STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225533	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wachusett Manor	32 Hospital Hill Road Gardner, MA 01440

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had recently been readmitted with new diagnoses of aspiration pneumonia (infection caused by inhaling something other than air into the lungs), and pericardial effusion (fluid around the heart), the Facility failed to ensure nursing notified the Provider when he/she experienced further decline with a change in condition. Findings include: Review of the Facility's policy titled, Acute Condition Changes-Clinical Protocol, revised March 2018 indicated: - The nurse will notify the residents' attending physician or physician on call when there has been a significant change in the resident (decrease in food intake, changes in skin color or condition). Resident #1 was admitted to the Facility in December 2024, diagnoses included Atrial Fibrillation, presence of cardiac pacemaker, hypertension, coronary artery disease, unstable angina, and protein calorie malnutrition. Review of Resident #1's Hospital Discharge summary dated [DATE], indicated he/she was seen in the Emergency Department for chest pain, diagnosed with Aspiration Pneumonia and started on antibiotic therapy. The Summary indicated Resident #1 had an echocardiogram (non-invasive ultrasound to create pictures of the heart), that showed cardiac effusion (fluid around the heart). During a telephone interview on 06/24/25 at 12:49 P.M., Certified Nurse's Aide (CNA) #1 said on 06/07/25, Resident #1 had not been feeling well and wasn't his/her usual self, and she reported her concerns to the Nurse. During a telephone interview on 06/24/25 at 12:27 P.M., Nurse #1 said that on 06/07/25 around 4 P.M., Resident #1 reported to her that he/she did not feel well, his/her color was extremely pale, and he/she was more lethargic than usual. Nurse #1 said she applied oxygen at 3 Liters via nasal cannula to Resident #1 due to his/her pale color and bluish tint to his/her lips. Nurse #1 said she continued to monitor Resident #1 and with the application of oxygen his/her lips returned to normal color and skin color improved, but he/she remained feeling unwell. Nurse #1 said she did not notify Resident #1's Provider his/her condition change, of the need to apply oxygen, or to obtain new orders. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's medical record indicated there was no documentation to support nursing notified the provider on 06/07/25 of his/her decline in condition, despite the need to apply oxygen, which was new for him/her. During an interview on 06/24/25 at 12:42 P.M., the Nurse Practitioner (NP) said she was not notified by nursing staff on 06/07/25 that Resident #1 had a change in condition, that he/she had required oxygen. During an interview on 06/24/25 at 11:59 A.M., the Director of Nursing (DON) said there was no documentation to support that Nurse #1 called the Provider to notify that Resident #1 had a decline in condition, including the need to place oxygen on him/her, which was new. The DON said that it is the facility's expectation that nursing staff assess for acute changes in the resident's condition, notify the resident's Provider, and document and in this case it was not done. On 06/24/25, the Facility presented the Surveyor with a Plan of Correction that addressed the areas of concern identified in this survey; the Plan of Correction provided is as follows: A. Resident #1 no longer resides at the facility. B. On 6/10/25, a Facility wide audit was initiated by the Nursing Administration on residents with acute condition changes to ensure Facility policy was followed. C. Starting on 6/10/25, audits were conducted daily by the DON/designee to ensure that the provider has been notified of any residents with changes in condition, and will be reviewed at the daily morning report until substantial compliance is met and the results of the audits will be reviewed at the next monthly QAPI meeting on 6/25/25. D. On 6/10/25, the education of Nursing and Certified Nursing Assistant (CNA) staff was initiated by the Staff Development Coordinator on the Change in Condition Policy. E. On 06/13/25, an AD HOC Quality Assurance Performance Improvement (QAPI) meeting was conducted, concern areas discussed included: immediate response and ongoing monitoring plan to sustain compliance with Facility Policy on Acute Condition Changes-Clinical Protocol, and results of the Audits. F. On 6/19/25, the Facility completed the Education of all nursing staff on the correct process when a resident has a change in condition. G. The Director of Nursing and/or Designee are responsible for overall compliance.

