

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Mary Ann Morse Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 45 Union Street Natick, MA 01760	

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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>47901</p> <p>Based on record and policy review, and interview, the facility failed to ensure that one Resident (#307) out of a total sample of 22 residents, was afforded the ability to review/sign documents pertaining to his/her medical care.</p> <p>Specifically, the facility failed to ensure that Resident #307, who was identified as his/her own person and was able to make his/her own decisions, was able to review and sign documentation relative to Advanced Directives (life sustaining measures), side rail consent, self-administration of medication consent and consent for the use of psychotropic medications.</p> <p>Findings include:</p> <p>Review of the facility policy titled MOLST (Massachusetts Medical Orders for Life Sustaining Treatment), dated 1/2014, indicated the following:</p> <ul style="list-style-type: none"> -The admitting nurse will note the existence of the MOLST form in the nursing notes and on the Physician's Orders. -Confirm with the patient/resident or their legally recognized healthcare agent that the MOLST form in hand has not been revoked or changed by a subsequent MOLST form. -A qualified health care provider, a licensed nurse or social worker, may conduct an initial review of the MOLST with the resident or if the resident lacks decision making capacity, the legally recognized health care agent. -The initial review and discussion about continuing, revising, or revoking the MOLST should be documented in the medical record. This documentation should include the time and date of the discussion, the parties involved and plans for follow-up action if needed. <p>(continued on next page)</p>

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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #307 was admitted to the facility in September 2024, with diagnoses including Adult Failure to Thrive (a syndrome of global decline in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment, weight loss, decreased appetite or poor nutrition and inactivity), Thoracic Aortic Aneurysm (ballooning of the upper aspect of the aorta, above the diaphragm) without Rupture, Status Post Kidney Transplant (surgery to replace a diseased or damaged kidney with a healthy one from a donor) and Severe Protein Malnutrition (an imbalance between the nutrients the body needs to function and the nutrients the body gets, that causes fluid retention, swollen abdomen and muscle wasting).</p> <p>Review of Resident #307's clinical record included the following:</p> <ul style="list-style-type: none"> -Nursing Facility Authorization to Treat signed by the Resident's Representative on 9/11/24. -Medication Reconciliation Worksheet signed by the Resident's Representative on 9/11/24. -Side Rail Utilization Informed Consent signed by the Resident's Representative on 9/11/24. -Self-Administration Medications signed by the Resident Representative on 9/11/24. -Informed Consent Form for Remeron (medication used to trat major depressive disorder) signed by Resident Representative on 9/11/24. -MOLST form completed and signed by Resident Representative on 9/11/24, as Do Not Resuscitate, Do Not Intubate. <p>Further review of Resident #307's clinical record indicated that the Resident's Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themselves) was not invoked (put into effect, was not dependent on a designated person to make medical and health care decisions) by the Physician/Medical Provider since his/her admission.</p> <p>On 9/20/24 at 7:45 A.M., the surveyor and Unit Manager (UM) #3 reviewed the Resident's clinical record. During an interview at the time, UM #3 said Resident #307's HCP was not invoked relative to decision making for health care treatment.</p> <p>During an observation and interview on 9/20/24 at 8:00 A.M., Resident #307 declined speaking to the surveyor. Resident #305 was lying in bed and when the surveyor attempted to talk to him/her, the Resident pulled up the blanket and covered his/her head.</p> <p>During an interview on 9/20/24 at 8:22 A.M., Social Worker (SW) #2 said the facility had not addressed Resident #307's medical decision capabilities. SW #2 said initial review and discussion about continuing, revising, or revoking the MOLST should have been completed and documented in the medical record, but it was not.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563</p> <p>Based on interview, record and policy review, the facility failed to ensure that Advance Directives (legal documents that provide instructions for medical care and only go into effect if you are unable to communicate your own wishes) were accurate for two Residents (#33 and #37) out of a total sample of 22 residents.</p> <p>Specifically, the facility failed to:</p> <ol style="list-style-type: none"> for Resident #33, ensure that the MOLST (Medical Orders for Life Sustaining Treatment: a form completed by the Resident to indicate their wishes for treatment to sustain their life in emergency situations in case they are not able to make their wishes known) was maintained as part of the Resident's active medical record and was accessible to facility staff in the event the Resident had a change in condition. for Resident #37, ensure that the Physician's orders matched the Resident's current MOLST. <p>Findings include:</p> <p>Review of the facility policy titled MOLST (Massachusetts Medical Orders for Life Sustaining Treatment), dated January 2014, indicated:</p> <ul style="list-style-type: none"> -Completed MOLST forms will be accepted as valid medical orders . -When the Physician or Nurse Practitioner visits in person (within 72 hours after admission) or at the time of signing a MOLST anytime after admission, the actual order saying Full Code, DNR (Do Not Resuscitate), Do Not Hospitalize etc. should be handwritten as a Physician's Order. -Once reviewed the MOLST should be copied and the current original form placed in a page protector in the advanced directives section of the chart along with any other advanced directives completed . <p>1. Resident #33 was admitted to the facility in February 2023, with diagnoses of Congestive Heart Failure (CHF- caused when the heart is unable to pump blood effectively resulting in fluid build-up in the lungs, arms, feet and other organs) and Cerebral Infarct (stroke: damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area).</p> <p>Review of Resident #33's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total 15.</p> <p>Review of Resident #33's clinical record indicated:</p> <ul style="list-style-type: none"> -A blank MOLST form in the front of the chart. -No evidence of a completed MOLST on file. <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #33's September 2024 Physician's orders indicated:</p> <p>-Full Code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive), No Dialysis, initiated 7/25/24, active</p> <p>During an interview on 9/19/24 at 12:58 P.M., Resident #33 said he/she believed that someone had completed a MOLST with him/her a long time ago but he/she could not recall when.</p> <p>During an interview on 9/19/24 at 1:20 P.M., the surveyor and Social Worker (SW) #1 reviewed the Resident's chart and Physician's orders. SW #1 said she would review her records and the Resident's clinical record and follow-up with the surveyor.</p> <p>During a follow-up interview on 9/19/24 at 1:28 P.M., SW #1 said her records indicated Resident #33 had declined to fill out a MOLST but that this would be addressed again at his/her upcoming care plan meeting.</p> <p>During an interview on 9/19/24 at 3:04 P.M., the Director of Nursing (DON) presented the surveyor with a completed MOLST form dated 2/15/23, that indicated the following:</p> <ul style="list-style-type: none"> -Attempt Resuscitation -Intubate and Ventilate -Use Non-Invasive Ventilation (e.g. CPAP [sic] - a device that provides Continuous Positive Airway Pressure) -Transfer to the Hospital -No dialysis -No artificial nutrition -Use artificial hydration <p>During a follow-up interview on 9/20/24 at 9:26 A.M., the DON said the MOLST form dated 2/15/23, had been located in Resident #33's old chart in medical records. The surveyor and the DON reviewed the portion of the MOLST where the Resident had indicated no dialysis and no artificial nutrition. The DON said that there would be concern because if Resident #33 became incapacitated, staff would not have been able to follow his/her wishes if they cannot access the MOLST form.