| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225545 | A. Building<br>B. Wing | 12/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Regalcare at Courtyard-Medford | 200 Governors Avenue<br>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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37342<br><br>Based on records reviewed and interviews, for one of three sampled residents (Resident #2), the Facility failed to ensure nursing staff maintained a complete and accurate medical record, when after Resident #2 experienced a medical emergency, Unit Manager #1 failed to accurately document her findings after assessing him/her.<br><br>Findings include:<br><br>The Facility Policy, titled Medical Record, dated ,d+[DATE], indicated documentation would include observations and descriptions of significant changes in the resident's condition.<br><br>The Facility Policy, titled Charting and Documentation, dated ,d+[DATE], indicated that services provided to the resident or any changes in condition would be documented in the resident's medical record.<br><br>Resident #2 was admitted to the Facility in [DATE], diagnoses included Amyloidosis (a multisystem, rapidly progressive nature of the disease leads to disability and premature death), dementia, neuropathy, fibromyalgia, and dysphagia.<br><br>Review of Resident #2's Nurse Progress Note, dated [DATE], indicated that at 09:13 A.M., Resident #2 was found without respirations and Cardiopulmonary Resuscitation (CPR) was initiated.<br><br>During an interview on [DATE] at 12:19 P.M., Unit Manager #1 said that on [DATE] at 09:13 A.M., she was called to Resident #2's room by staff, observed that Resident #2 had food in his/her mouth and had drool coming from his/her mouth. Unit Manager #1 said she removed a golf ball sized bolus of food from Resident #2's mouth at that time, that he/she was not breathing, that a Code Blue was called and CPR were initiated.<br><br>Unit Manager #2 said she did not document that Resident #2 had food in his/her mouth, but should have.<br><br>Further Review of Resident #2's Medical Record indicated there was no documentation to support that he/she was found with food in his/her mouth on [DATE].<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225545 | A. Building<br>B. Wing | 12/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Regalcare at Courtyard-Medford | 200 Governors Avenue<br>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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on [DATE] at 03:07 P.M., the Director of Nurses (DON) said it was expected that nursing staff would document any change in resident condition in the medical record and said Unit manager #1 should have documented that Resident #2 had a bolus of food in his/her mouth but did not. |