| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225615 | A. Building<br>B. Wing | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Riverbend of South Natick | 34 South Lincoln Street<br>S Natick, MA 01760 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>48206<br><br>Based on record review and interview, the facility failed to notify the Physician of a significant change in condition for one Resident (#3) out of a total sample of 13 Residents.<br><br>Specifically, the facility staff failed to notify the Physician/ Nurse Practitioner (NP) so treatment could be altered when Resident #3 was identified with significant weight loss by the Registered Dietician.<br><br>Findings include:<br><br>Review of the facility policy titled Weight Assessment and Intervention, undated, indicated:<br><br>-The threshold for significant unplanned and undesired weight loss will be based on the following criteria:<br><br>>1 month - 5% weight loss is significant, greater than 5% is severe<br><br>>3 months - 7.5% weight loss is significant, greater than 7.5% is severe<br><br>>6 months - 10% weight loss is significant, greater than 10% is severe<br><br>-The Physician and multidisciplinary team will identify conditions and medications that may be causing anorexia (eating disorder defined by restriction of energy intake relative to requirements, leading to a significantly low body weight), weight loss, or increasing weight loss.<br><br>Resident #3 was admitted to the facility in April 2023 with diagnoses including Dementia (progressive disease with impairment in memory and loss of judgement), Dysphagia (difficulty swallowing), Other Feeding Difficulties, Anemia (condition that develops when the blood produces a lower than normal amount of red blood cells and/or hemoglobin [protein in red blood cells that carries oxygen from the lungs to other organs/tissues] to carry oxygen to the body's tissues) and Celiac Disease (chronic digestive and immune disorder that damages the small intestine when the body has a reaction to gluten).<br><br>Review of Resident #3's Weights and Vitals report provided by the facility on 6/5/24 indicated:<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -12/12/23: 150.0 lbs (pounds)<br><br>-1/9/24: 154.0 lbs<br><br>-2/13/24: 154.1 lbs<br><br>-3/12/24: 156.4 lbs<br><br>-4/9/24: 140 lbs (-10.49% change from 3/12/24)<br><br>-5/14/24: 138.3 lbs (-1.2% change from 4/9/24 and -11.5% from 3/12/24)<br><br>Review of the May 2024 Physician's orders indicated:<br><br>-Weights Monthly, initiated 5/16/23<br><br>-Diet: >Puree with Thin Liquids gluten free, >lip plate with all meals, >slow pace cues 1 bite, 1 sip at a time, >1:1 supervision, initiated 3/18/24<br><br>-Ensure Original Liquid, give 237 ml (milliliters) by mouth twice daily at 8:00 A.M. and 5:00 P.M., initiated 4/24/24<br><br>Review of the Nutrition Progress notes indicated the following:<br><br>>3/3/24:<br><br>-Resident was able to eat his/her meal with minimal assistance.<br><br>-Weight remains stable at 154# (lbs), continues with gluten free (therapeutic diet) and puree (mechanically altered texture) diet.<br><br>-Intake is excellent, eating 100% of most meals.<br><br>-Will continue to monitor weight, intake, and skin.<br><br>>4/16/24 (recorded as late entry note on 4/22/24):<br><br>-A reweight has been requested due to a 16-lb. weight change over the course of one month [3/12/24 - 4/9/24], despite the Resident maintaining excellent intake<br><br>-We scheduled him/her to be weighed the following day.<br><br>-Will follow up regarding accuracy.<br><br>>4/23/24:<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The recent weight measurement shows a further decline, now at 133 lbs. compared to 154 lbs. during the annual check-up indicating a -21 lbs. weight change and -7 lbs. since the beginning of April 2024.<br><br>-The Resident's IBW (Ideal Body Weight) is 130 lbs. +/- 10% (117-143 lbs.), and he/she is currently within ideals, and therefore weight loss is not warranted at this time.<br><br>-Nursing is aware of the weight loss and will notify the Nurse Practitioner/Medical Doctor.<br><br>- Recommend initiating Ensure twice daily to help prevent further weight loss and obtain labs.<br><br>-Will remain involved and reassess.<br><br>Review of the Nursing Progress Note dated 4/24/24 indicated:<br><br>-Following recent weight loss, NP (Nurse Practitioner) called with the Dietician's recommendations.<br><br>-New orders for Ensure (nutritional supplement) twice daily to prevent further weight loss.<br><br>-Family notified.<br><br>-Plan of care ongoing.<br><br>Review of the Physician Progress Notes indicated:<br><br>-4/11/24: Resident #3 had diagnoses of adult failure to thrive (FTT: syndrome of weight loss, decreased appetite and poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms and impaired immune function) and moderately advanced Dementia requiring support for ADLs (activities of daily living such as bathing, dressing, eating). Further review of the Physician Progress Notes failed to indicate any concerns, discussion, or intervention regarding the Resident's recent weight loss on 4/9/24.<br><br>-5/16/24: The Physician Progress Notes failed to indicate any concerns, discussion, or intervention regarding the Resident's recent weight loss or nutritional status.<br><br>Further review of the medical record failed to indicate that the NP or the Physician evaluated the Resident for nutritional risk or impaired nutrition after the significant weight loss was identified on 4/9/24.<br><br>During an interview on 6/5/24 at 9:16 A.M., the Nurse Practitioner (NP) said typically the DON (Director of Nurses), or nursing staff communicate any weight loss to her. The surveyor and NP reviewed Resident #3's medical record and the NP said the Resident's weight loss from 3/12/24 to 4/9/24 was concerning and that she was not made aware of the weight loss, only the recommendation by the Dietician to add twice daily Ensure supplement on 4/24/24.<br><br>Please Refer to F692 |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337<br><br>Based on observation, record review and interview the facility failed to ensure one Resident (#27) was free from a potential restraint, out of a total sample of 13 residents.