</p> <p>2. Resident #37 was admitted to the facility in November 2019, with diagnoses including Cerebral Infarction and Chronic Obstructive Pulmonary Disease (COPD: a lung disease that causes restricted air flow in the lungs and difficulty breathing).</p> <p>Review of Resident #37's MDS assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a BIMS score of 13 out of total 15.</p> <p>Review of Resident #37's MOLST, dated 11/13/23, indicated:</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-MOLST had been signed by Resident #37</p> <p>-Do Not Resuscitate (DNR)</p> <p>-Do Not Intubate and Ventilate (DNI/DNV)</p> <p>-Option to use or not use Non-Invasive Ventilation left blank</p> <p>-Do Not Transfer to Hospital (unless needed for comfort) (DNH)</p> <p>-Page 2 of the MOLST form addressing treatment decisions for dialysis, artificial nutrition, and artificial hydration was left blank</p> <p>Review of Resident #37's September 2024 Physician's orders, initiated 7/25/24, active indicated the following:</p> <p>-DNR</p> <p>-DNI</p> <p>-may transport to hospital</p> <p>-use non- invasive ventilation</p> <p>-use artificial hydration short term only</p> <p>During an interview on 9/19/24 at 1:25 P.M., the surveyor and SW #1 reviewed the MOLST and Physician's orders. SW #1 said Resident #37 had declined to fill out the back of the MOLST form. SW #1 further said that the Physician's orders should match the MOLST form, but that the Physician's orders and MOLST did not match.</p>

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206</p> <p>Based on record review and interview, the facility failed to ensure that a Minimum Data Set (MDS) Assessment was accurately coded for four Residents (#72, #33, #2, #357) out of a total sample of 22 residents.</p> <p>Specifically, the facility failed to accurately code:</p> <ol style="list-style-type: none"> 1) For Resident #72, that Pneumonia Vaccination was not up to date. 2) For Resident #33, that Pneumonia Vaccination was not up to date. 3) For Resident #2, that Pneumonia Vaccination was not up to date. 4) For Resident #357, identify the type of urinary catheter in use. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #72 was admitted to the facility in December 2023, with diagnoses including Dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking). <p>Review of the MDS (Minimum Data Set) assessment dated [DATE], indicated that Resident #72's Pneumococcal Vaccination was up to date.</p> <p>Review of Resident #72's Massachusetts Immunization Information System (MIIS) record indicated his/her last Pneumococcal Vaccination was administered 1/1/05.</p> <p>During an interview on 9/20/24 at 7:35 A.M., the Infection Preventionist (IP) said that Resident #72's Pneumococcal Vaccination was not up to date.</p> <p>During an interview on 9/20/24 at 10:35 A.M., the MDS Coordinator said that the Pneumococcal Vaccination information was auto populated from the immunization documentation in a resident's record. The surveyor and the MDS Coordinator reviewed Resident #72's Pneumococcal Vaccination record and the MDS Coordinator said the 8/12/24 MDS Assessment was inaccurately coded and a modification would be submitted.</p> <ol style="list-style-type: none"> 2. Resident #33 was admitted to the facility in April 2023, with diagnoses including Cerebrovascular Accident (CVA- cerebrovascular accident, also known as stroke, when blood flow to a part of the brain is stopped either by a blockage or the rupture of a blood vessel). <p>Review of the MDS assessment dated [DATE], indicated Resident #33's Pneumococcal Vaccination was up to date.</p> <p>Review of Resident #33's MIIS record indicated his/her last Pneumococcal Vaccination was administered 11/27/19.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/20/24 at 7:35 A.M., the IP said that Resident #33's Pneumococcal Vaccination was not up to date.</p> <p>During an interview on 9/20/24 at 10:35 A.M., the MDS Coordinator said the 7/28/24 MDS Assessment was inaccurately coded and a modification would be submitted.</p> <p>3. Resident #2 was admitted to the facility in June 2023, with diagnoses including Dementia.</p> <p>Review of the MDS assessment dated [DATE], indicated Resident #2's Pneumococcal Vaccination was up to date.</p> <p>Review of Resident #2's MIIS record indicated his/her last Pneumococcal Vaccination was administered 11/5/14.</p> <p>During an interview on 9/20/24 at 10:35 A.M., the MDS Coordinator said the 8/12/24 MDS Assessment was inaccurately coded and a modification would be submitted.</p> <p>50563</p> <p>4. Resident #357 was admitted to the facility in September 2024, with diagnoses including Neuromuscular Dysfunction of the Bladder (a condition where the nerves and muscles of the bladder do not work together well and can cause problems with the emptying of the bladder) and Chronic Indwelling Catheter (device inserted into the bladder that drains urine into a collection bag).</p> <p>Review of Review of Resident #357's Minimum Data Set (MDS) Assessment, dated 9/12/24, indicated the presence of an indwelling catheter and an external catheter (a device placed over the external genitalia to collect urine that has exited the body and contain it in a collection bag).</p> <p>During an interview on 9/19/24 at 3:12 P.M., the surveyor and the MDS Coordinator reviewed the MDS assessment dated [DATE]. The MDS Coordinator said she would have to review her records and get back to the surveyor.</p> <p>During a follow-up interview on 9/19/24 at 3:23 P.M., the MDS Coordinator said that the external catheter was marked because a CNA had errantly marked external catheter instead of indwelling catheter during the look-back period and this transferred over to the MDS. The MDS Coordinator further said that the documentation that transferred over to the MDS should have been reviewed and corrected before the MDS was completed and submitted.</p> <p>Please Refer To F883</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>50563</p> <p>Based on observation, interview, record and policy review, the facility failed to provide treatment and services, consistent with professional standards of practice to prevent the development of pressure ulcers (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device)/skin injuries for one Resident (#357) out of a total sample of 22 residents.</p> <p>Specifically, for Resident #357, the facility failed to ensure:</p> <ol style="list-style-type: none"> 1. that a Licensed Nurse completed an assessment after a Certified Nurses Aide's (CNA) observation of an alteration to the Resident's skin which resulted in the development of pressure ulcers for the Resident. 2. that the Community Physician recommendation for a therapeutic air mattress/alternating pump pad mattress was reviewed with the facility Physician. <p>Findings include:</p> <p>Review of the facility policy titled Skin Conditions (Assessment of), revised January 2023, indicated the following:</p> <ul style="list-style-type: none"> -It is the policy of the facility to routinely assess and report resident skin condition, implement preventative measures as warranted . -A weekly skin assessment will be completed on shower days by [a] nurse, noting any abnormalities on the treatment record. Complete necessary documentation for any condition noted (e.g.nurse's note, etc.) -Any area(s) of skin breakdown or potential breakdown (i.e. unstageable reddened/purplish areas) will be sized on assessment and have the appropriate treatment plan and care plan put into place. <p>Resident #357 was admitted to the facility in September 2024, with diagnoses including, Chronic Obstructive Pulmonary Disease (COPD: a lung disease that causes restricted air flow in the lungs and difficulty breathing), Chronic Kidney Disease Stage 3a (mild to moderate loss of function of the kidneys causing them to be less able to filter waste and fluid from the blood) and Type 2 Diabetes Mellitus (DM II - long-term condition where the pancreas is unable to produce enough insulin hormone to regulate blood glucose [sugar] levels resulting in higher than normal blood sugar levels).