STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225556	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mont Marie Rehabilitation & Healthcare Center	36 Lower Westfield Road Holyoke, MA 01040

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44129 Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose physician's orders included the administration of multiple medications to help manage his/her specific gastrointestinal diseases, the Facility failed to ensure Resident #1 was provided with nursing care and treatment that met professional standards when the nursing staff failed to administer his/her bowel medications and other medications timely. Findings include: Review of the Facility's Policy titled, Administering Medications, dated as last revised April 2019, indicated the following: - Medications are administered within one (1) hour of prescribed time, unless otherwise specified (for example, before and after meal orders). Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of Registered Nurse and Practical Nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered Nurse and Practical Nurse respectively. The regulations stipulate that both the Registered Nurse and Practical Nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the Registered Nurse and Practical Nurse incorporate into the plan of care and implement prescribed medical regimens. The Rules and Regulations 9.03 define Standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. Resident #1 was admitted to the Facility in January 2025, diagnoses included Parkinson's disease (a progressive, neurological disorder primarily affecting movement, caused by the loss of brain cells that produce dopamine, a chemical that helps control movement), ulcerative colitis (a chronic inflammatory bowel disease that primarily affects the colon and rectum, causing inflammation and ulcers in the lining of the digestive tract), and he/she has an ileostomy (a surgically-created opening, called a stoma, constructed by bringing part of the small intestine through an opening in the abdominal wall). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/25 at 12:24 P.M., Resident #1's Representative said Resident #1 suffered from excessive amounts of loose stool and required several medications to be administered at specific intervals, including before meals to alleviate this condition. Resident #1's Representative said that there were many occasions where Resident #1 did not receive these (and other) medications timely and as a result there were issues managing the consistency and volume of output from his/her ileostomy. Review of Resident #1's Physician's Orders for February 2025, indicates they included the following medication orders: - Diphenoxylate-Atropine Oral Tablet (Lomotil, used to treat severe diarrhea), 2.5-0.025 milligrams (mg), give two tablets by mouth five times per day for loose stool, scheduled for 8:00 A.M., 11:00 A.M., 3:30 P.M., and 8:00 P.M. - Loperamide HCl Oral Tablet (Imodium, a medication used to treat diarrhea and also used to decrease the amount of drainage in patients with a stoma), 2 mg, give two tablets by mouth before meals and at bedtime for diarrhea, scheduled for 8:00 A.M., 11:00 A.M., 4:00 P.M., and 9:00 P.M. - Review of the Loperamide HCL (Imodium) product information website indicated to take the medication only on an empty stomach (1 hour before or 2 hours after a meal). - Cholestyramine Oral Powder (a medication that can be used to treat diarrhea caused by excess bile acids in the intestines), 4 grams (gm) per dose, give one dose by mouth before meals and at bedtime, scheduled for 8:00 A.M., 11:00 A.M., 4:00 P.M., and 9:00 P.M. - Review of the National Library of Medicine Medline Plus web page titled, Cholestyramine Resin, last revised 08/15/17, indicated to take the medication before a meal and/or at bedtime. - Benefiber Prebiotic-Probiotic Oral Tablet Chewable (a fiber supplement that can help slow bowel movements), give one tablet by mouth before meals, scheduled for 8:00 A.M., 12:00 P.M., and 5:00 P.M. Review of the Facility's Meal Delivery Times indicated that for the unit on which Resident #1 resided, the meals were scheduled to be delivered at the following times: - Breakfast: 7:45 A.M. and 7:50 A.M. - Lunch 11:45 A.M., and 11:50 A.M. - Dinner 4:45 P.M., and 4:50 P.M. Review of Resident #1's Medication Administration Audit Report for February, 2025 indicated the following medications were administered late on the following dates and times: - 02/06/25 -3:30 P.M. dose of Diphenoxylate-Atropine Oral Tablet administered at 4:54 P.M. (over an hour late) (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4:00 P.M. dose of Loperamide HCl Oral, administered at 5:49 P.M. (over an hour late and after the dinner meal) -4:00 P.M. Cholestyramine Oral Powder administered at 5:48 