<br><br>Specifically, the facility failed to assess the use of the right side of the bed positioned flush against the wall, preventing Resident #27 from exiting the right side of bed, being used as a potential restraint.<br><br>Findings include:<br><br>Review of the facility policy titled Restraints, undated, indicated the following:<br><br>-The intent of this policy is for each person to reach his or her practicable wellbeing in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints.<br><br>-A restraint used for any reason other than medical symptoms, violates the rights of the residents, reduces their quality of life, and presents significant physical and psychological risks.<br><br>-Physical Restraints are defined as any method, physical or mechanical device, material, or equipment attached to or adjacent to the resident's body, that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.<br><br>Resident #27 was admitted to the facility in December 2023 with diagnoses including 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, involves parts of the brain that control thought, memory, and language) and Intraductal Carcinoma of the breast (a non-invasive or pre-invasive breast cancer).<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #27 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of one out of a total score of 15.<br><br>On 5/30/24 at 9:33 A.M., the surveyor observed Resident #27 asleep in bed with the right side of the bed positioned flush against the wall.<br><br>On 6/4/24 at 8:50 A.M., the surveyor observed Resident #27 lying in bed, with the right side of the bed positioned flush against the wall. The surveyor also observed that the head of the bed was elevated.<br><br>Review of Resident #27's Physician's orders dated 5/1/24 through 6/30/24, did not indicate any orders for the Resident to have the bed positioned flush against the wall on the right side of the bed.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #27's clinical record did not provide any evidence that an assessment relative to positioning the right side of Resident #27's bed flush against the wall, had been completed as a potential restraint.<br><br>Further review of Resident #27's clinical record did not provide any evidence documented in the progress notes relative to positioning Resident #27's bed flush against the wall to the right side of the bed.<br><br>Review of Resident #27's current care plan last revised 5/29/24, did not provide any evidence of care planning relative to positioning the right side of Resident #27's bed flush against the wall.<br><br>During an interview and observation on 6/4/24 at 12:41 P.M., of Resident #27 lying in bed, Unit Manager (UM) #1 said that she did not know why Resident #27's bed was against the wall. UM #1 further said she was not sure if an assessment as a potential restraint had been completed relative to positioning the right side of Resident #27's bed flush against the wall.<br><br>During an interview on 6/4/24 at 1:09 P.M., Certified Nurses Aide (CNA) #1 said he worked full-time on the 2nd floor unit and often provided care to Resident #27. CNA #1 said Resident #27's bed was flush against the wall because the space in the room was small. CNA #1 said that Resident #27 sits up in the chair sometimes but prefers to be in bed with the head of the bed elevated.<br><br>During an interview on 6/4/24 at 2:23 P.M., UM #1 said that she could not provide any evidence that positioning the bed flush against the wall to the right side of the bed had been assessed as a potential restraint for the Resident. UM #1 also said that there was no Physician's order or care plan in place for the positioning of Resident #27's bed flush against the wall to the right side of the bed. UM #1 said that there should have been a restraint assessment performed, a Physician's order obtained, and a care plan put into place for the positioning of the right side of Resident #27's bed flush against the wall. |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>44337<br><br>Based on interview and record review, the facility failed to accurately code Minimum Data Set (MDS) assessments for one Resident (#27) out of a total sample of 13 residents.<br><br>Specifically, for Resident #27, the facility staff failed to accurately code two consecutive MDS assessments relative to Hospice services.<br><br>Findings include:<br><br>Resident #27 was admitted to the facility in December 2023 with diagnoses including 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, involves parts of the brain that control thought, memory, and language) and Intraductal Carcinoma of the breast (a non-invasive or pre-invasive breast cancer).<br><br>Review of Resident #27's clinical record indicated a Skilled Nursing Facility Notification Form that reflected the Resident had been started on Hospice services effective 9/8/23.<br><br>Review of the Admission Progress Notes dated 12/27/23, indicated Resident #27 was admitted to the facility on Hospice services.<br><br>Further review of the Resident's clinical record included a Nutrition Progress Note dated 5/30/24, that indicated Resident #27 continued under the care of Hospice services.<br><br>Review of Resident #27's MDS assessments dated 12/26/24 and 3/8/24, did not indicate that the Resident was receiving Hospice services.<br><br>During an interview on 6/5/24 at 7:58 A.M., the MDS Coordinator said that she had worked at the facility since the end of December 2023 and was responsible for coding MDS information for all residents in the facility. The MDS Coordinator said the MDS assessments dated 12/26/23 and 3/8/24, were coded incorrectly because the assessments did not reflect that Resident #27 was receiving Hospice services. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>48206<br><br>Based on policy, record review and interview, the facility failed to refer one Resident (#17) out of a total sample of 13 residents, for a Preadmission Screening and Resident Review (PASRR- a federal requirement to help ensure individuals are not inappropriately placed in long term care) Level II evaluation (an in-depth evaluation of a person who has a positive Level I screen (a pre-admission screening process used to determine if a person has a diagnosis or suspected diagnosis of developmental disabilities/related conditions or mental illness) for mental illness (MI), intellectual disability, or related condition to determine if they require specialized services).<br><br>Specifically, the facility failed to refer Resident (#17) for a Level II evaluation when the Resident had documented diagnoses of mental illness (MI) and the Level I screen completed in the hospital prior to the facility admission was inaccurate.<br><br>Findings include:<br><br>Review of the facility policy titled Pre-Admission Screen, undated, indicated the following:<br><br>-Upon receipt of the referral the Director of Social Services will request and/or initiate the need for an onsite or telephonic completion of the pre-admission screen.<br><br>-If an onsite medical record/patient review is necessary the social service/designee will complete the pre-admission screen after receiving the referral.<br><br>-The original copy of the pre-admission screen will be placed in the patient's chart.<br><br>Resident #17 was admitted to the facility in May 2024 with diagnoses including Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and Unspecified Psychosis (a mental disorder characterized by a disconnection from reality).<br><br>Review of the PASRR Level I Screening Form dated 5/8/24, indicated the Resident did not have a documented diagnosis of a mental illness or mental disorder and had not experienced any major life activity or functional impairments within the past six months, resulting in a negative PASRR Level I screen.<br><br>Review of the Hospital Patient Care Referral Form dated 5/8/24, indicated Resident #17:<br><br>-had a prior medical history of Mood Disorder-Depression.<br><br>-was prescribed Sertraline (an anti-depressant medication).<br><br>-had a Psychiatric Consult with recommendation to continue nightly Seroquel (an antipsychotic medication) with Haldol (an antipsychotic medication) through an IV (Intravenously) access as needed for agitation.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's Initial Nurse Practitioner (NP) Visit Note dated 5/9/24, indicated that Resident #17:<br><br>-had a history of Depression and Anxiety, and had medication changes to his/her antidepressant medications during his/her hospitalization .<br><br>-was started on Seroquel for agitation/psychosis and received IV Haldol during his/her hospitalization .<br><br>-had Psychosis and continues on Seroquel at night.<br><br>During an interview on 5/31/24 at 11:39 A.M., the facility Social Worker (SW) said she was responsible for reviewing the hospital documentation provided by the admissions department and then completing the PASRR Level I screen. The surveyor and the SW reviewed the Hospital's Patient Care Referral Form dated 5/8/24, and the SW said that the PASRR Level I screen was not accurate and a Level II evaluation was needed. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901<br><br>Based on observation, interview, record review and policy review, the facility failed to ensure the plan of care was revised for three Residents (#8, #18 and #10), out of a total sample of 13 residents.<br><br>Specifically, the facility staff failed to:<br><br>1. For Resident #8, revise the Resident's Incontinence Care Plan to reflect the current suprapubic catheter size.<br><br>2. For Resident #18, revise a Fall Care Plan after the Resident sustained a fall.<br><br>3. For Resident #10, ensure that the Resident and/or the Resident Representative were invited to participate in the Care Plan Conference Meetings.<br><br>Findings include:<br><br>Review of the facility policy titled Care Plan, Comprehensive Person-Centered revised 12/2016, indicated the comprehensive care plan will:<br><br>-Include assessment of the resident's strengths and needs and incorporate the resident's personal and cultural preferences in developing the goals of care<br><br>-Measurable objectives and timeframes<br><br>-Incorporate identified problems areas, risk factors associated with identified problems<br><br>-Aid in preventing or reducing decline in the resident's functional status and/or functional levels<br><br>-Enhance optimal functioning of the resident by focusing on a rehabilitative program<br><br>Review of the facility policy titled Care Planning-Interdisciplinary Team, undated, indicated the following:<br><br>-The care plan is based on the Resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which includes, but is not necessarily limited to the following personnel:<br><br>-Physician<br><br>-Registered Nurse who has responsibility for the Resident<br><br>-Dietician<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Social Worker<br><br>-Activity Director<br><br>-Nursing Assistants responsible for the Resident's care<br><br>-Charge Nurse responsible for the Resident's care<br><br>-Others as appropriate or necessary to meet the needs of the Resident<br><br>-The Resident, the Resident's family and/or the Resident's legal representative/guardian (a person appointed by the court to make decisions on behalf of someone else) or surrogate (an adult who has shown special care and concern for the individual, who is familiar with the individuals' personal values, is reasonably available, and is willing to serve as the surrogate) are encouraged to participate in the development of and revisions to the Resident's care plan.<br><br>1. Resident #8 was admitted to the facility in November 2022, with diagnoses including neurocognitive disorder (a group of conditions that cause a decline in mental function due to medical disease other than a psychiatric illness), retention of urine (inability to completely empty bladder of urine), and neuromuscular dysfunction of the bladder (lack of bladder control due to brain, spinal cord, or nervous system problems).