</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 9/12/24, for Resident #357 indicated:</p> <ul style="list-style-type: none"> -moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15. -was admitted to the facility with no pressure ulcers. <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-was dependent on staff for bed mobility (ability to position self and roll left to right or right to left).</p> <p>-was at risk for developing pressure ulcers.</p> <p>-had an indwelling urinary catheter.</p> <p>Review of Resident #357's care plans indicated an at risk for pressure ulcer care plan that was initiated on 9/6/24 with the following interventions:</p> <p>-follow facility policies/protocols for the prevention/treatment of skin breakdown.</p> <p>-skin check every shift with care [sic].</p> <p>1. Review of Resident #357's skin assessment titled Skin Only Evaluation, dated 9/5/24, indicated:</p> <p>-the only alteration to the Resident's skin was a biopsy site to the forehead.</p> <p>Review of the Skin Monitoring: Comprehensive CNA Shower Review Form, dated 9/9/24, indicated:</p> <p>-the CNA had documented the Resident's buttocks as red on 9/9/24.</p> <p>-the Charge Nurse signed the Comprehensive CNA Shower Review Form as received.</p> <p>-The assessment and intervention portion of the form was left blank.</p> <p>Review of Resident #357's Treatment Administration Record (TAR) indicated:</p> <p>-skin assessment was refused on 9/9/24.</p> <p>-skin assessment was rescheduled for 9/13/24, with blanks in the staff initial box of the TAR.</p> <p>-no evidence in the clinical record that skin assessment had been attempted on 9/13/24 by a Licensed Nurse.</p> <p>Review of Resident #357's Nursing Progress Notes indicated the following:</p> <p>-9/5/24: Skin Evaluation note indicated lower body and buttocks are free from any abnormalities</p> <p>-9/6/24: History and Physical indicated:</p> <p>>skin: dry protective dressing on scalp</p> <p>>cranial nerves: Oriented to person, city, month, year and POTUS (President of the United States), alert, calm, on exam, answers questions appropriately</p> <p>-no other documentation of skin assessment or skin alterations</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-9/16/24: a note written by Unit Manager (UM) #2 that a new area of Moisture Associated Skin Damage (MASD - a condition where the skin becomes inflamed and eroded from prolonged exposure to moisture) to the Resident's buttocks (7 days after the CNA first identified red areas on the Resident's buttocks on 9/9/24).</p> <p>Review of Resident #357's Physician's orders indicated:</p> <p>-order for Silver Sulfadiazine (a cream used to treat wounds and burns) to buttocks twice a day for incontinent (having no or insufficient voluntary control over urination or defecation) dermatitis (inflammation of the skin), initiated 9/16/24.</p> <p>On 9/19/24 at 10:31 A.M., the surveyor and UM #2 observed the Resident's buttocks. The surveyor observed that Resident #357 had multiple open areas on the buttocks including two small areas on the right buttock and coccyx (tailbone: tiny bones joined with the sacrum [large flat bone in the lower part of the spine]) and one larger area on the left buttocks. During an interview immediately following the observation, UM #2 said she believed the open areas to be MASD but was unsure of the cause as the Resident's bowel pattern had not identified a pattern of frequent incontinence and an indwelling urinary catheter (a device inserted into the bladder that drains urine into a collection bag) was already in place. UM #2 further said that the areas appeared worse, and the Resident would be seen by the Wound Doctor/Physician #2 that day (9/19/24).</p> <p>Review of the Wound Doctor/Physician #2's Initial Wound Evaluation and Management Summary Note, dated 9/19/24, indicated the following:</p> <p>-intermittent fecal incontinence</p> <p>-Stage 2 Pressure Wound (an open wound or blister that occurs when the skin breaks and some of the outer upper layers of skin are damaged) of the Left Buttock with etiology (cause) of pressure, documentation of exposed dermis (second layering of skin) and recommendation to offload (minimizing or removing weight placed on the wound to help prevent and heal ulcers) wound.</p> <p>-Stage 2 Pressure Wound of the Right Buttock with etiology of pressure, documentation of exposed dermis and recommendation to offload wound.</p> <p>-Stage 2 Pressure Wound of the Coccyx (tailbone) with etiology of pressure, documentation of exposed dermis and recommendation to offload wound.</p> <p>During an interview on 9/19/24 at 1:44 P.M., the Wound Doctor/Physician #2 said he had seen Resident #357 for the first time on 9/19/24. The Wound Doctor/Physician #2 further said that he did not feel the wounds were MASD or had a moisture component. The Wound Doctor/Physician #2 said that based on his assessment all three (wound) areas were Stage 2 Pressure Ulcers.</p> <p>During an interview on 9/19/24 at 2:47 P.M., the surveyor and UM #2 reviewed the skin assessment documentation in the Electronic Medical Record (EMR). UM #2 said a skin assessment should have been completed on 9/9/24, and that had not occurred. UM #2 further said the purpose of weekly skin assessment is to catch areas of skin breakdown before they develop or early in development to prevent development or worsening.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Mary Ann Morse Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 45 Union Street Natick, MA 01760	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/20/24 at 8:38 A.M., the surveyor and UM #2 reviewed the newly provided form titled Skin Monitoring: Comprehensive CNA Shower Review dated 9/9/24, and the TAR for Resident #357. UM #2 said that if the skin assessment was refused (by the Resident) it should have been re-attempted. UM #2 further said this was especially important because the CNA had identified a potential new area of skin breakdown.</p> <p>During an interview on 9/20/24 at 9:14 A.M., the surveyor and the Director of Nursing (DON) reviewed the Skin Monitoring: Comprehensive CNA Shower Review Form dated 9/9/24, and the TAR for Resident #357. The DON said that the 9/9/24 skin assessment should have been re-attempted if the Resident refused but it was not.</p> <p>2. Review of Resident #357's admission paperwork included a Physician Progress Note from the Community Physician, dated 9/4/24, that indicated:</p> <p>-would benefit from an alternating pump pad mattress (an air mattress that regulates the inflation and deflation of its air cells in a cyclical pattern, alternating pressure between different areas of the body) due to history of pressure ulcers and the inability to frequently change position.</p> <p>Review of Resident #357's History and Physical, dated 9/6/24, did not indicate that the facility Provider (Physician/ Nurse Practitioner [NP]/ Physician Assistan [PA]) reviewed the admission paperwork from the Community Physician.</p> <p>Review of Resident #357's clinical record indicated no evidence of an order for, or discussion of the Community Physician recommendations for an air mattress/alternating pump pad mattress.</p> <p>The surveyor observed Resident #357 lying in bed with a standard mattress in use at the following times:</p> <p>-9/18/24 at 8:12 A.M.</p> <p>-9/18/24 at 9:53 A.M.</p> <p>-9/19/24 at 8:00 A.M.</p> <p>-9/20/24 at 7:15 A.M.</p> <p>-9/20/24 at 9:50 A.M.</p> <p>During an interview on 9/20/24 at 10:55 A.M., the surveyor and UM #2 reviewed Resident #357's admission Physician's Progress Note dated 9/4/24. UM #2 said the Resident had not been put on an air mattress. UM #2 further said the (Community Physician) recommendation should have been reviewed with the (facility) Provider and the Provider should determine if the recommendation is or is not implemented.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/20/24 at 11:10 A.M., the surveyor and Physician #1 reviewed Resident #357's admission Community Physician's Progress Note, dated 9/4/24. Physician #1 said he did not specifically recall the conversation when the facility Nurse reviewed admission medications and recommendations with him. Physician #1 said that he would have given an order for the air mattress had the recommendation been relayed to him.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>42761</p> <p>Based on observation, interview, and record review, the facility failed to provide appropriate treatment and interventions for three Residents (#72, #63, and #94) out of a total of 22 sampled residents, who were diagnosed with Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment), to attain their highest practicable physical, mental, and psychosocial well-being.