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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225508	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Chelmsford LLC	40 Parkhurst Road Chelmsford, MA 01824

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50320

Based on interview, record and policy review, the facility failed to inform in advance of changes to the plan of care relative to the use of psychotropic (medication that affects how the brain works and causes changes in mood, awareness, thoughts, feelings or behavior) medications for two Residents (#9 and #29) out of a total sample of 20 residents.

Specifically, the facility failed to obtain written consent for the use of psychotropic medications before administering Lorazepam (Ativan - anti-anxiety medication) medication to Residents #9 and #29.

Findings include:

Review of the facility policy titled Psychoactive Medication Use, dated 2015 and revised December 2022, indicated:

-A psychotropic medication is any medication that affects the brain activity associated with mental processes and behavior.

-Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring and review requirements specific to psychotropic medications .anti-anxiety medications .

-Written consent must be obtained prior to the administration of these medications. The consent form must be completed and signed by either the alert and oriented resident or his/her legal representative.

1. Resident #9 was admitted to the facility in November 2021, with diagnoses including Dementia (loss of memory, language, problem-solving, and other thinking abilities severe enough to interfere with daily life activities) and Generalized Anxiety Disorder (mental health condition that causes fear, worry and a constant feeling of being overwhelmed).

Review of Resident #9's Minimum Data Set Assessment (MDS) completed 9/5/24, indicated a score of 0 out of a possible total score of 15 on the Brief Interview for Mental Status (BIMS) exam indicating severe cognitive impairment.

Review of Residents #9's Clinical Record 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident's Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself) was activated by the Physician, effective 12/7/21. Review of Resident #9's October 2024 Physician's orders indicated: -Lorazepam (anti-anxiety medication) Oral tablet 0.5 milligrams (mg) (Lorazepam) give 0.5 mg by mouth every 6 hours as needed (PRN) for agitation/restlessness. Start date 9/18/24 and discharge [sic] 10/18/24. Review of Resident #9's September 2024 Medication Administration Record (MAR) indicated the Lorazepam medication was administered once daily on the following dates: -9/20/24 - 9/23/24 -9/27/24 Review of Resident #9's October 2024 MAR indicated the Lorazepam medication was administered once daily on the following dates: -10/1/24 -10/4/24 -10/8/24 -10/10/24 Further review of Resident #9's Clinical Record indicated no evidence of a signed consent for the Lorazepam medication. During an interview on 10/16/24 at 1:19 P.M., the Director of Nursing (DON) said the Nurse who takes the order for a psychotropic medication should fill out a consent form and get it signed. The DON said Resident #9 did not currently have a consent form in place for Lorazepam. The DON said the Resident should have had a consent form in place for Lorazepam. 50138 2. Resident #29 was admitted to the facility in August 2024, with diagnoses including: Dementia and Bipolar Disorder (a mental health condition that causes extreme mood swings that include emotional highs [mania or hypomania] and lows [depression]). Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #29 scored a ten out of a possible total score of 15 on the Brief Interview for Mental Status (BIMS) exam indicating that Resident #29 had moderate cognitive impairment. Review of Resident #29's comprehensive medical record indicated: -Invocation (put into effect) of a Health Care Proxy, effective 3/27/21. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #29's Physician orders indicated: -Ativan (Lorazepam - psychotropic, anti-anxiety medication) 1 mg (milligram) by mouth, two times a day for agitation, effective 9/20/24. Review of Resident #29's Medication Administration Record (MAR) indicated: -Ativan medication was administered from 9/20/24 through 10/15/24. Further review of Resident #29's medical record indicated no evidence of written consent prior to the administration of the Ativan medication. During an interview on 10/16/24 at 10:42 A.M., Unit Manager (UM) #1 said all psychotropic medications require written informed consent before administration to a Resident. UM #1 said the Nurse who transcribed (to put data into printed form) the Provider's order was responsible for obtaining consent. UM #1 said Resident #29 had been given scheduled Ativan twice a day without written consent and that consent should have been obtained from the HCP before administration. During an interview on 10/16/24 at 11:05 A.M., the Assistant DON (ADON) said all psychotropic medications required written consent. The ADON said Resident #29 had been administered Ativan without consent being in place. The ADON said consent for psychotropic medication was important because there could be side effects (secondary, undesired effect of a medication).

