STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225531	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sudbury Pines Extended Care	642 Boston Post Road Sudbury, MA 01776

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 42761 Based on interview and record review, the facility failed to accurately complete Minimum Data Set (MDS) Assessments for two active Residents (#36 and #3) out of a total sample of 18 active Residents reviewed, and one discharged Resident (#86) out of a total sample of one discharged resident reviewed. Specifically, the facility staff failed to accurately code the MDS Assessment: 1. For Resident #36, relative to the use of Insulin (medication used to control one's blood sugar) injections (administering medication into one's body using a needle). 2. For Resident #3, relative to a skin condition and the use of pain medication for treatment. 3. For Resident #86, relative to discharge status. Findings include: 1. Resident #36 was admitted to the facility in March 2018 with a diagnosis of Diabetes Mellitus (DM: disease that affects how the body uses blood sugar). Review of Resident #36's March 2023 and April 2023 Physician's orders indicated: -Humalog (Insulin: medication used to control one's blood sugar) Subcutaneous (by injection) Solution 100 Units per Milliliter (ml) . per sliding scale (dose of Insulin to be administered based on one's blood sugar readings) . before meals and at bedtime related to DM, dated 3/31/23. Review of Resident #36's March 2023 Medication Administration Record (MAR) indicated the Resident did not receive any medication injections on 3/31/23. Review of Resident #36's April 2023 MAR indicated the Resident received Humalog on 4/2/23 and 4/5/23. Further review of the MAR indicated Resident #36 did not receive any other injections between 4/1/23 and 4/6/23. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #36's MDS Assessment, dated 4/6/23, indicated the Resident received Humalog injections seven out of seven days during the Assessment's observation period (3/31/23 through 4/6/23). 2. Resident #3 was admitted to the facility in April 2022 with diagnoses including Peripheral Vascular Disease (PVD: a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and Diabetes Mellitus Type Two (DM II: condition in which the body does not produce enough insulin and has trouble controlling blood sugar levels) with Diabetic Autonomic Polyneuropathy (nerve damage). Review of Resident #3's Wound Physician's Progress Note, dated 1/19/24, indicated the Resident had been treated for an arterial ulcer (wound that occurs as the result of occlusive disease when non-pressure related disruption or blockage of the arterial blood flow to an area causes tissue necrosis [devitalized tissue]. Arterial ulcers may be present in individuals with moderate to severe PVD) of the right foot/heel. Further review of the Wound Physician's Progress Note indicated that Resident #3's right foot/heel arterial ulcer was healed. Review of Resident #3's January 2024 Physician's orders indicated an active order, initiated 4/29/22, for: Hydrocodone - Acetaminophen (Opioid: medication used to treat moderate to severe pain) Oral Tablet 5-325 milligrams (mg), give one tablet by mouth three times a day (TID). Review of Resident #3's MDS Assessment, dated 1/24/24, indicated the Resident had one venous or arterial ulcer present. Further review of the MDS Assessment indicated Resident #3 did not receive any Opioid medication during the observation period. Review of Resident #3's January 2024 MAR indicated the Resident received Hydrocodone - Acetaminophen three times a day, all seven days during the observation period (1/18/24 through 1/24/24) for the MDS Assessment, dated 1/24/24. During an interview on 3/14/24 at 3:25 P.M., the MDS Coordinator said she reviewed the MDS Assessments for Residents #3 and #36, and that they were inaccurately coded. The MDS Coordinator said Resident #36 only received injectable medication two days during the assessment period for his/her MDS Assessment, not seven days as was indicated on his/her MDS Assessment, dated 4/6/23. The MDS Coordinator further said Resident #3's arterial ulcer was healed and should not have been coded as present on the MDS Assessment. The MDS Coordinator said Resident #3 received Opioid medication [as ordered] seven days during the assessment period, and this should have been coded on the MDS Assessment. 3. Resident #86 was admitted to the facility in December 2023 with a diagnosis of a Right Femur (thigh bone) Fracture (crack or break). Review of Resident #86's Nursing Telephone Order Note, dated 2/1/24, indicated the Nurse Practitioner (NP) had ordered: May discharge patient home . with medications and services . on 2/2/24. Review of a Social Services Progress Note dated 2/1/24, indicated Resident #86 was to be discharged home from the facility on 2/2/24 with homecare services and medications. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #86's Physician Progress Note, dated 2/2/24, indicated the Resident was to be discharged with his/her Representative to an Assisted Living Facility (ALF), where he/she would be followed by his/her Primary Care Physician, with homecare services and medications. Review of Resident #86's Nursing Progress Note, dated 2/2/24, indicated the Resident was discharged from the facility, with his/her Representative. Review of Resident #86's MDS Assessment, dated 2/2/24, indicated the Resident was discharged with anticipated return to the facility. During an interview on 3/15/24 at 9:38 A.M., the Director of Nurses (DON) said Resident #86 had been admitted to the facility for short term rehabilitation services and that his/her discharge plan was to return to his/her ALF. The DON said the facility did not anticipate that the Resident would return to the facility. The DON further said Resident #86's MDS Assessment, dated 2/2/24, should not have been coded as a discharge with return anticipated, but as a discharge with return not anticipated.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on interview and record review, the facility failed to coordinate an assessment with the pre-admission screening and resident review (PASRR- is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. PASARR requires that: 1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs [in the community, a nursing facility, or acute care setting]; and 3) receive the services they need in those settings) program for one Resident (#3) out of a total sample of 18 total residents. Specifically, the facility failed to refer Resident #3 for a Resident Review (person-centered assessment taking into account all relevant information) when he/she was admitted to the facility with a diagnosis of Schizoaffective Disorder (serious chronic mental illness), was being treated with antipsychotic (used to treat symptoms of mental illness, including delusions [fixed, false conviction in something that is not real or shared by other people] and psychosis [condition of the mind resulting in difficulty determining what is real and not real]) medication, and had a previously negative PASRR screen for serious mental illness (SMI). Findings include: Resident #3 was admitted to the facility in April 2022 with a diagnosis of Schizoaffective Disorder. Review of Resident #3's Level I (initial pre-screening completed prior to admission to a Nursing Facility) PASRR, dated 1/15/19, indicated the following: -The Resident had no documented diagnosis of mental illness or mental disorder (MI/MD). -The Resident's screen for SMI was negative. Review of Resident 3's Annual Physical Examination Care Plan, dated 5/12/21, indicated the Resident had a primary diagnosis of Schizoaffective Disorder. Review of Resident 3's Admission Record, undated, indicated the following: -The Resident was to be admitted to the facility, from another long-term care facility, in April 2022. -The Resident had a diagnosis of Schizoaffective Disorder. -The Resident required long-term care placement. -The Resident had a court appointed [NAME] Guardianship (when an individual is appointed by the court to make medical treatment decisions for an incapacitated person with mental illness). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident was prescribed and receiving Abilify (antipsychotic medication). -No evidence the Resident was referred to the PASRR program for review upon admission to the current facility in April 2022. Review of Resident #3's Psychotropic (any drug used to affect behavior, mood, thoughts, or perception) Medication Care Plan, initiated 5/6/22, indicated the Resident used psychotropic medication related to behavior management, aggression, delusions, . , psychosis, and Schizoaffective Disorder. Review of Resident #3's March 2024 Physician orders indicated the following: -Abilify Tablet 10 milligrams (mg). Give one tablet by mouth every day shift related to unspecified Psychosis . , initiated 12/21/23. -Abilify Tablet 20 mg. Give one tablet by mouth at bedtime related to unspecified Psychosis . , initiated 12/21/23. Review of Resident #3's clinical record during the survey period included no evidence that the facility referred the Resident to the PASRR program for review. During an interview on 3/13/24 at 3:11 P.M., the Social Worker (SW) said if a resident had a negative screen for SMI and was later diagnosed with SMI, the resident would be referred to the PASRR program for review. The SW said if Resident #3 had a negative screen for SMI, then was diagnosed with Schizoaffective Disorder, he/she should have been referred to the PASRR program for review. The SW further said she would look into this and get back to the surveyor. During a follow-up interview on 3/13/24 at 4:25 P.M., the SW said Resident #3 did have a diagnosis of Schizoaffective Disorder, which was not indicated on his/her initial PASRR, and had a court appointed [NAME] Guardianship. The SW said the diagnosis of Schizoaffective Disorder indicated the Resident should have been referred to the PASRR program for review, but as of 3/13/24, the PASRR referral had not been done.

