

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225591	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Royal Wayland Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 188 Commonwealth Road Wayland, MA 01778	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456</p> <p>Based on record reviews and interviews, the facility failed to follow the physician order to obtain weekly weights for 1 Resident (#35) out of a total sample of 16 residents.</p> <p>Findings include:</p> <p>Resident #35 was admitted to the facility in March 2024 with diagnoses including dementia and unspecified severe protein-calorie malnutrition.</p> <p>Review of Resident #35's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status exam and staff had assessed him/her to have severe cognition. The MDS also indicated Resident #35 required substantial assistance from staff for functional daily tasks.</p> <p>Review of Resident #35's physician orders indicated the following order:</p> <p>-Weekly Weights, initiated on 4/25/24.</p> <p>Review of Resident #35's weight log indicated the Resident had not been weighed weekly since 5/31/24.</p> <p>Review of the nutritional assessments dated 3/12/24 and 6/4/24 indicated the recommendation to weigh the Resident as ordered.</p> <p>During an interview on 7/23/24 at 11:41 A.M., Nurse #1 said Resident #35 has an order to have weights taken weekly. Nurse #1 reviewed Resident #35's weight log and said this order has not been followed in the past two months.</p> <p>During an interview on 7/23/24 at 12:07 P.M., the Director of Nursing said orders should be followed as written.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure quality of care was provided according to facility protocols and professional standards of practice for one Resident (#6) , out of a total sample of 16 residents. Specifically, the facility failed to identify a skin alteration on Resident #6's foot and document accordingly.</p> <p>Findings include:</p> <p>Review of the facility's policy titled 'Skin Integrity Management' indicated the following but not limited to:</p> <ul style="list-style-type: none"> -Resident's skin integrity status and need for prevention intervention or treatment modalities is identified through review of assessment information. -Perform and document skin inspection on admission and weekly. <p>Resident #6 was admitted to the facility in October 2017 with diagnoses including type 2 diabetes mellitus with diabetic neuropathy and dementia.</p> <p>Review of Resident #6's Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 10 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was moderately cognitively impaired. The MDS further indicated that the Resident was dependent on staff for activities of daily living (ADL) care.</p> <p>On 7/23/24 at 9:43 A.M., the surveyor observed Resident #6 lying in his/her bed with feet not covered. The surveyor observed a dark calloused area on the Resident's right foot 3rd toe.</p> <p>Review of the medical record indicated the following physician orders:</p> <ul style="list-style-type: none"> -Diabetic foot care every evening shift -Complete weekly skin check every day shift every Monday note skin alteration. <p>Review of the care plan titled Resident has diabetes mellitus with the following interventions:</p> <ul style="list-style-type: none"> -Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. -Check all of body for breaks in skin and treat promptly as ordered by doctor -Wash feet daily with mild soap and water, dry thoroughly, may use a light dusting powder or lotion. <p>Review of the Treatment Administration Record (TAR) for July indicated a weekly skin check and daily diabetic foot care had been completed and no skin alteration had been documented.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/24/24 at 7:59 A.M., Nurse #1 said she would describe the area on Resident #6's right foot 3rd toe as black dark toe, she said that area should be noted on the weekly skin check or during the diabetic foot care.</p> <p>During an interview on 7/24/24 at 10:23 A.M., the Director of Nursing (DON) said that she and the physician assistant went and observed the area on Resident #6's right foot 3rd toe and the physician assistant said it's not a soft tissue concern and to follow up with podiatry. The DON further said it was her expectation that any skin alteration noted on the Residents skin would have been documented.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019</p> <p>Based on record review and interview, the facility failed to ensure one Resident (#17), out of a total sample of 16 residents, received care and treatment to prevent worsening of a pressure injury. Specifically, the facility failed to implement a wound treatment timely resulting in a delay in treatment and deterioration of the wound to a stage 3 pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) to the Resident's sacrum (an area at the base of the spine).</p> <p>Findings include:</p> <p>Resident #17 was admitted to the facility in December 2023 with diagnoses including dementia and a history of a traumatic brain injury.