<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #8 had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 2 out of a total 15 and had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine outside the body).<br><br>Review of the Urinary Incontinence Care Plan initiated 12/19/22, indicated that Resident #8 had an indwelling Foley catheter, Size 22 French (Fr) and 30 milliliters (ml) balloon (retention balloon- a tiny balloon at the end of the indwelling urinary catheter that is inflated with water to prevent the indwelling urinary catheter from sliding out of the body).<br><br>Review of Resident #8's May 2024 Physician's orders included the following:<br><br>-Suprapubic catheter, Size 20 Fr and 5 ml balloon, dated 1/8/24.<br><br>On 6/4/24 at 10:19 A.M., during an observation with Unit Manager (UM) #1, UM #1 said Resident #8's suprapubic catheter was Size 18 Fr with 5 ml balloon.<br><br>During an interview on 6/4/24 at 1:44 P.M., the Director of Nursing (DON) said Resident #8's suprapubic catheter was Size 18 Fr and 5 ml balloon. The DON further said a Physician's order should have been obtained and the Resident's Urinary Incontinence Care Plan should have been revised for the correct catheter size but was not.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Resident #18 was admitted to the facility in July 2023, with diagnoses including Rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood), repeated falls, insomnia (sleep disorder with trouble falling asleep and/or staying asleep), and Psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality).<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #18 had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 5 out of a total 15 and had a history of falls.<br><br>Review of the Nursing Progress Note dated 12/26/23 indicated that Resident #18 was found on the floor in his/her room leaning against the wall. The Nursing Progress Note further indicated the Resident said that he/she was getting out of bed and the chair was not locked and he/she slid onto the floor.<br><br>Review of the Impaired Mobility Care Plan initiated 8/3/23 and revised 4/4/24, did not include any interventions for falls.<br><br>During an interview on 5/31/24 at 10:40 A.M., the DON said the Interdisciplinary Team (IDT) reviews any Resident falls, and new interventions to prevent falls would be updated in the Resident's plan of care after review with the IDT.<br><br>During a follow-up interview on 5/31/25 at 12:44 P.M., the DON said Resident #18's incident report for falls in 12/26/23 had not been reviewed by the IDT and no falls interventions had been put in place.<br><br>44337<br><br>3. Resident #10 was admitted to the facility in January 2023 with diagnoses including Diabetes Mellitus II (a long term condition in which the body has difficulty controlling sugar in the blood), left femur fracture (fracture of the thigh bone), Depression (a mental disorder characterized by a pervasive low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), and Chronic Kidney Disease (CKD: a condition in which the kidneys are damaged and can no longer filter waste from the blood).<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #10 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of seven out of a total score of 15.<br><br>During an interview on 5/30/24 at 9:21 A.M., Resident #10 said he/she was not sure if he/she had gone to any care plan meetings. Resident #10 also said that he had broken his leg and now uses a walker because he/she is unsteady on his/her feet.<br><br>Review of Resident #10's record indicated Care Plan Conference Summary Notes dated 10/19/23, 1/4/24 and 3/21/24.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Further review of the Care Plan Conference Summary Notes indicated that Social Worker (SW) #1 and the Activities Director (AD) attended the care plan conferences but did not indicate that the Resident and/or the Resident Representative (RR) or any other member of the Care Planning/Interdisciplinary Team attended the care plan conferences.<br><br>Review of the Social Work Progress Notes written by SW #1, dated from 10/10/23 to 5/29/24, did not provide any evidence that the Resident and/or the RR had been invited to attend the care plan conferences dated 10/19/23, 1/4/24, and 3/21/24.<br><br>Further review of the Social Work Progress Notes did not indicate that the Resident and/or the RR had declined to attend the care plan conferences dated 10/19/23, 1/4/24, and 3/21/24.<br><br>During an interview on 6/5/24 at 9:37 A.M., SW #1 said that she had worked at the facility for nine years and was responsible for the implementation of the care plan conference process. SW #1 said she received information from the MDS Coordinator that indicated which residents were due for a care planning conferences and then sent an email or letter to the Resident and/or the RR/family informing them of the date of the care plan conference. SW #1 said that a Certified Nurses Aide (CNA), a Nurse, the Physician, the Social Worker, the Activities Director and any other discipline involved in the Resident's care were required to attend the care plan conference. SW #1 said the Care Plan Conference Summary Notes, kept in the Resident's record, contained all documentation regarding the care plan conference and included which disciplines attended the conference and if the Resident and/or the RR/family had attended or declined to attend the conference. The surveyor and SW #1 reviewed Resident #10's Care Plan Conference Summary Notes dated 10/19/24, 1/4/24 and 3/21/24, and SW #1 said that there was no documentation that indicated Resident #10 and/or RR/family had been invited to attend or had declined to attend the care plan conference. SW #1 said if there was no documentation then that meant the Resident and/or the RR/family had not been invited to the conference. SW #1 also said that there was no documentation that reflected the required disciplines had attended Resident #10's care plan conference and there should have been documentation. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>48206<br><br>Based on record review, policy review, and interview, the facility failed to recognize and address nutritional needs timely when weight loss of greater than 10% was identified for one Resident (#3), out of a total sample of 13 residents.