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on observation, interview, and record and policy review, the facility failed to ensure that devices utilized for two Residents (#50 and #103), were assessed and consent was obtained by the Resident Representative, when used as physical restraints (defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: is attached or adjacent to the resident's body, cannot be removed easily by the resident; and restricts the resident's freedom of movement or normal access to his/her body), for two applicable Residents who had gastrostomy tubes (G-tube: tube inserted through the stomach that delivers nutrition/hydration), out of a total sample of 20 residents. Specifically, the facility failed to: 1. For Resident #50, obtain written consent for a restraint, and assess the need for an abdominal binder (wide compression belt that hook and loop fastens and encircles the abdomen) to cover Resident #50's G-tube site in order to prevent him/her from pulling on the G-tube. 2. For Resident #103, obtain written consent for a restraint for an abdominal binder and bilateral hand mitts (mitts to cover the hands of a patient who is prone to disrupting medical treatment, picking, or tube pulling) that were being administered to cover Resident #103's G-tube site and bilateral hands in order to prevent him/her from pulling on the G-tube. Findings include: Review of the facility policy titled Use of Restraints, dated 2017, indicated: -Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. -Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. -Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, and lap cushions and trays that the resident cannot remove. -Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. -Restraints shall only be used upon the written order of a Physician and after obtaining consent from the resident and or representative (sponsor). Review of the facility form titled Physical Restraints -Record of Informed Consent, last revised 2012, indicated: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-that use of restraint will only be necessary/be considered to treat a medical condition or symptom that endangers my physical safety or the safety of other residents. -only be used upon my written consent or the written consent of my representative (sponsor). 1. Resident #50 was admitted to the facility in March 2023, with diagnoses including Cerebral Infarction (stroke: damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area), Hemiplegia Unspecified Affecting Right Dominant Side (partial or complete paralysis on one side of the body), and Gastrostomy Status (G-tube placed in the stomach for nourishment). Review of Resident #50's clinical record included a Decree and Order of Appointment of Guardian for an Incapacitated Person, dated 11/15/22, at which time a Guardian (a court appointed person who makes important personal and healthcare decisions for an adult who lacks the capacity to make their own decisions) was appointed for the Resident. Review of Resident #50's Physician's Progress note, dated 5/15/24, indicated that the Nurses had reported to the Nurse Practitioner (NP) that the Resident had pulled on their G-tube and the site was reddened/irritated. The Physician Progress note also included that staff may use an abdominal binder if patient/ Resident keeps pulling on G-tube. Review of Resident #50's current Physician's orders included: -Abdominal Binder, place and check for skin integrity; may remove for ADL (Activities of Daily Living) every shift. Order Active, initiated 5/15/24 Review of Resident #50's Minimum Data Set (MDS) assessment dated [DATE] included: -the Resident was severely cognitively impaired and rarely/never understood or made decisions -the Resident had a range of motion (ROM) deficit on one side -the Resident had G-tube feeding -the Resident was dependent on staff for all upper body dressing tasks Review of Resident #50's September 2024 Treatment Administration Record (TAR) indicated that the Abdominal Binder had been utilized daily for the entire month. Review of Resident #50's October 2024 TAR indicated that the Abdominal Binder had been utilized daily from 10/1/24 through 10/15/24. Review of the Resident's clinical record did not provide any documented evidence of an Informed Consent for the use of restraints that was reviewed with the Resident's Guardian, nor any assessment of the Abdominal Binder restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 10:15 A.M., during a G-tube feeding observation, the surveyor observed Nurse #1 remove the bed clothes from the Resident's upper body. The surveyor observed an Abdominal Binder fastened around the Resident's abdomen and the G-tube tubing was not visible. Nurse #1 unfastened the Abdominal Binder to expose the Resident's abdomen and the G-tube tubing. Nurse #1 completed administering the G-tube feeding and then re-applied the Abdominal Binder over the Resident's abdomen, covering the G-tube tubing. During an interview at the time, Nurse #1 said that the Abdominal Binder was applied for the purpose of keeping the Resident from pulling on the G-tube tubing, which the Resident had done in the past, causing irritation to the skin around the G-tube opening and making the skin bleed. Nurse #1 said the Resident has had the Abdominal Binder applied since last May 2024. Nurse #1 said the Resident was not able to remove the Abdominal Binder. During an interview on 10/17/24 at 9:28 A.M., the Director of Nursing (DON) said there was no written informed consent for the use of restraints for the application of the Abdominal Binder obtained from the Resident's Guardian before the application of the Abdominal Binder, but there should have been. The DON also said that there was never an assessment of the restraint when the Abdominal Binder was applied, but there should have been an assessment completed. 45429 2. Resident #103 was admitted to the facility in September 2024, with diagnoses including Gastrostomy and Cerebral Infarction. Review of Resident #103's Nurse Practitioner (NP) progress note, dated 9/20/24, indicated that the Resident was admitted to the facility with bilateral hand mittens and an Abdominal Binder in place. Review of the Minimum Data Set (MDS) Assessment, dated 9/24/24, indicated Resident #103: -was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. -had a gastrostomy. -had a limb restraint. Review of Resident #103's October 2024 Physician's orders indicated: -Abdominal Binder for prevention of PEG (feeding) tube displacement every shift, start date of 9/19/24 -mittens (glove that covers the hands but does not have individual finger openings) to bilateral hands, remove to check for skin integrity every shift, start date of 9/19/24 Review of Resident #103's September 2024 Treatment Administration Record (TAR) indicated that both the bilateral mittens and Abdominal Binder had been utilized daily. Review of Resident #103's October 2024 TAR indicated that the Abdominal Binder had been utilized daily, and the bilateral hand mittens had been utilized from 10/13/24 to 10/16/24. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 9:03 A.M., the surveyor observed Resident #103 lying in bed with mittens on his/her hands and a feeding tube administering Glucerna (liquid enteral feed specially designed for patients with a glucose intolerance). On 10/16/24 at 1:52 P.M., the surveyor and Nurse #2 observed Resident #103 lying in bed with an Abdominal Binder in use. During an interview at the time, Nurse #2 said that the Abdominal Binder and mittens were being used to prevent Resident #103 from dislodging his/her feeding tube. Review of the Resident's clinical record indicated the following: -a Restraint Evaluation was completed on 9/29/24 and 10/13/24, after the Resident's admission to the facility and after the use of restraints had already been administered to the Resident. -no documented evidence that informed consent had been obtained prior to the administration of the bilateral hand mittens or Abdominal Binder. During an interview on 10/16/24 at 2:08 P.M., Resident #103's invoked (made active by a Physician) Health Care Proxy (HCP- a legal document that allows you to appoint someone you trust to make medical decisions on your behalf if you are unable to do so) said that he/she had not signed consent paperwork for the use of restraints for Resident #103. During an interview on 10/17/24 at 9:14 A.M., the Director of Nursing (DON) said that informed consent should have been obtained prior to the administration of the abdominal restraint and mittens to Resident #103 and it had not been obtained.