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE], indicated Resident #17 could not participate in the Brief Interview for Mental Status due to severe cognitive impairment. Review of the MDS indicated Resident #17 was dependent for mobility and care.</p> <p>Review of the policy titled Skin Integrity Management, dated December 2023, indicated the following:</p> <ul style="list-style-type: none"> - Resident's skin integrity status and need for prevention intervention or treatment modalities is identified through review of assessment information. * care plan for residents at high risk for skin breakdown * perform and document skin inspection on admission and weekly * perform wound assessment upon initial identification or altered skin integrity and weekly thereafter - Comprehensive care plan developed to include prevention and wound treatments as indicated * evaluate need for support surfaces * Refer to wound MD/wound clinic as appropriate. Implement wound care modalities - Products for skin and wound care will be selected based on RHG guidelines - Document all treatments per facility policy <p>Review of the skin integrity care plan for Resident #17 indicated the following interventions:</p> <p>-Impaired Skin Integrity Risk: I have the potential for pressure ulcer development r/t impaired mobility, double incontinence, and comorbidities (initiated 12/29/23)</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interventions:</p> <p>-Air Mattress (initiated 4/25/24)</p> <p>-Monitor/document/report to MD (doctor) PRN (as needed) changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size, stage (initiated 12/29/23)</p> <p>-Educate the resident/family/caregivers as to cause of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning (initiated 12/29/23)</p> <p>Review of the skin check, dated 4/18/24, indicated Resident #17 presented with a pressure ulcer on the coccyx. Further review of the skin check failed to indicate a description of the wound.</p> <p>Review of the Medication Administration Record for April 2024 indicated, on 4/18/24, Resident #17 had an alteration in skin integrity, which was warm and dry.</p> <p>Review of the clinical record failed to indicate that the physician or nurse practitioner (NP) was notified of the change in skin condition on 4/18/24.</p> <p>Review of the progress note, dated 4/22/24, indicated Resident #17's wound had opened and needed a protective dressing.</p> <p>Review of the skin check, dated 4/22/24, indicated the following Pressure ulcer to the sacrum is open to a stage II. awaiting appropriate dressing.</p> <p>Review of the clinical record did not indicate that any treatment measures had been put in place for the open wound on 4/22/24 and failed to indicate that the physician or NP was notified of the open wound.</p> <p>Review of the progress note, dated 4/25/24, indicated the following:</p> <p>Note Text: NP reported to this writer on 4/24/24 that resident had area on sacrum. Wound MD in on 4/24/24 and was able to see resident. New Dx of stage 3 pressure wound (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue) on sacrum. New order to apply Silver Sulfadiazine (a medication cream used to treat open wounds) daily followed with a silicone bordered foam dressing. New order for Vit C bid (twice a day), Zinc for 14 days.</p> <p>Review of the wound physician note, dated 4/24/24, indicated Resident #17 had a stage 3 pressure wound to the sacrum that measured 1.4 centimeters in length, 0.5 centimeters in width, and 0.1 centimeters in depth.</p> <p>Review of the physician orders indicated that the Silver Sulfadiazine was ordered on 4/24/24, 6 days after the initial change in condition of Resident #17's skin.</p> <p>(continued on next page)</p>

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/24/24 at 8:18 A.M., the Director of Nursing said that if a nurse identifies a new area on a Resident then it needs to be reported to the doctor and a treatment would be put in place right away. The Director of Nursing said that barrier cream was being used per house protocol when the skin alteration was first identified and that it is put on bony prominences to prevent skin breakdown and a dressing was put in place, but that the Silvadene was ordered on 4/24/24. The Director of Nursing said that the barrier cream had been in place prior to the skin alteration discovered on 4/18/24 since that was standard protocol.		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431</p> <p>Based on observations, record review and interview the facility failed to implement a physician's order for the use of a bed alarm for one Resident (#1) out of a total sample of 16 residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled 'Managing Falls and Fall Risk, dated December 2023 indicated; Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident-Centered Approaches to Managing Falls and Fall Risk, 8. Position-change alarms will not be used as the primary or sole interventions to prevent falls, but rather will be used to assist staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner.</p> <p>Resident #1 was admitted to the facility in September 2018 with diagnoses that include but are not limited to unspecified dementia, neuropathy, pain, and depression.</p> <p>Review of the Minimum Data Set assessment dated [DATE] indicated Resident #1 was assessed by staff as having severely impaired cognitive skills and is dependent on staff for bathing and bed mobility.</p> <p>Review of a facility reported incident report dated 2/8/24 indicating Resident #1 had a fall out of bed on 2/7/24, resulting in a displaced condyle fracture of the lower right femur and a displaced fracture of the medial condyle of left tibia.</p> <p>Review of Resident #1's medical record indicated the following:</p> <p>-Fall risk assessments dated 7/31/23, 2/11/24 and 6/11/24 indicate Resident #1 is 'At risk' for falls.</p> <p>-A current physician's order dated 2/12/24 alarms: bed-check function and placement every shift for safety/fall risk.</p> <p>-A fall risk care plan dated as initiated 9/28/2018, revised 8/19/2021, I am at high risk for fall and injury r/t (related to) decreased mobility, impaired safety awareness, use of antidepressant medications, chronic pain, and comorbidities, history of fall. Interventions * bed alarm at all times in bed date initiated 2/19/2024.</p> <p>-A Kardex (a guide for resident care and interventions used by staff) report, dated as of 7/24/24 Safety: bed alarm at all times in bed.</p> <p>During the survey the following observations were made:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/23/24 at 4:55 P.M., Resident #1 was resting in bed with the head of the bed elevated. The bed alarm box was affixed to his/her left side of the bed, a light on the box was blinking red and the alarm box was not attached to anything. The sensor pad was behind the bed resting on top of the bed frame and not attached to the bed alarm box.</p> <p>On 7/24/24 at 8:08 A.M. Resident #1 was in bed, eating is/her breakfast. The bed alarm box was affixed to the left side of his/her bed, was blinking red and was not attached to anything. The sensor pad was behind the bed resting on top of the bed frame.</p> <p>On 7/24/24 at 8:47 A.M., staff exited Resident #1's room with his/her breakfast tray. Resident #1's bed was in a lower position and the bed alarm box was affixed to the left side of the bed, blinking red, and was not attached to the sensor pad. The sensor pad was behind the bed on top of the bed frame.</p> <p>During an interview and observation on 7/24/24 at 9:26 A.M., Nurse #1 said the nurses are responsible for documenting on the Treatment Administration Record the use of a bed alarm to ensure it is in place and functioning. Nurse #1 said Resident #1 makes her needs known and chooses to stay in bed most of the time. Nurse #1 said Resident #1 did have a fall a few months back and has a bed alarm to alert staff. Nurse #1 went to Resident #1's room, said the blinking light means it (the bed alarm) is not working and needs to be attached to the sensor pad. Nurse #1 located the sensor pad behind the bed and attempted to attach the cord to the alarm box but was unable to do so and said the part that plugs into the box is broken. Nurse #1 said the bed alarm should be plugged in and always working. Nurse #1 said she was not made aware that the bed alarm was not in place and working and that staff have been in and out of the room.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019</p> <p>Based on record review and interview, the facility failed to prevent unnecessary medication after the recommendation of a gradual dose reduction for one Resident (#30) out of a total sample of 16 residents.</p> <p>Findings include:</p> <p>Resident #30 was admitted in February 2023 with diagnoses including dementia with agitation and major depressive disorder.</p> <p>Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #30 is severely cognitively impaired and could not participate in the Brief Interview for Mental Status (BIMS).</p> <p>Review of the physician's orders indicated Resident #30 was taking 150 milligrams of Seroquel at night in June 2023.</p> <p>Review of the Psychiatric Evaluation and Consultation, dated 6/27/23, indicated Resident #30 had had increased lethargy (a feeling of fatigue) and a recommendation was made to decrease Resident #30's Seroquel (a medication used to treat mood disorders) dose to 125 milligrams at night in an attempt to reduce the lethargy.</p> <p>Review of the Medication Administration Record failed to indicate the change in medication until 8/30/23, over a month after the initial recommendation.</p> <p>Review of the physician notes did not indicate that the recommendation was reviewed or addressed after 6/27/23.</p> <p>During an interview on 7/24/24 at 10:23 A.M., the Director of Nursing said that it is facility protocol to present the recommendation to the doctor and it would get approved or denied. The Director of Nursing could not say why the medication reduction was put in on 8/30/23 and not when the recommendation was made.</p>