STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225545	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Courtyard-Medford	200 Governors Avenue Medford, MA 02155

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 37342 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), whose physician's orders included hemodialysis three times a week, the Facility failed to ensure he/she received care and services consistent with professional standards of practice, when he/she did not receive hemodialysis as ordered, per his/her established schedule, experienced mental status changes, and was transferred to the Hospital to receive dialysis. Findings include: Review of the Facility Policy, titled Care of a Resident With End Stage Renal Disease, dated as revised 04/2022, indicated residents with end stage renal disease (ESRD) would be cared for according to currently recognized standards of care, and the Facility would arrange for the resident to receive dialysis treatment from a dialysis facility. Resident #1 was admitted to the Facility in December 2017, diagnoses included diabetes, ESRD, and dementia. Review of Resident #1's Medication Administration Record (MAR), for August 2024 indicated he/she had a physician's order for nursing staff to transport him/her to the Dialysis Center in the basement of the Facility every Monday, Wednesday, and Friday. Further review of Resident #1's August 2024 MAR indicated that the box for Friday, 08/09/24 was coded as 5 which meant Dialysis was on hold and to refer to the Progress Note. Review of Resident #1's Nurse Progress Note, dated 08/09/24, indicated the Dialysis Center at the Facility was closed that day, and Resident #1 would have dialysis on 08/10/24. Review of the Email, dated 08/10/24, indicated the Administrator was informed by the Dialysis Center that Resident #1 had not had dialysis since 08/07/24, and would need to be transferred to the Hospital Emergency Department. Review of Resident #1's Transfer/Discharge Evaluation, dated 08/10/24 indicated Resident #1 was transferred to the Hospital Emergency Department because he/she had not had dialysis since Wednesday, 08/07/24. (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Hospital Admission Note, dated 08/10/24, indicated he/she missed dialysis on 08/09/24 and was added to the schedule for 08/10/24, however due to a miscommunication, he/she missed dialysis again on 08/10/24 and was subsequently transferred to the Hospital Emergency Department for dialysis. The Hospital Admission Note indicated Resident #1 was admitted to the Hospital and diagnosed with altered mental status in the setting of having missed his/her dialysis treatment. During a telephone interview on 09/10/24 at 11:08 A.M., Unit Manager #1 said that on 08/09/24 she was notified by the Facilty's Dialysis Center that residents who would normally receive dialysis on that day would instead receive dialysis on 08/10/24. Unit Manager #1 said she notified the 07:00 A.M. to 03:00 P.M., nursing staff on Resident #1's unit of the change and expected that staff would pass on that information in shift reports. During an interview on 09/09/24 at 01:26 P.M., Nurse #1 said that on 08/10/24, she was the nurse assigned to Resident #1's unit and said that she was not made aware of any change in the dialysis schedule until 10:00 A.M., when the dialysis nurse called the unit asking for another resident to be transferred down to the Dialysis Center. Nurse #1 said when she transferred the other resident, that was when she was told that residents who would normally have been dialyzed on 08/09/24 were rescheduled to 08/10/24. Nurse #1 said she knew Resident #1 had not had dialysis since 08/07/24, and that he/she usually went very early in the morning but had not gone yet on 08/10/24. Nurse #1 said she asked the dialysis nurse about whether Resident #1 was on the schedule and said the dialysis nurse said she did not have him/her on the schedule for 08/10/24. Nurse #1 said that on 08/10/24, Nurse Supervisor #1 told her he had heard from the Administrator that since Resident #1 had not had dialysis since 08/07/24, he/she would have to be transferred to the Hospital Emergency Department for dialysis. During a telephone interview on 09/10/24 at 02:05 P.M., Nurse Supervisor #1 said that later in the day on 08/10/24, he received a call from the Administrator stating that Resident #1 had not received dialysis since 08/07/24 and would require transfer to the Hospital Emergency Department. Nurse Supervisor #1 said prior to this, he was not aware that there was a schedule change for any of the residents who required dialysis. During an interview on 09/09/24 at 04:15 P.M., the Administrator said that on 08/10/24, he received an email from the Facility's Dialysis Center that indicated Resident #1 would need to be transferred to the Hospital Emergency Department because he/she had not received dialysis treatment since 08/07/24. The Administrator said he was unsure why Resident #1 did not receive dialysis on 08/10/24, but said he/she should have. During a telephone interview on 09/09/24 at 03:34 P.M., the Assistant Director of Nurses (ADON) said it was never determined exactly where the communication breakdown between the Facility's Dialysis Center staff and nursing unit staff occurred and said that nursing should have ensured that Resident #1 received dialysis as scheduled but did not.

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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	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37342 Based on records reviewed and interviews, for two of three sampled residents (Resident #1 and Resident #3), the Facility failed to ensure it maintained complete and accurate medical records when 1) for Resident #1, nursing staff failed to ensure there was documentation of a physician's order to transport him/her to the Hospital Emergency Department on 08/10/24, and 2) for Resident #3, documentation by nursing related to the conduction of weekly skin assessments was not consistently completed. Findings include: Review of the Facility Policy, titled Charting and Documentation, dated 04/2022, indicated that services provided to the resident, any changes in the resident's medical, physical, functional, or psychological condition would be documented in the resident's medical record. 1) Review of the Facility Policy, titled Physician Order, dated 04/2022, indicated physician orders would be maintained in chronological order. Resident #1 was admitted to the Facility in December 2017, diagnoses included diabetes, ESRD, and dementia. Review of Resident #1's Transfer/Discharge Evaluation, dated 08/10/24 indicated Resident #1 was transferred to the Hospital Emergency Department. Further review of Resident #1's medical record indicated there was no documentation to support there was a physician's order to transfer him/her to the Hospital Emergency Department on 08/10/24. Review of Resident #1's Physician's Order Recap Report for order dates 08/01/24 through 08/31/24 indicated there was no documentation to support that he/she had a physician's order for a transfer to the Hospital Emergency Department on 08/10/24. During an interview on 09/09/24 at 11:18 A.M., the Regional Nurse Consultant said there should be a physician's order documented any time a resident was transferred to the Hospital, but for Resident #1 there was not. 2) Review of the Facility Policy, titled, Preventative Pressure Ulcer, dated 04/2022, indicated nursing would conduct weekly skin assessments. Review of the Facility Policy, titled Pressure Ulcer/Injury Risk Assessment, dated 03/2022, indicated assessments would be documented utilizing facility forms. Resident #3 was admitted to the Facility in April 2019, diagnoses included End Stage Renal Disease, Parkinsonism, and Cerebral Palsy. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's medical record indicated he/she had a physician's order, dated as initiated 07/27/20 and as of September 2024 was still an active order, for nursing to conduct weekly skin checks every Friday. Review of Resident #3's Treatment Administration Records for August and September 2024 indicated that he/she was scheduled to have weekly skin checks on 08/01/24, 08/08/24, 08/15/24, 08/22/24, 08/29/24, and 09/05/24. Further review of Resident #3's TAR indicated for his/her weekly skin checks, that all these dates were checked off as having been conducted by nursing. However, further review of Resident #3's Medical Record indicated that there was no documentation to support that Weekly Skin Assessment Forms were completed for 08/01/24, 08/15/24, 08/22/24, 08/29/24, and 09/05/24. During an interview on 09/09/24 at 11:18 A.M., the Regional Nurse Consultant said nursing should document weekly skin assessments on the Facility's electronic skin observation tool for Resident #3, but had not.