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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, interview, and record review, the facility failed to provide respiratory care and services in accordance with professional standards of practice, for one Resident (#58) out of a total sample of 18 residents. Specifically, the facility failed to: 1. Obtain a Physician's order to determine the appropriate liter flow for Oxygen administration to Resident #58, for a Resident with diagnoses that require prescribed flow rates to prevent hypercapnia (high carbon dioxide levels in the blood). 2. Store and handle oxygen tubing in a sanitary manner, to decrease the risk of contamination and infection for the Resident. Findings include: Review of the facility's policy titled Oxygen Administration, undated, indicated a Physician's order was necessary for the administration of Oxygen. Review of the facility's policy titled Nasal Cannula Oxygen Administration, undated, indicated the following: -The nasal cannula delivers oxygen in low concentrations. -Verify the Physician's order . -Set the liter flow. -Place tips of the cannula into the patient's nostrils, loop the tubing over the ears. -Record start of oxygen in the patient's chart. -Replace cannula periodically and more frequently when the patient has an upper respiratory infection. Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014, at: 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Undesirable results or events may result from noncompliance with Physicians' orders or inadequate instruction on Oxygen therapy . -There is a potential in some spontaneously breathing hypoxemic patients with hypercapnia and chronic obstructive pulmonary disease that Oxygen administration may lead to an increase in PaCO2. -Equipment maintenance and supervision: All oxygen delivery equipment should be checked at least once daily Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply Resident #58 was admitted to the facility in June 2021, with diagnoses including: Chronic Obstructive Pulmonary Disease (COPD- a chronic lung disease that causes obstructed airflow and breathing problems), Asthma (a long-term disease of the lungs that causes airway inflammation/narrowing making it difficult to breathe), Wheezing (a high-pitched whistling sound made while breathing often associated with difficulty breathing), Acute Respiratory Failure with Hypoxia (a life-threatening condition where the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body), and Dementia (decline in cognitive abilities that impacts a person's ability to perform everyday activities, typically involves problems with memory, thinking, and behavior). Review of Resident #58's COPD Care Plan, initiated 6/28/21, revised 12/31/23, indicated: -Give Oxygen therapy as ordered by the Physician. Review of Resident #58's Minimum Data Set (MDS) Assessment, dated 2/27/24, indicated the Resident used Oxygen. Further review of the MDS Assessment indicated the Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of nine out of 15 total points. On 3/12/24 at 10:38 A.M., the surveyor observed Resident #58 lying in bed with an oxygen concentrator (medical device that delivers oxygen) next to his/her bed. The surveyor observed that oxygen tubing attached to a nasal cannula (thin, flexible tube that typically hooks around one's ears, with two prongs that sit in one's nose to deliver oxygen) was connected to the oxygen concentrator which was in use by the Resident, and part of the oxygen tubing was laying on the floor. The surveyor also observed that the oxygen concentrator was set to three (3) liters per minute (LPM: flow rate) of oxygen. The oxygen tubing and nasal cannula did not include the date that the equipment had been provided to the Resident. Review of Resident #58's March 2024 Physician's orders did not indicate any order for the use of Oxygen. During an interview on 3/14/24 at 1:40 P.M., Nurse #1 said that Resident #58 sometimes required the use of Oxygen at 2 - 2.5 LPM. Review of Resident #58's March 2024 Medication Administration Record (MAR) indicated no documented use of Oxygen, including the dates (3/12/24 and 3/14/24) the surveyor observed Oxygen being administered to the Resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/24 at 2:10 P.M., the surveyor observed Resident #58 lying in bed with the oxygen concentrator next to the bed, on and running, and Oxygen flow rate set between 3 - 3.5 LPM. The surveyor observed that the Resident's oxygen tubing was attached to the oxygen concentrator, with a portion of the tubing laying on the floor, and the nasal cannula was laying between the back of the Resident's head and the pillow (not in the Resident's nose). The surveyor observed Nurse #1 enter Resident #58's room and use his bare hands to handle the tubing that was laying on the floor, then remove the nasal cannula from behind the Resident's head and placed it into the Resident's nose. Nurse #1 did not replace the oxygen tubing that was laying on the floor or perform hand hygiene prior to placing the nasal cannula in the Resident's nose. During an interview at the time, Nurse #1 said he would know how much Oxygen to administer to a resident based on the Physician's order. Nurse #1 observed Resident #58's oxygen concentrator setting and said it was set to about 3 LPM. Nurse #1 said he would have to check the Resident's orders to see what Oxygen liter flow had been ordered by the Physician. Nurse #1 said he was unsure how long the Resident had been using Oxygen. The surveyor and Nurse #1 reviewed Resident #58's orders and Nurse #1 said that no order for the administration of Oxygen had been obtained for Resident #58. During an interview on 3/14/24 at 4:20 P.M., Nurse #2 said she was covering that day for the Unit Manager (UM) and that she used to be the facility's Infection Preventionist. Nurse #2 said that a Nurse could administer Oxygen to a resident if there was an urgent need but would then need to contact the Physician to obtain an order, which would include the flow rate. Nurse #2 said staff were required to change oxygen tubing at least weekly and if the tubing was observed to be kinked, dirty, or in disrepair. Nurse #2 said when the oxygen tubing was changed, the tubing would be dated to indicate when it was changed. Nurse #2 further said this was tracked on the Treatment Administration Record (TAR) for each resident using Oxygen. Nurse #2 said it was important to obtain an order from the Physician for the use of Oxygen because that was how staff knew how much Oxygen to administer and to monitor whether the ordered flow of Oxygen was effective for the resident. Nurse #2 also said this was important for residents with COPD because administering too much Oxygen could be harmful. Nurse #2 said tubing that was not clean could result in bacteria, infection, and Pneumonia. Nurse #2 said an order should have been obtained from the Physician to determine how much Oxygen Resident #58 required and to ensure that he/she was not administered too much Oxygen. Nurse #2 also said there was no way to tell how long the Resident's oxygen tubing had been in place since it was not labeled and there was no place to indicate on the TAR when the tubing had been provided or replaced. Nurse #2 said the Resident's oxygen tubing should have been replaced when it was observed on the floor and that Nurse #2 should not have handled the tubing that was resting on the floor and then used his hands to place the nasal cannula into the Resident's nose.