressed before the consultant pharmacist's next MRR, the facility staff and the consultant pharmacist will confer on the timeliness of attending physician/prescriber responses to identified irregularities based on the specific resident's clinical condition. - The facility should maintain readily available copies of the consultant pharmacist's reports on file in the facility, and as a part of the resident's permanent health record. Resident #9 was admitted to the facility in January 2024 with diagnoses including but not limited to type II diabetes, anxiety, and depression. Review of the monthly reports from the Pharmacist Consultant indicated irregularities were noted on 2/14/24, 4/11/24, and 5/14/24. Review of the electronic and paper medical record failed to include the Consultation Report forms which identified the irregularities. During an observation with interview on 6/12/24 at 1:00 P.M., Unit Manager #1 and the surveyor reviewed the medical record for Resident #9. Unit Manager #1 said she was unable to locate the Consultation Report forms and would contact the Consultant Pharmacist. The surveyor requested copies of the February, April and May recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/24 at 3:25 P.M., Unit Manager #1 provided the surveyor with a copy of the Consultation Report form dated 5/14/24. The copy of the Consultation Report form was addressed by the attending physician but there was no date identifying when the response was completed. Unit Manager #1 said she had spoken to the Consultant Pharmacist who stated the May 2024 recommendation was a re-issued recommendation from February 2024 that was never addressed. Unit Manager #1 said she did not have a copy of the February 2024 Consultation Report form. Unit Manager #1 said she reached out to the Consultant Pharmacist to retrieve the records of the forms because she did not have a signed copy of the form at the facility. Unit Manager #1 said the Consultant Pharmacist was sending over a copy of the April 2024 recommendations that were addressed by the attending physician and they would be filed in the paper medical record. Unit Manager #1 said after a recommendation is reviewed by the Physician, the recommendation should be filed in the Resident's medical record and a copy faxed to the Consultant Pharmacist. During an interview on 6/13/24 at 8:41 A.M., the Director of Nursing (DON) said MRRs are completed by the Consultant Pharmacist monthly. The DON said the Consultant Pharmacist documents in the electronic medical record whether there are any irregularities. The DON said if irregularities are noted, the Consultation Report is sent to the facility for the Physician to review. The DON said unless there are immediate concerns, irregularities should be addressed prior to the next MRR completion. The DON said MRR Consultation Reports should be kept in the medical record.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on record review and interview, the facility failed to maintain accurate medical records in accordance with professional standards of practice for one Resident (#31), out of a total sample of 17 residents. Specifically, the facility failed to ensure the Resident's Massachusetts Medical Order for Life-Sustaining Treatment (MOLST- form that indicates a person's medical wishes regarding life sustaining treatments) was consistent with current physician's orders. Findings include: Review of the facility's policy titled Health Information Management Policy, undated, indicated but was not limited to the following: Purpose: -To ensure that health information, including but not limited to clinical records, is maintained in accordance with state, federal regulations, and professional practice standards, complete, accurately documented, readily accessible and systematically organized. Procedure: -A clinical record will be maintained for each resident and contain enough information to show that the facility knows the status of the individual, has adequate plans of care, and provides sufficient evidence of the effects of the care provided. -The medical record will contain complete and accurate documentation that clearly identified the resident, justifies the diagnoses, conditions, treatment, and care approaches, and response to the care provided. -Documentation should provide a picture of the resident's progress, including response to treatment, change in condition, and changes in treatment. Review of the facility's policy titled Advanced Directive Guideline, revised [DATE], indicated but was not limited to the following: -Advanced Directives will be respected and honored in accordance with State Law and resident/legal representative preferences. -Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she chooses to do so. -If the resident is incapacitated and unable to receive information about his or her right to formulate an advanced directive, the information may be provided to the resident's legal representative. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advanced directives. -The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directive. -The resident's attending physician will clarify and present any relevant medical issues and decisions to the resident or legal representative as the resident's condition changes in an effort to clarify and adhere to the resident's wishes. -The Interdisciplinary Team (IDT) will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment (MDS). -The Director of Nursing Services or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. Resident #31 was admitted to the facility in [DATE] and had diagnoses including Alzheimer's disease, dementia, and age-related cognitive decline. Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #31 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. Review of the admission Social Services progress note, dated [DATE], indicated the Resident's MOLST selections were as follows: attempt resuscitation, intubate and ventilate short term, use noninvasive ventilation short term, transfer to hospital, use dialysis, no artificial nutrition, hydrate. Review of current Physician's Orders indicated the following: -Attempt resuscitation, intubate and ventilate, use non-invasive ventilation, transfer to hospital, use dialysis, no artificial nutrition, use artificial hydration, [DATE] Review of the medical record indicated Resident #31 had a Decree and Order of Appointment of Guardian (someone who has received permission through a legal process to take care of and make decisions for a child or incapacitated adult) for an Incapacitated Person, dated [DATE]. Review of the MOLST, signed by the Resident and Nurse Practitioner (NP) #1 on [DATE], indicated the following: -Do not resuscitate -Do not intubate and ventilate -Do not use non-invasive ventilation (e.g. CPAP) -Transfer to hospital (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No dialysis -Artificial nutrition, undecided -Artificial hydration, use artificial hydration, but short-term only Review of a Nurse's Note, dated [DATE], indicated the NP had been in to see the Resident that morning with a new order to honor the MOLST. Review of the medical record failed to indicate the NP's order (change in directive) was transcribed into the medical record. The Resident remained a full code. NP #1 was unavailable for interview. Review of a Social Services progress note, dated [DATE], indicated Resident #31's legal guardian was confirmed on [DATE]. Further review of the medical record did indicate Resident #31 had capacity at the time of signing the MOLST or that the legal guardian was