</p> <p>Specifically, the facility staff failed to:</p> <p>1a. provide individualized interventions when Resident #72 and Resident #63 were engaged in verbal interactions and Resident #72 directed undignified statements toward Resident #63.</p> <p>1b. respond timely to Resident #63's requests to disengage in an activity when the Resident voiced that he/she did not want to participate, and the Resident's escalating symptoms and behaviors were not immediately addressed by the Activities staff.</p> <p>1c. respond promptly to Resident #63 when the Resident initiated a request to use the bathroom.</p> <p>2. provide appropriate individualized interventions for Resident #94, when the Resident stood up from his/her wheelchair multiple times, and staff identified that standing from the wheelchair indicated the Resident wanted to use the bathroom or move, but neither intervention was offered timely to the Resident by facility staff.</p> <p>Findings include:</p> <p>1. Resident #72 was admitted to the facility in December 2023 with diagnoses including Dementia with Behavioral Disturbance and Alzheimer's Disease (a progressive disease beginning with mild memory loss and leading to the loss of the ability to carry on a conversation and respond to the environment, that is severe enough to interfere with daily life).</p> <p>Review of Resident #72's Physical Mobility Care Plan, initiated 3/22/24, indicated the following:</p> <ul style="list-style-type: none"> -The Resident could propel his/her wheelchair, but preferred to have staff assist him/her. -The Resident required assistance from staff to walk. <p>Review of Resident #72's Alzheimer's Care Plan, initiated 12/6/23 and revised 1/9/24, indicated the following:</p> <ul style="list-style-type: none"> -The Resident had the potential to be . verbally aggressive. -Staff were required to modify the Resident's environment by taking the Resident to a quieter place and attempt to redirect. <p>(continued on next page)</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-When the Resident became agitated, staff were required to intervene before the Resident's agitation escalated by guiding the Resident away from the source of distress, . engaging the Resident calmly in conversation or activity.</p> <p>Review of Resident #72's MDS Assessment, dated 8/19/24, indicated the following:</p> <ul style="list-style-type: none"> -The Resident was unable to complete the Brief Interview for Mental Status (BIMS) Assessment. -The Resident's cognitive skills for daily decision making were severely impaired as evidenced by staff interview. -The Resident had short and long-term memory problems. -The Resident demonstrated physical and verbal behaviors directed at others. <p>Resident #63 was admitted to the facility in June 2024, with diagnoses including Dementia with Behavioral Disturbance (progressive disease with impairment in memory and functioning that includes symptoms such as depression, anxiety, psychosis, agitation, aggression, disinhibition, and sleep disturbances), Dementia with Agitation, and Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>Review of Resident #63's Dementia Care Plan, initiated 6/13/24 and revised 7/2/24, indicated the following:</p> <ul style="list-style-type: none"> -The Resident had impaired cognitive function or impaired thought process related to Dementia. -The Resident's goal was to be able to communicate basic needs on a daily basis. <p>Review of Resident #63's Communication Care Plan, initiated 6/21/24 and revised 7/2/24, indicated the following:</p> <ul style="list-style-type: none"> -The Resident had a communication problem related to Dementia, Anxiety, and Depression. -Staff were required to anticipate and meet the Resident's needs. <p>Review of Resident #63's MDS Assessment, dated 9/9/24, indicated the Resident's cognitive skills were severely impaired as evidenced by a score of zero out of 15 total possible points.</p> <p>a. On 9/17/24, between 8:58 A.M. and 9:17 A.M., the surveyor observed the following in the Birch Unit Multi-Purpose Room:</p> <ul style="list-style-type: none"> -Resident #63 sat in a wheelchair with his/her back to the windows in the room and faced the other residents in the room. -Resident #72 sat in a wheelchair, at a table, diagonally to the left side and in front of Resident #63. <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #63 yelled loudly, One two three four five! Put it on a can! . One two three four five six seven eight nine ten! You do not have one now!</p> <p>-The surveyor observed Resident #72 look at Resident #63 and say shut up</p> <p>-Resident #63 then said, no!, and Resident #72 immediately responded, while looking at Resident #63, by saying, shut up!</p> <p>-The surveyor observed Resident #63 shake his/her hands repeatedly in the air while saying, No more food! Bring it back! One two three five four three two one stop!</p> <p>-At 9:03 A.M., the surveyor observed Resident #63 call out loudly, Shacka shacka shacka eeka eeka eeka! . We did not get kicked off because we were working with the people involved! . No! .</p> <p>-At the same time, the surveyor observed the Activities Director (AD) approach Resident #63. The Resident said, Go to [expletive] and the AD walked away from the Resident.</p> <p>-The surveyor observed Resident #72 look at Resident #63 and say, You're are a mess!</p> <p>-At 9:17 A.M., the surveyor observed Resident #63 call out loudly, Ahhh and Resident #72 said, shut up!</p> <p>At no time during the surveyor's observation did any staff modify Resident #72's environment, intervene to guide Resident #72 away from Resident #63, or attempt to engage Resident #72 calmly in conversation or activity.</p> <p>b. On 9/17/24 between 9:33 A.M. and 10:09 A.M., the surveyor observed the following in the Birch Unit Multi-Purpose Room:</p> <p>-Resident #63 participated in large group exercise activity until the activity was completed at 9:52 A.M.</p> <p>-The AD immediately transitioned the activity from exercise group to a large group activity using a large ball.</p> <p>-The surveyor observed Resident #63 wave his/her hands in the air repetitively and say, Where are you! Where are you! Stop doing so much stuff!</p> <p>-At 9:59 A.M., Resident #63 called out loudly while in the group activity, I can't do this .! I've got to get out of here! I can't play this! I will be dead! I'm sick, I've got to go!</p> <p>-No staff were observed to offer to remove Resident #63 from the activity at this time.</p> <p>-The surveyor observed the AD move the ball toward Resident #63 and the Resident used his/her hands to push the ball, then yelled, No! Stop it! I'll shot you! Get out of here! I'm going home! It's too much for me! I can't do this! Ahhh! .</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The surveyor further observed the ball come back to Resident #63 and the Resident shook his/her hands in the air and called out, Don't bring it back around to me! Ahhh! I don't want it! I can't play this! It's too much for me! I'm going home! .</p> <p>-At the time, the surveyor observed the AD approach Resident #63 and say, You are good at this game and the Resident responded, Stop, don't anymore!</p> <p>At no time during the surveyor's observation did any staff offer to assist Resident #63 away from the activity or offer to provide an alternate activity for the Resident.</p> <p>On 9/17/24 at 10:10 A.M., the surveyor observed the Administrator enter the Birch Unit Multi-Purpose Room while Resident #63 continued to call out loudly during the activity. The surveyor observed the Administrator approach the Resident, then the AD and request that the AD assist the Resident away from the activity. The surveyor observed the AD offer to assist Resident #63 away from the activity, the Resident agreed, and the AD assisted to the Resident to a table in the room. The AD provided the Resident with a book to look at and the Resident's calling out and yelling stopped at that time.</p> <p>c. On 9/18/24, between 3:13 P.M. and 3:20 P.M., the surveyor observed the following in the Birch Unit Multi-Purpose Room:</p> <p>-Resident #63 was seated in his/her wheelchair, waving and pointing his/her finger in the air saying, I need to go to the bathroom . I've been waiting a long time</p> <p>-The surveyor observed Resident #63 count loudly and repetitively and said, Now! . No! No! . while the Resident slapped the armrest of his/her wheelchair and used his/her hands on the armrests to push up and move forward in the wheelchair seat repeatedly.