<br><br>Specifically, the facility failed to:<br><br>-notify the Registered Dietician (RD) and Physician/ Nurse Practitioner (NP) timely when the significant weight loss occurred,<br><br>-implement a recommendation from the RD to obtain labs for Resident #3,<br><br>-obtain a re-weigh and implement nutritional interventions timely, resulting in a two week delay of care.<br><br>Findings include:<br><br>Review of the facility policy titled Weight Assessment and Intervention, undated, indicated:<br><br>-Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Registered Dietitian (RD) in writing. Verbal notification must be confirmed in writing.<br><br>-The RD will review the unit Weight Record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met.<br><br>-The threshold for significant unplanned and undesired weight loss will be based on the following criteria:<br><br>>1 month- 5% weight loss is significant, greater than 5% is severe<br><br>>3 months- 7.5% weight loss is significant, greater than 7.5% is severe<br><br>>6 months- 10% weight loss is significant, greater than 10% is severe<br><br>-Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding:<br><br>>Resident's target weight range<br><br>>Approximate calorie, protein, and other nutrient needs compared with the Resident's current intake.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | >The relationship between current medical condition or clinical situation and recent fluctuations in weight; and<br><br>> Whether and to what extent weight stabilization or improvement can be anticipated.<br><br>-The Physician and multidisciplinary team will identify conditions and medications that may be causing Anorexia (eating disorder defined by restriction of energy intake relative to requirements, leading to a significantly low body weight), weight loss, or increasing weight loss. For example:<br><br>>Cognitive or functional decline<br><br>>Chewing or swallowing abnormalities<br><br>>Pain<br><br>>Medication-related adverse consequences<br><br>>Environmental factors<br><br>>Increased need for calories and/or protein<br><br>>Poor digestion or absorption<br><br>Resident #3 admitted to the facility in April 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), Dysphagia (difficulty swallowing), Other Feeding Difficulties, Anemia (condition that develops when the blood produces a lower than normal amount of red blood cells and/or hemoglobin [protein in red blood cells that carries oxygen from the lungs to other organs/tissues] to carry oxygen to the body's tissues), and Celiac Disease (chronic digestive and immune disorder that damages the small intestine when the body has a reaction to gluten).<br><br>Review of the Resident's Care Plan for Risk of GI (Gastro-Intestinal) Distress related to Celiac Disease, initiated 4/6/23, indicated the following interventions:<br><br>-Labs as ordered, initiated 4/6/23<br><br>-Monitor for signs and symptoms of nausea, vomiting, diarrhea, bloated stomach, weight loss, constipation, gas, initiated 4/6/23<br><br>Review of the Resident's Care Plan for Nutritional Status, initiated 6/19/23, indicated the following:<br><br>-The Resident had an inability to tolerate regular texture meals as evidenced by the need for altered texture diet and increased risk of aspiration (when something such as food or liquid enters your airway or lungs by accident which may cause serious health problems such as pneumonia) related to dysphagia.<br><br>-1:1 (one staff to be with the Resident) for all oral intake, initiated 6/19/23<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Diet as ordered, initiated 6/19/23<br><br>-Maintain adequate intake greater than 50% of most meals, initiated 6/19/23<br><br>-Continue to provide supervision for all meals, initiated 6/23/23<br><br>Review of the MDS (Minimum Data Set) Assessment, dated 5/24/24, indicated the Resident:<br><br>-Had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 1 out of a total 15<br><br>-Required setup assistance with eating tasks<br><br>-Had no indicators of swallowing difficulties<br><br>-Last weight was 138 lbs<br><br>-Had a weight loss of 5% or more in the past month and greater than 10% in the last 6 months<br><br>-Had a mechanically altered diet (a type of texture-modified diet for people who have difficulty chewing and swallowing)<br><br>-Had a therapeutically altered diet (a meal plan where foods and/or nutrients are adjusted to assist with controlling medical conditions or symptoms)<br><br>Review of the May 2024 Physician's orders for Resident #3 indicated:<br><br>-Weights Monthly, initiated 5/16/23<br><br>-Diet:<br><br>>Puree with Thin Liquids Gluten Free,<br><br>>lip plate (a rimmed plate) with all meals,<br><br>>slow pace cues 1 bite, 1 sip at a time,<br><br>>1:1 supervision, initiated 3/18/24<br><br>-Ensure Original Liquid (a liquid nutritional supplement), give 237 milliliters (mls) by mouth twice daily at 8:00 A.M. and 5:00 P.M., initiated 4/24/24<br><br>Review of Resident #3's Weights and Vitals Report provided by the facility on 6/5/24 indicated:<br><br>-12/12/23: 150.0 lbs (pounds)<br><br>-1/9/24: 154.0 lbs<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -2/13/24: 154.1 lbs<br><br>-3/12/24: 156.4 lbs<br><br>-4/9/24: 140 lbs (-10.49% change from 3/12/24)<br><br>-5/14/24: 138.3 lbs (-1.2% change from 4/9/24 and -11.5% since 3/12/24)<br><br>Review of the RD's Nutrition Progress Notes indicated the following:<br><br>-3/3/24: Resident was able to eat his/her meal with minimal assistance. A few months ago, he/she needed more feeding assistance but lately, he/she initiated self-feeding. Weight remains stable at 154# (lbs), continues with gluten free (therapeutic diet) and puree (mechanically altered texture) diet. Intake is excellent, eating 100% of most meals. Will continue to monitor weight, intake, and skin.<br><br>-4/16/24: (recorded as late entry note on 4/22/24) - A re-weight has been requested due to a 16-lb. weight change over the course of one month, despite the Resident maintaining excellent intake We scheduled him/her to be weighed the following day. Will follow up regarding accuracy.