P.M. (over an hour late and after the dinner meal) -4:00 P.M. Carbidopa-Levodopa Oral Tablet, 25-100 mg administered at 5:45 P.M. (over an hour late) -4:30 P.M. Famotidine (reduces stomach acid) Oral Tablet administered at 5:48 P.M. (over an hour late) -7:00 P.M. Carbidopa-Levodopa Oral Tablet, 25-100 mg administered at 9:35 P.M. (over an hour late) -8:00 P.M. dose of Diphenoxylate-Atropine Oral Tablet administered at 9:35 P.M. (over an hour late) - 02/17/25 -11:00 A.M. Diphenoxylate-Atropine Oral Tablet administered at 1:58 P.M. (over an hour late) -11:00 A.M. Cholestyramine Powder administered at 1:58 P.M. (over an hour late and after the lunch meal) -11:00 A.M. Loperamide HCl Oral Tablet administered at 1:58 P.M. (over an hour late after the lunch meal) -12:00 P.M. Benefiber Prebiotic-Probiotic Oral Tablet administered at 1:59 P.M. (over an hour late and after the lunch meal) - 02/20/25 -3:30 P.M. Diphenoxylate-Atropine Oral Tablet administered at 5:23 P.M. (over an hour late) -4:00 P.M. Cholestyramine Oral Powder administered at 5:23 P.M. (over an hour late and after the dinner meal) -4:00 P.M. Loperamide HCL Oral Tablet administered at 5:23 P.M. (over an hour late and after the dinner meal) -4:00 P.M. Carbidopa-Levodopa Oral Tablet administered at 5:23 P.M. (over an hour late) - 02/24/25 -11:00 A.M. Cholestyramine Oral Powder administered at 12:31 P.M. (over an hour late and after the lunch meal) -11:00 A.M. Loperamide HCl Tablet administered at 12:31 P.M. (over an hour late and after the lunch meal) (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4:00 P.M. Cholestyramine Oral Powder administered at 6:23 P.M. (over an hour late and after the dinner meal) -4:00 P.M. Loperamide HCl Tablet administered at 6:23 P.M. (over an hour late and after the dinner meal) -4:00 P.M. Carbidopa-Levodopa Oral Tablet administered at 6:25 P.M. (over an hour late) -5:00 P.M. Benefiber Prebiotic-Probiotic Oral Tablet administered at 6:23 P.M. (over an hour late and after the dinner meal) On 04/15/25 at 3:00 P.M., after reviewing Resident #1's Medication Administration Audit Report with the surveyor, the Director of Nursing said all of these medications were administered late, and not according to the Physician's Orders.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on record reviews and interviews for one of three sampled residents (Resident #1), whose physician's orders included the administration of a medication to manage his/her movement disorder, the Facility failed to ensure he/she was free from significant medication errors, when upon admission, the medication was inaccurately reconciled from his/her Hospital Discharge Summary by nursing and he/she was administered incorrect dosages of the medication for multiple days. Findings include: Review of the Facility's Policy titled, Medication Reconciliation, dated as last revised [DATE], indicated that the medication reconciliation procedure is to ensure medication safety by accurately accounting for resident's medications, routes and dosages upon admission or readmission to the facility. The Policy further indicated that: - Medication reconciliation is a process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. - Medication reconciliation helps to ensure that medications, routes and dosages have been accurately communicated to the Attending Physician and the care team. Resident #1 was admitted to the Facility in [DATE], with a diagnosis of Parkinson's disease (a progressive, neurological disorder primarily affecting movement, caused by the loss of brain cells that produce dopamine, a chemical that helps control movement). During a telephone interview on [DATE] at 12:24 P.M., Resident #1's Representative said Resident #1 told her that he/she could not keep his/her eyes open and wanted to see a doctor. Resident #1's Representative said she inquired about Resident #1's medications to see if he/she was receiving anything new and learned Resident #1 was receiving the incorrect dose of Carbidopa-Levodopa (a medication used to alleviate the symptoms of Parkinson's disease) since he/she was admitted . Review of Resident #1's Hospital Discharge Medication List, dated [DATE], indicated his/her orders included the following: - Carbidopa-Levodopa, oral tablet, ,d+[DATE] milligrams (mg), administer two tablets (,d+[DATE] mg) orally five times per day (for a total of ,d+[DATE] mg daily) - Carbidopa-Levodopa, ,d+[DATE] mg extended release oral tablet, administer two tablets (for a total of , d+[DATE] mg) orally daily at bedtime. Review of Resident #1's [DATE] Physician Order Summary Report indicated the following: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Carbidopa-Levodopa oral tablet, ,d+[DATE] mg, administer one tablet by mouth five times per day (for a total of only ,d+[DATE] mg daily) - Carbidopa-Levodopa extended