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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** 50138 Based on record review and interview the facility failed to complete an accurate assessment to reflect resident status for one Resident (#106) out of a total sample of 3 closed resident records. Specifically, for Resident #106, the facility failed to accurately enter in Minimum Data Set (MDS) Assessment that the Resident was discharged to the hospital and not to home/community resulting in an inaccurate medical record. Findings include: Resident #106 was admitted to the facility in July 2024. Review of the Resident's comprehensive medical record included: -A Provider order to transfer the Resident to the hospital on 7/22/24. -A Nursing progress note dated 7/22/24 that indicated the Resident was in the hospital due to abnormal laboratory (blood) work. -A Social Service progress note dated 7/23/24, which indicated Resident #106 had a change in condition and was sent to the hospital for evaluation on 7/22/24. -A Minimum Data Set (MDS) assessment dated [DATE], which indicated Resident #106 had been discharged to their home on 7/22/24. During an interview on 10/17/24 at 12:18 P.M., MDS Nurse #1 said that Resident #106 was discharged from the facility to the hospital on 7/22/24. MDS Nurse #1 said the discharge location entered to the MDS dated [DATE], for Resident #106 was inaccurate. MDS Nurse #1 said that the Resident's MDS should have indicated that the Resident was discharged to a short-term hospital, not the home/community and therefore would require modification to accurately reflect the Resident's discharge location.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on observation, record and policy review, and interview, the facility failed ensure a Resident who was dependent for activities of daily living (ADL's- personal care activities including but not limited to, eating, grooming, and personal hygiene) received the necessary care and services to maintain grooming for one Resident (#94) out of a total sample of 20 residents. Specifically, for Resident #94, the facility failed to provide assistance for grooming of facial hair per the Resident's preference. Findings include: Review of the facility policy titled Activity of Daily Living (ADL's)- Supporting, dated 2001 with revision date of 3/2018, indicated: -Residents will be provided with care, treatment and services .to carry out ADL's. -Residents who are unable to carry out ADL's independently will receive the services necessary to maintain good .grooming and personal care. Resident #94 was admitted to the facility in June 2024, with diagnoses including fall, fracture (a complete or partial break of a bone) of the neck, and fracture of right radius (a long bone in the forearm that supports movement of the arm and wrist). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #94: -was moderately cognitively impaired as evidenced by a score of 12 out of a total score of 15 on the Brief Interview for Mental Status (BIMS) exam. -required substantial/maximum assistance (the Resident can perform between 25 and 50 percent of the ADL activity, with the remainder performed by the staff member) with personal hygiene which included facial grooming. Review of a Comprehensive Person-Centered Care Plan with a revision date of 10/14/24, indicated that Resident #94: -needed intervention of substantial/maximum assistance with personal hygiene due to decreased strength, decreased endurance and multiple fractures in the upper extremities. During an observation and interview on 10/15/24 at 9:57 A.M., the surveyor observed Resident #94 lying in bed with two patches of approximately one inch long facial hair present on the jaw line. Resident #94 said that he/she had been assisted with a shower that morning but was not offered assistance to remove the facial hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/15/24 at 4:45 P.M., the surveyor observed Resident #94 lying in bed with facial hair still present on the jaw line. Resident #94 said he/she liked to remove facial hair at home with an electric razor and prefered not to have any hair on his/her face. Resident #94 said it was not possible to shave his/herself as yet due to weakness in the right arm. Resident #94 said he/she was right hand dominant. During an interview on 10/16/24 at 10:09 A.M., the surveyor observed Resident #94 lying in bed and remained with patches of facial hair on the jaw line/chin. Resident #94 said that he/she would like the hair to be removed from his/her face. Resident #94 said he/she liked to remove the facial hair everyday when he/she was at home, but nobody has offered to remove the facial since being admitted to the facility. Resident #94 said he/she had no way of removing the facial hair his/herself due to the weakness in his/her right arm and removing the facial hair was important to him/her. During an interview on 10/16/24 at 10:10 A.M., Certified Nurses Aide (CNA) #1 said that Resident #94 was dependent for all personal care like washing, dressing and grooming. CNA #1 said that removal of facial hair should be part of daily care not just on shower days, and both male and female Residents should be offered facial hair removal with morning care. During an interview on 10/16/24 at 10:53 A.M., the Assistant Director of Nursing (ADON) said shaving should be offered to all Residents during AM (morning) care, because grooming/shaving was part of good hygiene, personal choices, and dignity.