</p> <p>-At the time, the surveyor observed three staff members (Nurse #2, Nurse #3, and Certified Nurses Aide[CNA] #3) in area of the Multi-Purpose Room, but no staff were observed to respond to the Resident's request.</p> <p>-The Resident continued to move him/herself up and forward in the wheelchair repeatedly.</p> <p>-At 3:20 P.M., Resident #63 stopped moving up and forward in the wheelchair and no longer requested the use of the bathroom.</p> <p>During an interview on 9/18/24 at 3:25 P.M., the AD said Resident #63 had difficulty with transitions between activities and transitions within different rooms in the facility. The AD also said that she thought large activities in the Birch Unit's Multi-Purpose Room was too much, . over-stimulating for Resident #63.</p> <p>During an interview on 9/18/24 at 3:30 P.M., the surveyor shared the observation of Resident #63 requesting to use the bathroom, waving his/her arm in the air, and moving up and forward in the wheelchair with Nurse #2 and Nurse #3. At the time, Nurse #2 said she had worked the day (7:00 A.M. through 3:00 P.M.) shift and did not stay through the conclusion of the interview. Nurse #3 said she was working the current (3:00 P.M. through 11:00 P.M.) shift, then asked the surveyor if any of the staff in the room responded to Resident #63's request to use the bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/19/24 at 8:55 A.M., Unit Manager (UM) #1 said all staff at the facility were required to undergo training to care for residents with Dementia. UM #1 said if residents raised their voices or made undignified comments to each other, staff were required to intervene immediately by offering a calm approach, separating the residents, and offering diversional activity. UM #1 said staff should have intervened, as required, when Resident #72 raised his/her voice and made undignified comments toward Resident #63. UM #1 also said someone should have responded to Resident #63 when he/she demonstrated signs for needing, and requested use of the bathroom.</p> <p>During an interview on 9/19/24 at 10:00 A.M., the Administrator said if residents became upset with or raised their voices at each other, staff were required to intervene by separating the residents and offering diversional activity. The Administrator said that staff should have intervened when Resident #63 repetitively called out by offering a change in the environment and diversional activity, and that staff should also have intervened when Resident #72 raised his/her voice and made undignified comments toward Resident #63. The Administrator said she observed Resident #63 clearly state that he/she did not want to participate in the large group activity with the ball on 9/17/24 and that the staff should have responded to the Resident's request to leave the activity. The Administrator also said staff should have assisted Resident #63 away from the ball activity when the Resident requested to leave and that staff should have offered the Resident something else to do. The Administrator said that staff should have been aware of Resident #63's movement in his/her wheelchair when he/she requested to use the bathroom and should have responded to the Resident's request to use the bathroom.</p> <p>2. Resident #94 was admitted to the facility in March 2024, with diagnoses including Dementia, Parkinson's Disease (PD - a progressive degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination), and Abnormalities of Gait (pattern one uses to walk) and Mobility.</p> <p>Review of Resident #94's Cognitive Function Care Plan, initiated 3/21/24 and revised 4/4/24 indicated the following:</p> <ul style="list-style-type: none"> -The Resident had impaired cognitive function. -One of the Resident's goals was to be able to communicate basic needs on a daily basis. -Staff were required to face the Resident when speaking and make eye contact. -The Resident understood consistent, simple, directive sentences. -Staff were required to ask yes/no questions in order to determine the Resident's needs. <p>Review of Resident #94's Activities of Daily Living (ADL) Care Plan, initiated 3/22/24 and revised 7/11/24, indicated the following:</p> <ul style="list-style-type: none"> -The Resident had ADL self-care performance deficit related to PD. -The Resident required assistance of two staff for transfers. -The Resident required assistance of two staff to ambulate (walk). <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #94's Physical Therapy Evaluation, dated 9/16/24, indicated the following:</p> <ul style="list-style-type: none"> -The Resident had been referred for a PT evaluation due to reduced ability to transfer and ambulate. -The Resident required maximal assistance of two staff members to transition from sitting to standing, with step by step cues. -The Resident was able to ambulate 50 feet with assist of two staff, use of a rolling walker with cues, and use of a wheelchair to follow behind the Resident. <p>On 9/19/24, between 8:55 A.M. and 9:25 A.M., the surveyor observed the following in the Birch Unit Multi-Purpose Room:</p> <ul style="list-style-type: none"> -Resident #94 was seated in a wheelchair with a table in front of him/her. -CNAs #1 and #2 were in the Multi-Purpose Room. -The Resident used his/her hands to push up on the armrests of the wheelchair and stood. -After approximately 20 seconds, the surveyor observed CNA #2 approach Resident #94 at the Resident's left side, instruct the Resident to sit down, and the Resident complied. The surveyor observed that CNA #2 did not make eye contact with the Resident or ask any yes/no questions in attempt to determine the Resident's need at that time. -At 9:10 A.M., the surveyor observed CNA #1 standing next to Resident #94's right side. -The Resident placed his/her hands on the wheelchair armrests and began to stand when CNA #1 touched the Resident's right upper back and instructed the Resident to sit down. The Resident complied. -The surveyor observed that CNA #1 did not make eye contact with the Resident or ask any yes/no questions in attempt to determine the Resident's needs at that time. <p>During an interview at the time, CNA #2 said Resident #94 had difficulty making his/her needs known and that the Resident was always trying to stand up. CNA #2 also said he did not ask Resident #94 what he/she needed when he/she stood up because the Resident couldn't say what he/she needed. CNA #2 said that Resident #94 was able to transfer and walk with staff assistance and that when the Resident stood up, it usually meant that he/she wanted to move. CNA #2 said the Resident usually sat in one of the recliner chairs in the Multi-Purpose room following breakfast and that that was where the Resident probably wanted to go at that time.</p> <ul style="list-style-type: none"> -At 9:16 A.M., Resident #94 placed his/her hands on the wheelchair armrests again and began to stand. CNA #1 was still standing next to the Resident, instructed the Resident to sit down, and the Resident complied. <p>No staff were observed to make eye contact with Resident #94 or ask any yes/no questions to determine what the Resident needed until 9:25 A.M. when the Resident was assisted away from the table.</p> <p>(continued on next page)</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/19/24 at 9:26 A.M., CNA #1 said staff were required to watch Resident #94 all of the time because the Resident always tried to stand. CNA #1 said she did not ask the Resident what he/she needed when he/she attempted standing during the surveyor's observation because when staff asked the Resident what he/she needed, he/she would answer with a statement that did not align with the question asked. CNA #1 said Resident #94 was able to transfer with assistance of two staff and that changing the Resident's position had not been offered to the Resident until another CNA came to assist him/her away from the table at 9:25 A.M. to provide the Resident with daily personal care.</p> <p>During an interview on 9/19/24 at 10:08 A.M., UM #1 said Resident #94 had difficulty communicating his/her needs verbally to staff and that staff had identified when the Resident attempted standing, he/she usually wanted to get up, walk, or use the bathroom. UM #1 said that the Resident had experienced a decline in transfers and walking recently and required assistance of two staff for transfers. UM #1 further said there were enough staff working on the Unit to provide the required assistance for Resident #94 and that staff should have offered to assist the Resident to move away from the table and use the bathroom.</p>		