<br><br>-4/23/24: The recent weight measurement shows a further decline, now at 133 lbs compared to 154 lbs during the annual check-up (3/12/24) indicating a -21 lbs. weight change and -7 lbs. since the beginning of April 2024. The Resident's IBW (Ideal Body Weight) is 130 lbs. +/- 10% (117-143 lbs.), and he/she is currently within ideals, and therefore weight loss is not warranted at this time. Nursing is aware of the weight loss and will notify the Nurse Practitioner/Medical Doctor. Despite being on a gluten-free puree diet, the Resident's meal intake ranges from 60-80%. He/she .requires assistance with feeding on occasion. Recommend initiating Ensure twice daily to help prevent further weight loss and obtain labs. Will remain involved and reassess.<br><br>-6/2/24: His/her recent weight is 138 pounds, with no significant change over the past month. Staff report good intake of his/her supplement, Ensure [supplement] 237 mls twice daily. The last labs obtained on 1/3/24 were reviewed and were within normal limits which was improved since 10/18/23. The plan indicated to continue to monitor weight, intake, and skin.<br><br>Further review of the Nutrition Progress Notes did not indicate that labwork was obtained and/or referenced per the previous RD recommendation on 4/23/24.<br><br>Review of the Nursing Progress Notes dated 4/24/24, indicated:<br><br>-Following recent weight loss, NP (Nurse Practitioner) [was] called with the Dietician's recommendations.<br><br>-New orders for Ensure twice daily to prevent further weight loss.<br><br>-Family notified.<br><br>-Plan of care ongoing.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Medical Record failed to indicate documentation of the weight of 133 lbs. referenced in the Nutrition Note on 4/23/24 and that labwork was obtained per the RD recommendations when the Resident's weight loss was verified.<br><br>Further review of Resident #3's Medical Record failed to indicate:<br><br>-that a re-weight was obtained for verification the day after the 4/9/24 weight, which indicated a significant weight loss of 16.4 lbs. in one month (10.49% loss).<br><br>-that the NP or the Medical Doctor (MD) was notified.<br><br>-that the NP or Medical Doctor evaluated the Resident for nutritional risk and/or impaired nutrition when the significant weight loss was identified after the re-weight was obtained on 4/23/24.<br><br>During an interview on 6/4/24 at 2:43 P.M. the RD said that she prints a weight report on her weekly visits and reviews the report to see if there are any changes or discrepancies. The RD said she was not notified by Nursing of Resident #3's weight loss on 4/9/24 but discovered the weight change when reviewing the weekly weight report. The RD said that she notified Nursing of Resident #3's weight loss and recommended that labs be obtained. The RD further said that she was unable to confirm if more frequent weights were obtained between 4/9/24 and 5/14/24 as none were documented in the Weights and Vitals Report. The RD said that her recommendation for labs on 4/23/24 was verbally communicated to the nursing staff for follow-up with the MD or NP. The RD said that she would want a normal panel of labs such as a TSH (Thyroid Stimulating Hormone - measurement of thyroid levels in the blood), Albumin Levels (measurement of liver protein in the blood. Low levels would indicate kidney or liver issues) and H and H (Hematocrit and Hemoglobin - measurements of protein and red blood cells. Low levels could indicate Anemia [lower than normal amount of red blood cells]). The RD said Resident #3 did not have any labwork obtained since the RD's 4/23/24 recommendation, and that she did not recommend additional labs in her 6/2/24 note. The RD said that she did not have any direct communication regarding Resident #3's weight loss/nutritional status with the NP or MD, and that she relied on Nursing to communicate any dietary recommendations to the MD or NP.<br><br>During an interview on 6/5/24 at 9:16 A.M., the NP said that when a Resident experiences a weight loss, the facility would typically re-weigh the Resident to verify the weight loss, do weekly weights for 4 weeks to see if the Resident's weight was stable, would add nutritional supplements, review the Resident's intake and appetite, perform a KUB (Kidney Ureter Bladder scan) to determine if there was constipation, obtain updated labwork, and do a medication review for concerns for sedation (the calming of mental excitement or abatement of physiological function, especially by the administration of a drug). The NP said that typically the Director of Nursing (DON) or Nursing staff communicate to her any weight loss. The NP said she was available Monday through Friday 8:00 A.M. to 5:00 P.M. and that her office has on-call staff that are available afterhours. The NP said that she had not communicated with the RD directly. The surveyor and the NP reviewed Resident #3's record and the NP said that labwork for Resident #3 had not been obtained since 1/3/24. The NP further said Resident #3's weight loss from 3/12/24 to 4/9/24 was concerning and that she was not notified of the Resident's weight loss but was notified of the recommendation to add the Ensure supplement twice daily on 4/24/24.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/5/24 at 9:45 A.M., the Unit Manager (UM) said the CNA's (Certified Nurses Aides) were to obtain weights as ordered by the MD and document them in the medical record. The UM said that if a resident had an identified weight loss, the Nursing staff would contact the RD, the MD or NP, and the resident's family to discuss the weight loss. The UM said she would expect to be notified of the weight loss to begin an assessment which would include ordering labwork, review of the Resident's ability to eat, bowel regimen, review of any issues with pain, mouth or dental needs, and medications. The UM said that she had not participated in any multidisciplinary meetings relative to residents at risk or experiencing weight loss.