granted the authority to make and communicate decisions concerning continuance or withdrawal of life-sustaining treatment. The MOLST form remained in Resident #31's chart to the current date even though it was determined, approximately 11 months ago, that it was not valid and was inconsistent with current physician's orders. During an interview on [DATE] at 3:54 P.M., Unit Manager (UM) #1 said the current MOLST should be in the Resident's chart and match the physician's electronic order, but Resident #31's did not. During an interview on [DATE] at 10:58 A.M., the Director of Social Services said when the Resident was admitted in June of last year, they didn't know that he/she had a legal guardian until the guardian dropped off paperwork a month later. She said the facility spoke to the attorney who validated it. The Director of Social Services said the paperwork did not include an expansion for the guardian to have advanced directive decision making powers and would have to go back to court to allow for that. Until then, she said, the Resident would remain a full code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive). She said the MOLST was completed by NP #1 with the Resident on [DATE] before they knew he/she had guardianship and didn't even know the Resident had a MOLST in the chart prior to the surveyor's inquiry. During an interview on [DATE] at 11:27 A.M., Nurse #5 said when a code blue is called on the overhead pager, one staff member grabs the automated external device (AED), one grabs the code cart, and one grabs the physical chart, and they all go to the room the code was called for. She said a nurse will initiate cardiopulmonary resuscitation (CPR) or no CPR for a resident, by what the MOLST says in the chart. She said no matter what the electronic medical record says, she always goes by what it says in the chart. She said that's why someone must bring the chart to the code, to double check the MOLST. During an interview on [DATE] at 11:28 A.M., Nurse #1 said during a code situation she defers to the paper MOLST in the medical record, and someone runs for the chart and confirms the code status at the bedside. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:30 A.M., the Infection Preventionist (IP) said she uses the paper MOLST from the hard chart to confirm code status during any code to help guide her in what the ordered life sustaining wishes are for the resident. During an interview on [DATE] at 11:30 A.M., UM #2 said the expectation is that the code status is verified using the MOLST during an active code and that document is what her staff uses and how she trains new staff to verify code status even though there are scanned orders in the electronic medical record (EMR). During an interview on [DATE] at 11:31 A.M., Nurse #3 said if the Resident coded, she would look at the MOLST in the chart as well as current physician's orders to verify it. She said if the two were conflicting she'd call the physician to verify. She said if the physician didn't answer she'd have to call the Director of Nursing (DON). Nurse #3 said it would delay emergency medical treatment for the Resident because she'd need to know what she was doing. She said the physician's advanced directive order and the MOLST should be matching in the medical record. During a phone interview on [DATE] at 11:31 A.M., the DON said she spoke to Resident #31's guardian and advised him/her that he/she needed to get an expansion for the advanced directive, to have the right to make advanced directive decisions on behalf of the Resident. She said the MOLST form currently in the Resident's chart indicates a DNR status (do not resuscitate) but was a full code upon admission. The DON said there was no order from NP #1 that the advanced directive was changed and said she thought maybe the NP filled out the MOLST but didn't flag it as a new order and didn't write a note about it. The DON said they received the guardianship paperwork after the MOLST was signed by the Resident which indicated the Resident was incapacitated, therefore, it wasn't valid. The DON said the MOLST form should have been removed from the chart but was not and the Resident was currently a full code. She said if there were any discrepancy during a potential code, then the Resident would be presumed to be a full code. During an interview on [DATE] at 12:01 P.M., Nurse #4 said a resident's code status should not be conflicting and the electronic record should match the paper MOLST. She said if this occurred during a code, she would need to call the DON or representative, if that's who signed it, to verify. Nurse #4 said this could delay potential life-saving emergency treatment because she'd need to know what to do. During an interview on [DATE] at 12:14 P.M., the Medical Director said if an advanced directive is amended such as in a MOLST, then the electronic order would typically say honor the MOLST and there should be a progress note completed by the practitioner as to why the code status was changed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225503	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion , The	876 Falmouth Road Hyannis, MA 02601

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:08 A.M., the Director of Social Services said when a resident is admitted , they gather information prior to coming in including whether they have a Health Care Proxy (HCP), is it invoked, and do they have legal guardianship. She said each guardianship has differences with legal matters, language specifying what the guardian is allowed to do including allowance to make advanced directive decisions. She said she wants the resident to be part of the decision-making process, but the point person would make the decisions. She said the admissions staff work in conjunction with social services staff upon admission to seek documentation of the existence of any advanced directive, but the guardian didn't tell them or provide paperwork upon admission that he/she was the legal guardian for Resident #31. The Director of Social Services said they had a quarterly IDT meeting within the first 21 days after the Resident was admitted , then quarterly discussions at care plan meetings but was not aware NP #1 completed a MOLST or that it was even in the chart. She said she wasn't sure what prompted NP #1 to even introduce that to the Resident. She said the MOLST was not valid, and the guardian didn't have the authority to select advanced directives for the Resident. She said the plan of care for each resident should be consistent with his/her documented treatment preferences and advanced directives and that the Resident had been deemed incompetent in [DATE] by a court of law but didn't know about it until [DATE]. She further said she didn't know if anyone had revisited the Resident's wishes and preferences since indicated on the [DATE] MOLST. During an interview on [DATE] at 10:37 A.M., Medical Records said professional standards are followed regarding medical record maintenance. She said guardianship, conservatorship, and the MOLST are part of a resident's record, and the medical record includes both electronic and hard copy charts. She said the medical record should be maintained for each resident, be complete, accurately documented, readily accessible, and systematically organized. She said she wasn't aware of the situation, but this did not seem to be the case for Resident #31. She further said the medical record should reflect a consistent code status and that the hard copy MOLST should have been removed from the record last year if deemed invalid.