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NAME OF PROVIDER OR SUPPLIER Mary Ann Morse Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 45 Union Street Natick, MA 01760	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>47901</p> <p>Based on observation, interview, record and policy review, the facility failed to ensure that residents were free of significant medication errors during the medication pass process for one Resident (#207) out of five residents observed, out of a total sample of 22 residents.</p> <p>Specifically, for Resident #207, the facility staff failed to administer the Sevelamer medication (phosphate binder -used to control high blood levels of phosphorus in people with chronic kidney disease who are on dialysis [the process of cleansing the blood by passing it through a special machine, necessary when the kidneys are unable to filter the blood]) timely and with meals as required.</p> <p>Findings include:</p> <p>Review of the facility policy titled Medication Administration; Information Needed, revised 5/2012 indicated:</p> <ul style="list-style-type: none"> -To ensure resident/patient safety, the facility will define what information will be available to the licensed nursing staff who administer medications. -Other resources are available if the licensed staff has questions relating to medication administration, for example: Current Nursing Drug Handbook. <p>Facility follows Nursing 2024 Drug Handbook relative to Sevelamer medication, which indicated:</p> <ul style="list-style-type: none"> -Assess patient for GI (gastrointestinal) side effects periodically during therapy. -Administer with meals. -Advise patient to notify health care professional if GI effects (worsening of existing constipation, bloody stools) occur. -Instruct patient to take Sevelamer medication with meals as directed and to adhere to prescribed diet. <p>Resident #207 was admitted to the facility in September 2024, with diagnoses including End Stage Renal Disease (ESRD - a medical condition where the kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and Dependence on Renal Dialysis.</p> <p>Review of Resident #207's September 2024 Physician's orders indicated:</p> <ul style="list-style-type: none"> -Sevelamer 800 mg, give one tablet with meals related to End Stage Renal Disease, ordered 9/16/24 <p>Review of Resident #207's September 2024 Medication Administration Record (MAR) indicated:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Sevelamer 800 mg tablet, give one tablet with meals scheduled for 8:00 A.M., 12:00 P.M., 5:00 P.M.</p> <p>On 9/18/24 at 1:52 P.M., the surveyor observed Nurse #4 prepare and administer the Sevelamer medication (the 12:00 P.M. dose) for Resident #207. Nurse #4 was observed bringing the medication to Resident #207, and the Resident told Nurse #4 that he/she took the Sevelamer medication with food. Nurse #4 told the Resident that he/she could take the Sevelamer medication at any time. Resident #207 was observed to swallow the Sevelamer medication with a cup of water.</p> <p>During an interview on 9/18/24 at 2:24 P.M., Nurse #4 said was she was not aware the Sevelamer medication needed to be taken with food and that she did not read the medication instructions.</p> <p>During an interview on 9/18/24 at 2:45 P.M., Unit Manager (UM) #3 said Nurse #4 should have reviewed the medication instructions and listened to the Resident but she did not.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>47901</p> <p>Based on interview, policy and record review, the facility failed to maintain complete and accurate medical records for one Resident (#81), out of a total sample of 22 residents.</p> <p>Specifically, For Resident #81, the facility failed to:</p> <ul style="list-style-type: none"> -maintain accurate documentation of advanced directives (legal documents that provide instructions for medical care and only go into effect if you are unable to communicate your own wishes) when the MOLST (Massachusetts Medical Orders for Life-Sustaining Treatment) form was not signed by the Resident. -maintain accurate documentation of the Resident's code status (advanced directives) on the dialysis (the process of cleansing the blood by passing it through a special machine, necessary when the kidneys are unable to filter the blood) communication sheet sent from the facility to the dialysis center which would inform the dialysis staff on the appropriate response for the Resident in the event of a cardiac emergency. <p>Findings include:</p> <p>Review of the facility policy titled, Physician's orders: Receiving and Noting Of, revised March 2016, indicated:</p> <ul style="list-style-type: none"> -Document all changes and orders in the nurses' progress notes adding reasons for the orders or changes in the orders. -Document the notification of the resident/patient and/or the responsible party. -Document in the care plan as needed. -Document in the logbook and communicate the changes to the on-coming nurse. <p>Resident #81 was admitted to the facility in May 2024, with diagnoses including Altered Mental Status (change in awareness, cognition, attention, or consciousness), Malignant Neoplasm of Prostate (cancer in the tissues of the prostate gland), and Hypertensive Chronic Kidney Disease of the Kidney (high blood pressure caused by the narrowing of the arteries that carry blood to the kidneys).</p> <p>Review of Resident #81's September 2024 Physician's orders indicated:</p> <ul style="list-style-type: none"> -Dialysis scheduled in the morning on Monday, Tuesday, Thursday, and Friday, by the facility Kidney Care Center, ordered 7/19/24. -Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themselves) Invoked (put into effect by a Physician indicating that a resident is unable to make medical decisions), ordered 7/2/24. <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Do Not Resuscitate (DNR), ordered 8/27/24.</p> <p>Review of the facility's Health Care Proxy (HCP) invocation form titled Documentation of Patient Incapacity, signed on 7/1/24, indicated:</p> <p>-Resident #81 had moderate incapacity for medical decision making.</p> <p>-Health Care Proxy (HCP) has been invoked.</p> <p>-Invocation was temporary.</p> <p>-Duration was questionable of two weeks from 7/1/24.</p> <p>Review of Resident #81's Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) dated 8/26/24, indicated the Resident's HCP signed the MOLST form with decision for Do Not Resuscitate (DNR) code status.</p> <p>Review of the facility's Dialysis Transition of Care Form indicated Resident #81's code status as follows:</p> <p>-8/27/24: Code Status is blank.</p> <p>-8/29/24: Code Status is DNR.</p> <p>-8/30/24: Code Status is Full Code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive).</p> <p>-9/2/24: Code Status is Full Code.</p> <p>-9/3/24: Code Status is Full Code.</p> <p>-9/5/24: Code Status is DNR.</p> <p>-9/9/24: Code Status is DNR.</p> <p>-9/10/24: Code Status is blank.</p> <p>-9/12/24: Code Status is blank.</p> <p>-9/13/24: Code Status is Full Code.</p> <p>During an interview on 9/19/24 at 10:24 A.M., Unit Manager (UM) #3 said Resident #81's HCP was invoked temporarily for two weeks from 7/1/24. UM #3 said there had been no follow-up to the invocation by the facility. UM #3 said the Dialysis Transition of Care Form was a communication tool between the facility and the dialysis department. UM #3 further said the Transition of Care Form had not been filled out correctly to reflect Resident #81's advanced directives and that the facility should not have had the HCP sign the MOLST form.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50563</p> <p>Based on observation, interview, record and policy review, the facility failed to adhere to infection control standards to prevent the potential transmission of communicable diseases and infections within the facility on two Units (Birch and Cedar) out of three total Units.