release tablet, ,d+[DATE] mg, administer one tablet by mouth at bedtime, (for a total of only ,d+[DATE] mg at bedtime). Review of Resident #1's Medication Administration Record (MAR) indicated he/she received only one tablet (instead of the two tablets he/she was supposed to receive) of the following: - Carbidopa-Levodopa ,d+[DATE] mg five times daily (received one tablet only) for a total of 14 times - Carbidopa-Levodopa ER ,d+[DATE] (received one tablet only) for a total of four times Therefore, Resident #1 received half the amount of medication that he/she had been receiving in the Hospital, to manage his/her movement disorder. Review of an article in MedCentral.com related to the administration of Carbidopa-Levidopa, indicated this medication must be carefully adjusted according to individual requirements, response and tolerance. The risk of precipitating (to happen suddenly) a system complex resembling neuroleptic malignant syndrome (rare but potentially fatal reaction to certain drugs, characterized by symptoms such as fever, muscle rigidity, and altered mental status, triggered by increasing or stopping a dose) patients should be watched closely if carbidopa- levodopa dose is reduced abruptly. During an interview on [DATE] at 1:55 P.M., Nurse #1 said there is a process to reconcile medications when a resident is admitted or readmitted to the Facility. Nurse #1 said it is the responsibility of the nurse performing the admission to review the medication list supplied by the hospital (if the resident is being admitted from the hospital). Nurse #1 said the process was to carefully go through the list, go over the list with the Facility Provider so they can approve the orders or make any necessary changes, and after verifying the orders with the Provider, the nurse enters the orders into the computer. During an interview on [DATE] at 2:03 P.M., the Nursing Supervisor said when reconciling admission medications, the preferred hospital documentation is within the Hospital Discharge Summary, titled Discharge Medications. The Nursing Supervisor said the Discharge Medication List contains details such as which medications were newly prescribed, which medications were changed, and which medications were unchanged or discontinued at the hospital. The Nursing Supervisor reviewed Resident #'1's Discharge Medication List with the surveyor, and said Resident #1 had been receiving two tablets of Carbidopa-Levodopa both immediate release (,d+[DATE] mg) and extended release (,d+[DATE] mg) while in the hospital. The Nursing Supervisor and the surveyor then reviewed a Physician Assistant (PA) Visit Note, dated [DATE], where the PA indicated Resident #1's Carbidopa-Levodopa order was ,d+[DATE] mg, two tablets five times per day and ,d+[DATE] mg extended release, two tablets at bedtime. The Nursing Supervisor said Resident #1 should have been receiving two tablets of each Carbidopa-Levodopa formulations since admission, and the nurse had entered the admission orders incorrectly. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:00 P.M., the Director of Nursing (DON) said when Resident #1 was admitted , the Nurse transcribed and obtained orders for the incorrect dose of Carbidopa-Levodopa (both immediate release and extended release tablets), and Resident #1 was administered the incorrect dose until it was remedied on [DATE]. On [DATE], the Facility was found to be in Past Non-Compliance and provided the surveyor with a plan of correction which addressed the area of concern as evidenced by: A) On [DATE], The Physician Assistant assessed Resident #1 and his/her physician's orders were immediately corrected. B) On [DATE], the Director of Nursing (DON) conducted a Medication Administration Review with the Nurse who reconciled Resident #1's medications incorrectly with education provided on the Five Rights of Medication Administration and Admission Process for Medication Reconciliation along with a competency evaluation administered by the Staff Development Coordinator. C) From [DATE] through [DATE] the DON provided in-person education to Licensed Nursing staff, titled Admission Medication Reconciliation and the Five Rights of Medication Administration with competencies. D) On [DATE], the DON immediately audited all new admissions starting from [DATE] to ensure admission medication orders were reconciled correctly. E) Weekly audits continue to be conducted by the DON to ensure admission medication orders were reconciled correctly. F) On [DATE] an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held. The Facility leadership team developed a plan of correction related to the deficient practice. I) Effectiveness of this plan will be reviewed during Monthly QAPI meetings until further notice. J) The Director of Nursing and/or designee will be responsible for overall compliance.