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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. 50138 Based on observation, policy and record review, and interview, the facility failed to provide respiratory care and services consistent with professional standards of practice for one Resident (#29) out of a total sample of 20 residents. Specifically, the facility failed to obtain Physician's orders for oxygen administration and maintenance of oxygen and respiratory equipment. Findings include: Review of facility policy titled Oxygen Administration, dated 2001 with revision date of 10/2022, indicated: -Verify that there is a physician's order for oxygen administration. -Adjust the Oxygen delivery device so that it is comfortable for the resident and the proper flow of Oxygen is being administered. Review of the facility policy titled Respiratory Equipment/Supply Cleaning/Disinfecting, undated with revision date of 7/15/2024, indicated: -Schedule for supply changes of Nasal Cannula (NC - a clear, soft flexible tube with prongs which are positioned in the nose for oxygen delivery) should occur every seven days and as needed for soiling. Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf indicates: -All oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Undesirable results or events may result from noncompliance with physicians' orders or inadequate instruction for oxygen therapy. -There is a potential in some spontaneously breathing hypoxemic patients with hypercapnia [high carbon dioxide levels in the blood) and chronic obstructive pulmonary disease that oxygen administration may lead to an increase in $PaCO_2$. -Equipment maintenance and supervision: >All oxygen delivery equipment should be checked at least once daily (continued on next page)