</p> <p>Specially, the facility failed to ensure:</p> <ol style="list-style-type: none"> 1. On the Cedar Unit, that staff utilized the indicated Personal Protective Equipment (PPE-items such as gowns, gloves, etc. worn to protect the wearer for exposure to potential infection or from exposing the care recipient to potential infection) while caring for a Resident (#357) on Enhanced Barrier Precautions (EBP - protective barrier gowns and gloves used as an infection control intervention designed to reduce transmission of multi-drug-resistant organisms [MDROs] during high contact resident care). 2. On the Birch Unit, that staff cleaned and disinfected glucometers (multiuse device used to check blood sugar levels) between use on multiple residents. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the undated facility policy titled Enhanced Barrier Precautions indicated the following: <ul style="list-style-type: none"> -Enhanced Barrier Precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. -EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. -Examples of high-contact care activities requiring the use of gown and gloves for EBPs include: .changing briefs .wound care. <p>Resident #357 was admitted to the facility in September 2024, with diagnoses including Neuromuscular Dysfunction of the Bladder (a condition where the nerves and muscles of the bladder do not work together well and can cause problems with the emptying of the bladder) and Chronic Indwelling Urinary Catheter (a thin, flexible tube inserted into the bladder to drain urine outside the body).</p> <p>Review of Resident #357's Enhanced Barrier Precautions care plan, initiated 9/6/24, indicated:</p> <ul style="list-style-type: none"> -Staff will wear appropriate PPE when providing close contact care. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a wound observation on 9/19/24 at 10:31 A.M., the surveyor observed an EBP sign posted at the door of Resident #357's room indicating the Resident was on EBP. The surveyor observed Unit Manager (UM #1) perform hand hygiene prior to entering Resident #357's room. The surveyor further observed that UM #1 did not don (put on) gloves, or a gown as indicated, before proceeding to position Resident #357 on his/her right side. The surveyor observed UM #1 then hold the Resident's left hip and lateral (near the side) buttocks near open wounds with her bare hands and no gown, while she observed the buttocks wounds with the surveyor. During an interview immediately following the observation, UM #1 said she did not wear a gown or gloves while assessing the wound with the surveyor but should have.</p> <p>During an interview on 9/19/24 at 1:48 P.M. the Infection Preventionist (IP) said when doing care and assessing a wound of a Resident on EBP, the expectation was that the Nurse should wear a gown and gloves.</p> <p>47901</p> <p>2. Review of the facility policy titled Blood Glucose Testing Policy, revised March 2013, indicated:</p> <ul style="list-style-type: none"> -The glucometer will be used according to the manufacturer's guidelines (refer to the following pages and/or manual in the nursing policy and procedure book). -Disinfect glucometer with bleach wipes or approved facility disinfectant. <p>The facility references the glucometer brand (Assure Prism) instructions manual, page 38 on cleaning and disinfecting which indicated:</p> <ul style="list-style-type: none"> -The meter should be cleaned and disinfected after use on each patient. -The cleaning procedure is needed to clean dirt as well as blood and other body fluids on the exterior of the meter and lancing device before performing the disinfection procedure. -The disinfection procedure is needed to prevent transmission of blood-borne pathogens. -Clorox healthcare bleach germicidal wipes and dispatch hospital cleaner disinfectant towels with bleach have been validated as cleaning agents for the blood glucose meter. -All parts of the Assure Prism multi blood glucose system should be considered potentially infectious and are capable of transmitting blood-borne pathogens between patients and healthcare professionals. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the medication administration observation on the Birch Unit on 9/19/24 at 7:44 A.M., the surveyor observed Nurse #1 perform blood glucose testing on a Resident. The surveyor observed that Nurse #1 wore gloves during the blood glucose testing, returned to her medication cart after testing with gloves still in place, placed the glucometer machine back in the device carrying case and then placed the device carrying case in the medication cart. Nurse #1 then removed her gloves and sanitized her hands. During an interview immediately following the observation, Nurse #1 said she forgot to sanitize the glucometer machine. Nurse #1 then removed the glucometer machine from the device carrying case, wiped the machine with an alcohol wipe, and placed the machine back in the carrying case. Nurse #1 said the facility used alcohol wipes to clean the glucometer machine.</p> <p>During an interview on 9/19/24 at 11:32 A.M., the Director of Nursing (DON) said the facility used disinfecting with bleach wipes and not alcohol wipes to disinfect the glucometer machine. The DON said Nurse #1 should have cleaned the glucometer machine with the facility approved disinfecting bleach wipes. The DON further said Nurse #1 could have contaminated the carrying case and should not have placed the glucometer machine back in the carrying case and into the medication cart.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206</p> <p>Based on interview, record and policy review, the facility failed to ensure that Pneumococcal (any infection caused by bacteria called Streptococcus Pneumoniae, or Pneumococcus that can range from ear and sinus infections to Pneumonia and blood stream infections) Vaccinations were offered to three Residents (#72, #33, #2) out of five applicable residents, out of a total sample of 22 residents, increasing the residents risk for developing facility acquired Pneumococcal infections.</p> <p>Specifically, the facility failed to:</p> <ol style="list-style-type: none"> 1. Offer Resident #72 an updated Pneumococcal Vaccine when the Resident was not up to date and was eligible to receive an updated vaccine. 2. Offer Resident #33 an updated Pneumococcal Vaccine when the Resident was not up to date and was eligible to receive an updated vaccine. 3. Offer Resident #2 an updated Pneumococcal Vaccine when the Resident was not up to date and was eligible to receive an updated vaccine. <p>Findings include:</p> <p>Review of the facility policy titled Pneumococcal Vaccine, revised August 2016, indicated:</p> <ul style="list-style-type: none"> -Upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. -Assessments of pneumococcal vaccination status will be conducted within seven working days of the resident's admission . -Pneumococcal vaccines with be administered to residents (unless medically contraindicated, already given, or refused) . -Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Preventions (CDC) recommendations at the time of vaccination. <p>Review of CDC (Center for Disease Control and Prevention) guidelines titled Pneumococcal Vaccination Timeline for Adults, dated 9/14/24, indicated the following for adults aged [AGE] years and older:</p> <ul style="list-style-type: none"> -Make sure your patients are up to date with Pneumococcal Vaccination. -If the following vaccines series has been completed: PCV (Pneumococcal Conjugate Vaccine) 13 at any age & PPSV (Pneumococcal Polysaccharide Vaccine) 23 at [AGE] years of age or older, <p>(continued on next page)</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-then together with the patient, vaccine Providers may choose to administer PCV20 and PCV21 (Pneumococcal Conjugate Vaccine/ Prevnar 20/21: vaccine used to protect against 20 and 21 types of Pneumococcal bacteria that commonly cause serious infections) to adults [AGE] years of age or older, who already received PCV13 (but not PCV15 [Pneumococcal Conjugate Vaccine 15-valent: vaccine used to protect against 15 types of pneumococcal bacteria that commonly cause serious infections in adults] or PCV20) at any age, and PPSV23 at or after the age of [AGE] years old.</p> <p>-PCV20, PCV21, and PPSV23 may be administered after a minimum interval of greater than one year after the last dose of PPSV23 or PCV13.</p> <p>1. Resident #72 was admitted to the facility in December 2023 with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment), and was over the age of 65.