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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** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was a full code, who during the evening shift (3:00 P.M. to 11:00 P.M.) on [DATE], was found unresponsive, pulseless with no respirations by the nursing staff, the facility failed to ensure he/she was provided care and services that met professional standards of nursing practice, when although nursing staff initiated a Code Blue, called 911, and provided Cardiopulmonary Resuscitation (CPR), to him/her until Emergency Services arrived, nursing failed to obtain and use the facility's Automated External Defibrillator (AED) device, during the Code Blue. Findings include: Review of the Facility's Policy, titled Emergency Procedure-Cardiopulmonary Resuscitation and Basic Life Support, dated [DATE], indicated the following: - Activation and retrieval of the AED by the lone healthcare provider or by the second person sent by the rescuer, must occur immediately after the check for no normal breathing and no pulse, - Immediately begin CPR and use the AED/defibrillator, - When the second rescuer arrives, provide 2-rescuer CPR and use the AED. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated [DATE], indicated on [DATE], Resident #1 was found unresponsive by a Certified Nurse Aide (CNA, later identified as CNA #1) who alerted the Nurse (later identified as Nurse #1), a code was called, crash cart obtained and Nurse #1 began compressions and another staff member (later identified as Nurse #2) called 911 and assisted with CPR until EMS arrived. Further review of the report indicated Resident #1 expired at the facility. Resident #1 was admitted to the Facility in [DATE], diagnoses included Atrial Fibrillation, presence of cardiac pacemaker, hypertension, coronary artery disease, unstable angina, and protein calorie malnutrition. Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated he/she was seen in the Emergency Department for chest pain, diagnosed with Aspiration Pneumonia and started on antibiotic therapy. Further review indicated Resident #1 had an echocardiogram (non-invasive ultrasound to create pictures of the heart), that showed cardiac effusion (fluid around the heart). During a telephone interview on [DATE] at 12:49 P.M., (which included review of her written statement) CNA #1 said on [DATE] sometime after 9:00 P.M., she found Resident #1 unresponsive and immediately notified the nurse, (later identified as Nurse #1) who assessed him/her. CNA #1 said Nurse #1 called a code blue over the hand held radio system and initiated CPR after retrieving the crash cart. CNA #1 said Nurse #2 called 911 to activate EMS services and then assisted Nurse #1 with CPR on Resident #1 until EMS arrived. CNA #1 said she was not directed to retrieve the AED device. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 12:27 P.M., (which included review of her written statement) Nurse #1 said on [DATE] sometime after 9:00 P.M., (exact time unknown) CNA #1 told her that she found Resident #1 unresponsive and pale, that she assessed him/her, found no pulse or respirations and called a Code Blue three times via the hand held radio system, obtained the crash cart and began CPR. Nurse #1 said she did not direct a staff member to retrieve the AED. Nurse #1 said she had directed CNA #1 to alert Nurse #2 who activated EMS services (called 911) and then assisted her with CPR. Nurse #1 said when EMS arrived (exact time of arrival unknown) and took over CPR, they then determined Resident #1 had expired and informed them (herself and Nurse #2) that further resuscitation efforts would not be beneficial. Review of Nurse #2's witness statement (documented by the DON per telephone interview) dated [DATE], indicated he was alerted of the Code Blue, called 911 and went to Resident #1's room to assist with CPR, but did not see an AED in the room. Review of the EMS Provider Response Report, dated [DATE], indicated EMS was activated at 9:29 P.M., units arrived at the facility at 9:34 P.M. and observed two rescuer CPR in progress. The Report indicated the resident had no signs of life and they (EMS) determined further resuscitation efforts were futile. The Report also indicated there was no AED present on Resident #1 or on the scene (in the room). During an interview on [DATE] at 12:42 P.M., the Nurse Practitioner (NP) said, she would have expected nursing to apply to an AED to a resident during a Code Blue, but also said during this event, the use of the AED on Resident #1 would not have changed the outcome due to his/her poor cardiac effusion and cardiac history. During an interview on [DATE] at 11:14 A.M., the Director of Nursing (DON) said she spoke to Nurse #1, who said CNA #1 informed her (Nurse #1) that she found Resident #1 unresponsive and pale sometime after 9:00 P.M. (exact time unknown). The DON said Nurse #1 assessed him/her, he/she was pulseless without respirations and she called a Code Blue, obtained the crash cart and began compressions while, Nurse #2 called 911 to initiate EMS services and then went to assist Nurse #1. The DON said Nurse #1 should have delegated a staff member to retrieve the AED, and it should have been applied and used during the code, but it was not. The DON said her expectation is always nursing best practice, patient-centered care and that all Facility Protocols and Policies are being followed by the nurses and staff. The DON said she holds the nurses to the highest standard for professional conduct for residents' safety. On [DATE], the Facility presented the Surveyor with a Plan of Correction that addressed the areas of concern identified in this survey; the Plan of Correction provided is as follows: A. Resident #1 no longer resides at the facility. B. An Audit was conducted immediately by the Staff Development Coordinator (SDC) to ensure Nursing staff were current on CPR certifications and determined all nursing staff were current. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. On [DATE], a Facility wide audit was initiated by the Nursing Administration to ensure the Code Cart Daily Checklist and the 11:00 P.M.-7:00 A.M. (night shift) Daily Checklist (which includes checking the AED) were completed. D. Ongoing audits will be conducted daily by the DON/designee to ensure both the Code Cart Daily Checklist, and the night shift Daily Checklist are completed and will be reviewed at the next monthly QAPI meeting on [DATE]. E. On [DATE], the education of Nursing and Certified Nurse Aide (CNA) staff was initiated by the Staff Development Coordinator on the Code Blue Policy, which included assigning and nursing responsibility to ensure a staff member (across all shifts) retrieves and brings the AED in event of Code Blue. F. On [DATE], an AD HOC Quality Assurance Performance Improvement (QAPI) meeting was conducted, concern areas discussed included immediate response and ongoing monitoring plan to sustain compliance with MOLST and Facility Policy on Emergency Procedures and results of the Audits. G. On [DATE], the Facility completed the Education of all nursing staff on the correct process for Emergency Procedures, including but not limited to ensuring the AED is brought and used as directed during a Code Blue. H. The Director of Nursing and/or Designee are responsible for overall compliance.