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

>Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply.

Resident #29 was admitted to the facility in August 2024, with diagnoses including Acute Hypoxic Respiratory Failure (a life-threatening condition where the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body, with difficulty attaining normal blood oxygen levels) secondary to multifocal Pneumonia (an infection of the lungs that may be caused by bacteria, viruses, fungi or aspiration [when food or liquid is accidentally inhaled into airways and lungs] and characterized by severe cough with phlegm, fever, chills and difficulty breathing), empyema (pockets of pus collection in the pleural space [area between the lung and the inner surface of the chest wall surrounding the lung]) and Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment).

Review of the Resident's comprehensive medical record indicated:

-Invocation (made active by Physician) of a Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself), effective 3/27/21.

-No Physician orders for Oxygen administration or oxygen and respiratory equipment maintenance.

Review of Resident #29's Minimum Data Set (MDS) Assessment, dated 8/30/24, indicated:

-that the Resident had moderate cognitive impairment as evidenced by a score of ten out of a total score of 15 on the Brief Interview for Mental Status (BIMS) exam.

-that the Resident had been receiving Oxygen therapy.

On 10/15/24 at 8:27 A.M., the surveyor observed Resident #29 seated in the Unit dining area with Oxygen flowing at 2.5 LPM (Liters Per Minute- the flow rate set for Oxygen delivery) via nasal cannula (NC). The surveyor observed that the nasal cannula included the date 10/6/24 written on white tape in red ink and attached to the tubing. The surveyor observed Nurse #3 approach the Resident, adjust the oxygen delivery device on the Resident's face, have a short conversation with the Resident and leave the area.

On 10/15/24 at 11:29 A.M., the surveyor observed Resident #29 seated in the Unit dining area with Oxygen flowing at 2.5 LPM via NC, and the NC tubing was dated 10/6/24. The surveyor observed Nurse #3 approach the Resident and provided a beverage to him/her.

During an observation and interview on 10/15/24 at 12:15 P.M., the surveyor and Nurse #3 observed Resident #29 seated in the Unit dining area with Oxygen flowing at 2.5 LPM and NC tubing in his/her nose. Nurse #3 said Resident #29 was getting 2.5 LPM and had been receiving Oxygen since being admitted from the hospital in August 2024. Nurse #3 said when Residents are admitted to the facility with Oxygen, the admitting Nurse should obtain an order for the Oxygen, and tubing changes were every week on Sundays. Nurse #3 said that Resident #29 did not have Physician orders in place for Oxygen administration or tubing changes, but should have so all the Nurses would know how much Oxygen to administer and change the tubing weekly to prevent germs (contamination).