</p> <p>Review of Resident #72's MIIS (Massachusetts Immunization Information System) record indicated he/she was administered the PPSV23 on 1/1/05.</p> <p>Review of the CDC PneumoRecs VaxAdvisor recommendation indicated:</p> <p>-Give one dose of PCV15, PCV20, or PCV21 at least 1 year after the last dose of PPSV23.</p> <p>Review of Resident #72's Medical Record did not indicate that the Resident and/or Representative was offered an updated Pneumococcal Vaccination or that the Pneumococcal Vaccination was medically contraindicated.</p> <p>During an interview on 9/19/24 at 2:03 P.M., the Infection Preventionist (IP) said the facility process was to review and offer vaccination to residents on admission and as needed (PRN). The IP said the facility would review a resident's MIIS and contact the Community Primary Care Provider to verify or obtain vaccination records if needed. The surveyor and the IP reviewed Resident #72's MIIS vaccination record. The IP said that the Resident's Pneumococcal Vaccination was not up to date and it had been [AGE] years since his/her last vaccination. The IP said that she will review if there was documentation in the Resident record indicating an updated Pneumococcal Vaccination had been offered or refused.</p> <p>During a follow-up interview on 9/20/24 at 7:35 A.M., the IP said that Resident #72's Pneumococcal Vaccination was not up-to-date and she was unable to provide evidence any vaccination had been offered.</p> <p>2. Resident #33 was admitted to the facility in April 2023, with diagnoses including Cerebrovascular Accident (CVA- also known as stroke, when blood flow to a part of the brain is stopped either by a blockage or the rupture of a blood vessel), and was over the age of 65.</p> <p>Review of Resident #33's MIIS record indicated he/she was administered the PCV13 on 11/27/19.</p> <p>Review of the CDC PneumoRecs Vax Advisor indicated:</p> <p>-Give one dose of PCV20, PCV21, or PPSV23 at least 1 year after PCV13.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Medical Record did not indicate that Resident #33 and/or their Representative was offered an updated Pneumococcal Vaccination or that the Pneumococcal Vaccine was medically contraindicated.</p> <p>During an interview on 9/20/24 at 7:35 A.M., the IP said that she was not aware that Resident #33's Pneumococcal Vaccination was not up-to-date.</p> <p>3. Resident #2 was admitted to the facility in June 2023, with diagnoses including Dementia, and was over the age of 65.</p> <p>Review of Resident #2's MIIS record indicated he/she was administered the PCV13 on 11/5/14.</p> <p>Review of the CDC PneumoRecs Vax Advisor indicated:</p> <p>-Give one dose of PCV20, PCV21, or PPSV23 at least 1 year after PCV13.</p> <p>Review of the Medical Record did not indicate evidence that Resident #2 and/or their Representative was offered an updated Pneumococcal Vaccination or that a Pneumococcal Vaccine was medically contraindicated.</p> <p>During an interview on 9/20/24 at 7:35 A.M., the IP said that Resident #2's Pneumococcal Vaccination was not up- to-date and she was unable to provide evidence an that updated vaccination was offered.</p> <p>The facility did not provide any additional evidence to the survey team relative to Resident's #72, #33, and #2 Pneumococcal Vaccinations at the time of survey exit.</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>48206</p> <p>Based on interview, record and policy review, the facility failed to provide education regarding the benefits and potential risks associated with COVID-19 vaccines for three Residents (#33, #2, and #81), out of five residents reviewed for immunizations, out of a total sample of 22 residents.</p> <p>Specifically, the facility failed:</p> <ol style="list-style-type: none"> 1. For Resident #33, to provide education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine prior to administration of the vaccine. 2. For Resident #2, to provide education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine prior to administration of the vaccine. 3. For Resident #81, to provide education regarding changes in the benefits and risks of additional COVID-19 vaccination doses. <p>Findings include:</p> <p>Review of the facility policy titled Vaccination of Residents, revised August 2016, indicated:</p> <ul style="list-style-type: none"> -Prior to receiving vaccinations, the resident or legal representative will be provided with information regarding the benefits and potential side effects of the vaccinations. -Provision of such education shall be documented in the resident's medical record. -If vaccines are refused, the refusal shall be documented in the resident's medical record. <p>1. Resident #33 was admitted to the facility in April 2023, with diagnoses including Cerebrovascular Accident (CVA- cerebrovascular accident, also known as stroke, when blood flow to a part of the brain is stopped either by a blockage or the rupture of a blood vessel).</p> <p>Review of Resident #33 MIIS (Massachusetts Immunization Information System) record indicated he/she was administered COVID-19 Vaccinations on 10/18/23 and 4/5/24.</p> <p>Further review of the medical record did not indicate that education on the risks and benefits or potential side effects associated with the COVID-19 vaccinations was provided to the Resident prior to administration of the vaccine.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Mary Ann Morse Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 45 Union Street Natick, MA 01760	
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)		
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/19/24 at 1:52 P.M., the Infection Preventionist (IP) said that the process is to ask Residents or their Responsible Parties if appropriate, about their vaccination status. The IP said if the Resident requests vaccination, the facility will obtain a Physician's order for the vaccine and order it from the Pharmacy. The IP said that the facility does not have a process for using consent forms. The IP said that she or other nursing staff will obtain consent verbally and will provide a VIS (Vaccine Information Sheet) form to the Resident or Responsible Party. The IP said if the Resident or their Responsible Party refuses a vaccine, the refusal will be documented in the Resident's electronic record immunizations information.</p> <p>During a follow-up interview on 9/20/24 at 7:35 A.M., the IP said that she did not have evidence that Resident #33 consented to the COVID vaccinations or that education on the risks and benefits or potential side effects were provided prior to the COVID vaccines being administered.</p> <p>2. Resident #2 was admitted to the facility in June 2023, with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment).</p> <p>Review of Resident #2 MIIS record indicated he/she was administered a COVID-19 Vaccination on 10/19/23. Further review of the medical record did not indicate that education on the risks and benefits or potential side effects associated with the COVID-19 vaccinations was provided to the Resident prior to administration.</p> <p>During an interview on 9/20/24 at 7:35 A.M., the IP said that she did not have evidence that Resident #2 or their Responsible party was provided education on the risks and benefits or potential side effects were provided prior to the COVID vaccine being administered.</p> <p>3. Resident #81 was admitted to the facility in May 2024, with diagnoses of fracture (break) of lower leg.</p> <p>Review of Resident #81's MIIS record indicated he/she was last administered a COVID vaccine on 10/12/23. Further review of the medical record did not indicate education was provided to Resident #81 or their Representative on the risks and benefits or potential side effects associated with the COVID-19 vaccinations or that an updated vaccine had been offered and declined.</p> <p>During an interview on 9/20/24 at 7:35 A.M., the surveyor and the IP reviewed Resident #81's medical record. The IP said that an updated COVID booster was offered to Resident #81 on 5/29/24, but the Resident refused, and this was documented in the electronic medical record immunizations tab, which was shown to the surveyor. The IP said she was unable to provide evidence that education on the risks and benefits of the vaccine were provided to the Resident or their Representative.</p> <p>The facility did not provide any additional evidence to the survey team relative to Resident's #33, #2, or #81 COVID vaccinations at the time of survey exit.</p>		