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER: Vantage at Chelmsford LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 40 Parkhurst Road Chelmsford, MA 01824	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 12:38 P.M., Unit Manager (UM) #1 said that Resident #29 was admitted from the hospital in August 2024 with the Oxygen already in place. UM #1 said that Resident #29 should have had orders in place for Oxygen administration and tubing changes but did not. UM #1 said it was the responsibility of the admitting Nurse to obtain the orders to ensure proper administration of Oxygen and equipment maintenance.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50320 Based on interview, record and policy review, the facility failed to ensure that an Influenza (Flu) vaccine was administered to one Resident (#16) out of five applicable residents, out of a total sample of 20 residents. Specifically, the facility failed to administer the Influenza vaccine for Resident #16 who had signed a consent for the vaccine to be administered. Findings include: Review of the facility policy titled Respiratory Protection Program Policy, (not dated), indicated: -The Center will ensure that all center staff and Residents/Patients have the opportunity to receive the respiratory illness vaccinations in accordance with the Centers for Disease Control and Prevention (CDC)recommendations and federal/state regulations . -Provide resident/resident representative with the current vaccine administration sheet as education regarding risks/benefits of vaccination if unvaccinated and document education. -Obtain consent. -Document exemptions/declinations. -Obtain a physician's order. -Administer vaccine. -Document vaccine administration. Review of the CDC guidelines titled Who Needs a Flu Vaccine, dated 10/3/24, indicated the following: -Everyone 6 months and older should get a flu vaccine every season with rare exceptions. Vaccination is particularly important for people who are at higher risk for serious complications from influenza. -Flu vaccination has important benefits. It can reduce flu illnesses, visits to doctor's office's .as well as make symptoms less severe and reduce flu-related hospitalization s and deaths in people who get vaccinated but still get sick. Review of the CDC guidelines titled People at Increased Risk for Flu Complications, dated 9/11/24, indicated some of the people at increased risk for complications of the flu are: -Adults aged 65 and older (continued on next page)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-People with Chronic lung disease -People with blood disorders -People with heart disease -People with a Body Mass Index (BMI) of 40 Kg (kilograms)/M (meters) 2 or higher -People with a weakened immune system due to .chronic conditions requiring chronic corticosteroids or other drugs that suppress the immune system. Resident #16 was admitted to the facility in March 2019, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD- a chronic lung disease that causes obstructed airflow from the lungs and difficulty breathing), Vitamin B12 Deficiency Anemia (a condition in which your body does not have enough healthy red blood cells), Chronic Diastolic Heart Failure(condition in which the left ventricle [the heart's main pumping chamber] becomes stiff and unable to relax between heartbeats to fill properly with blood), and morbid obesity (a chronic disease in which a person has a body mass index of 40 Kg or higher). Review of the Resident's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15. Review of Resident #16's medical record indicated the Resident received Influenza vaccinations on: 10/07/19, 10/19/20, 10/05/21, 10/06/22, and the Resident signed a consent form on 9/15/22 giving the facility permission to administer the appropriate Influenza vaccine annually. Further review of Resident #16's clinical record indicated a Physician's order, dated 11/27/23, for the following: -Fluzone High-Dose Quadrivalent Suspension Prefilled Syringe 0.7 ML (Influenza Vac High-Dose Quad). Inject 0.7 milliliter (ml) intramuscularly as needed for vaccination yearly per CDC guidelines for patients [AGE] years or older, unless contraindicated. -Check for allergies prior to administration. -Any signs or symptoms of moderate to severe acute illness contact Provider (Physician) prior to administration and document in PN (progress note). Inject 0.7 ml intramuscularly one time only for vaccine, until 11/28/23. Hold 11/30 - 12/1. During an interview on 10/16/24 at 4:01 P.M., Unit Manager (UM) #1 said that the Unit Nursing staff was responsible for administering the flu shots for the Residents on the unit. UM #1 said she knew the Resident was acutely ill in October 2023 and November 2023 and had been on IV antibiotics. UM #1 said the Influenza vaccine would have been held due to the Resident being on antibiotics. UM #1 was unable to say if the Influenza vaccine had been offered when the Resident recovered from the acute illness and was finished with the course of antibiotics. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/24 at 10:12 A.M., The Infection Preventionist (IP) said if a resident was acutely ill at the time the facility was administering the flu vaccines the vaccine would be held. The IP said Resident #16's vaccination was held because he/she was on antibiotics and was also receiving steroid injections. The IP said when Resident #16 had recovered and their antibiotic treatment was completed, the facility should have contacted the Physician and get recommendations for administering the flu shot to the Resident. During an interview on 10/18/24 at 11:16 A.M., Resident #16 said he/she could not remember if he/she was administered the flu vaccine in 2023. Resident #16 said he/she always get a flu vaccine if it is offered, and the Doctor says he/she can have the flu vaccine.