<br><br>During an interview on 6/5/24 at 10:08 A.M, the DON said that the process regarding weight assessment for Resident #3 was not followed and should have been. |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>47901<br><br>Based on review and interview, the facility failed to provide evidence that the services of a Registered Nurse (RN) were used for at least eight consecutive hours a day, seven days a week.<br><br>Specifically, the facility failed to provide evidence that at least eight consecutive hours of RN coverage was provided on 5/4/24 and 5/11/24, when no Nurse staff waivers were in place, and there was no Director of Nursing (DON) serving as a charge nurse placing all residents at risk for not having their clinical needs met either directly by the RN or indirectly by the Licensed Practical Nurse (LPN) or Certified Nurses' Aides (CNA) that the RN was responsible for overseeing with provision of resident care.<br><br>Findings include:<br><br>Review of the Daily Nurse Staff Schedule provided by the facility for 5/1/24 through 5/31/24 indicated no evidence that the required eight consecutive hours of RN covered was provided on Saturday 5/4/24 and Saturday 5/11/24.<br><br>During an interview on 5/30/24 at 4:58 P.M., the facility Scheduler said the facility was not able to have RN coverage for 5/4/24 and 5/11/24.<br><br>During an interview on 5/31/24 at 2:21 P.M., the Director of Nursing (DON) said she was not employed in the facility at the time and could not have covered Saturday 5/4/24 or Saturday 5/11/24 as a charge nurse.<br><br>During an interview on 5/30/24 at 5:09 P.M., the facility Administrator said the facility had no RN coverage for 5/4/24 and 5/11/24. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>47901<br><br>Based on observation, record review, policy review, and interview, the facility failed to ensure that the medication error rate was not five percent (5%) or greater when Nurse #1 made four errors out of 25 opportunities, resulting in a medication error rate of 16% for two Residents (#9 and #4).<br><br>Specifically, Nurse #1 failed to:<br><br>1. For Resident #9,<br><br>a. administer the correct dose of Cholecalciferol (Vitamin D3 - drug class vitamin used to treat Vitamin D deficiency) medication.<br><br>b. observe and encourage the Resident to completely take all of his/her MiraLAX (used to treat constipation) medication.<br><br>2. For Resident #4,<br><br>a. accurately check the Resident's blood pressure and heart rate as ordered prior to administering Metoprolol (used to lower blood pressure) medication.<br><br>b. offer and encourage the Resident to rinse his/her mouth after administering orally inhaled medication to prevent fungal infections.<br><br>c. administer the correct dose of Vitamin B12 medication per Physician's Orders.<br><br>Findings include:<br><br>Review of the facility policy titled Administering medications, revised 2012, indicated the following:<br><br>-Vital signs must be checked/verified for each resident prior to administering medications, if necessary.<br><br>-The individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medication.<br><br>-Medication must be administered in accordance with the orders, including any required time frame.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1. Resident #9 was admitted to the facility in February 2024, with diagnoses including CVA (cerebrovascular accident or stroke: [damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area]), Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations), Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and Diabetes (disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in elevated blood glucose [sugar] levels in the blood).<br><br>On 5/31/24 at 7:36 A.M., during a medication pass procedure, the surveyor observed Nurse #1 prepare and administer the following medications to Resident #9:<br><br>-Cholecalciferol (Vitamin D3) 25 micrograms (mcg) - 1 tablet (not two tablets as ordered)<br><br>-Buspirone (used to treat general anxiety disorder) 15 milligram (mg) - 1 tablet<br><br>-Metformin (used to control blood sugar) 500 mg - 1 tablet<br><br>-MiraLAX 17 grams (g) (used to soften stool) - 1 scoop<br><br>-Atorvastatin (used to control cholesterol in the blood) 20 mg - 1 tablet<br><br>-Escitalopram (used to control Depression) 10 mg - 1 tablet<br><br>The surveyor observed Nurse #1 pour the MiraLAX powder 17 grams into a cup with water, entered Resident #9's room and handed Resident #9 the previously prepared medications in a cup. The surveyor observed that the Resident swallowed the medications with a sip of the water that contained the MiraLAX powder which had settled at the bottom of the water in the cup. The Resident was observed to place the remaining water with the MiraLAX powder on the table. The surveyor observed that the Nurse exited the room without ensuring that the Resident drank all the MiraLAX medication.<br><br>Review of Resident #9's May 2024 Medication Administration Records (MAR) indicated:<br><br>-8:00 A.M., Vitamin D3 25 mcg - 2 tablets<br><br>-8:00 A.M., Buspirone 15 mg - 1 tablet<br><br>-8:00 A.M., Metformin 500 mg - 1 tablet<br><br>-8:00 A.M., MiraLAX 17 gm - 1 scoop, mix in 6 ounces fluid of choice<br><br>-8:00 A.M., Atorvastatin 20 mg - 1 tablet<br><br>-8:00 A.M., Escitalopram 10 mg - 1 tablet<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225615 | A. Building<br>B. Wing | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverbend of South Natick | 34 South Lincoln Street<br>S 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) |
|---|---|
| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Resident #4 was admitted to the facility in February 2024, with diagnoses including Hypertension (high blood pressure), Heart Failure (HF: when the heart is unable to pump blood as it should resulting in fluid buildup in the feet, arms, lungs and other organs), Coronary Artery Disease (CAD: heart condition that occurs when fatty deposits of plaque build up in the coronary arteries causing them to narrow and restrict blood flow to the heart) and Depression.<br><br>On 5/31/24 at 7:50 A.M., the surveyor observed Nurse #1 prepare and administer the following medications to Resident #4:<br><br>-Vitamin B12 (used to strengthen the immune system) 100 mcg, 1 tablet<br><br>-GERI KOT (used to soften stool) 8.6 mg, 2 tablets<br><br>-Magnesium Oxide 400 mg, 1 tablet<br><br>-Fluticasone furoate/Vilanterol Ellipta Inhalation powder (Breo Ellipta)100 mcg/25 mcg<br><br>-Buspirone (used to treat depression) 15 mg, 1 tablet<br><br>-Sertraline (used to treat depression)100 mg, 1 tablet<br><br>-Sertraline 25 mg, 3 tablets<br><br>-Famotidine (used to treat acid reflux) 20 mg, 1 tablet<br><br>-Metoprolol (used to control blood pressure) 50 mg, 1 tablet<br><br>-Creon 6 (helps to digest food) 6000 international unit (IU), 1 capsule<br><br>-Refresh eye drops<br><br>a. The surveyor observed Nurse #1 enter Resident #4's room with a blood pressure cuff and the previously prepared medications in a medication cup. Nurse #1 wrapped the blood pressure cuff on Resident #4's right lower arm, (closest to the wrist), inflated the cuff, then deflated the cuff and removed the cuff from the Resident's arm. The surveyor did not observe Nurse #1 use a stethoscope while obtaining the blood pressure measurement.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225615 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/05/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverbend of South Natick | 34 South Lincoln Street S 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) |
|---|---|
| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b. The surveyor further observed Nurse #1 remove a tissue from her pocket, instilled one drop of the Refresh eye drop into each of Resident #4's eyes and then wiped both of the Resident's eyes with the same tissue. Nurse #1 then gave Resident #4 the Breo Ellipta inhaler and the Resident inhaled one puff of the medication orally. The surveyor observed Nurse #1 exit the Resident's room and placed the Breo Ellipta inhaler medication, and the Refresh eye drop together with the blood pressure cuff back into the medication cart. The surveyor observed that Nurse #1 entered Resident #4's blood pressure reading into the electronic medical record (EMR) as 127/68 mmHg (millimeters of mercury). When the surveyor asked Nurse #1 how the blood pressure reading was obtained, Nurse #1 said she forgot her stethoscope. Nurse #1 then said she needed to obtain Resident #4's heart rate. The surveyor observed Nurse #1 re-enter Resident #4's room and held his/her hand, then said she needed to look for a watch. Nurse #1 was observed walking around the unit asking the other staff members if anyone had a watch. At 8:27 A.M., Certified Nurses Aide (CNA) #1 brought Nurse #1 a wall clock. Nurse #1 took the wall clock from CNA #1, entered Resident #4's room, held the Resident's hand while watching the clock for about 30 seconds, then exited the room and documented a heart rate of 76 bpm (beats per minute).<br><br>During an interview on 5/31/24 at 8:41 A.M., the Director of Nursing (DON) said a blood pressure measurement cannot be obtained with just a blood pressure cuff and without a stethoscope. The DON said that the blood pressure reading of 127/68 mmHg for Resident #4 documented by Nurse #1 was an error.<br><br>On 5/31/24 at 8:45 A.M., Unit Manager (UM) #1 came to the unit and assumed responsibility of the medication cart from Nurse #1 and UM #1 continued with the medication administration procedure to the unit residents.<br><br>Review of Resident #4's May 2024 Physician Orders indicated:<br><br>-Artificial Tears one drop into each eye ordered 2/15/24<br><br>-Breo Ellipta 100-25 mcg one puff inhale into lungs once daily, rinse mouth after each use ordered 2/20/24<br><br>-Buspirone 15 mg tablet, ordered 2/20/24<br><br>-Creon 6,000-unit capsule, ordered 2/20/24<br><br>-Famotidine 29 mg tablet, ordered 4/24/24<br><br>-Furosemide 40 mg tablet, ordered 2/20/24<br><br>-Magnesium Oxide 400 mg tablet, ordered 2/15/24<br><br>-Metoprolol 50 mg tablet, ordered 4/24/24<br><br>-Senna 8.6 mg (2) tablets, ordered 2/15/24<br><br>-Sertraline 100 mg tablet, ordered 2/20/24<br><br>-Sertraline 25 mg (3) tablets, ordered 2/20/24<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225615 | A. Building<br>B. Wing | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverbend of South Natick | 34 South Lincoln Street<br>S 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.

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|---|---|
| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Vitamin B12 500 mcg tablet, ordered 2/15/24<br><br>Review of Resident #4's May 2024 MAR indicated:<br><br>-8:00 A.M., Artificial Tears 1 drop into each eye<br><br>-8:00 A.M., Breo Ellipta 100-25 mcg inhaler, one puff into lungs once daily, rinse mouth after each use.<br><br>-8:00 A.M., Buspirone 15 mg, 1 tablet<br><br>-8:00 A.M, Creon 6,000 IU, 1 capsule<br><br>-8:00 A.M., Famotidine 20 mg, 1 tablet<br><br>-8:00 A.M., Furosemide 40 mg, 1 tablet<br><br>-8:00 A.M., Magnesium 400 mg, 1 tablet<br><br>-8:00 A.M., Metoprolol 50 mg, 1 tablet, hold for systolic blood pressure less than 100 and heart rate less than 50<br><br>-8:00 A.M., Senna 8.6 mg, 2 tablets<br><br>-8:00 A.M., Sertraline 100 mg, 1 tablet<br><br>-8:00 A.M., Sertraline 25 mg, 3 tablets<br><br>-8:00 A.M., Vitamin B12 500 mcg, 1 tablet<br><br>During an interview on 5/31/24 at 11:03 A.M., UM #1 said Resident #9 should have received two tablets of Vitamin D3 and Nurse #1 should have observed Resident #9 drink the entire cup of water mixed with the MiraLAX medication as ordered by the Physician. UM #1 also said that a blood pressure and heart rate measurements should have been obtained before Nurse #1 administered the Metoprolol medication to Resident #4. UM #1 further said that Nurse #1 should have given Vitamin B12 500 mcg, not 100 mcg to Resident #4 and that Resident #4 should have rinsed his/her mouth after using the oral inhaler.<br><br>During an interview on 5/31/24 at 11:47 A.M., the DON said she would report to the Medical Doctor (MD) about Resident #9 receiving 1 tablet of Vitamin D3 instead of 2 tablets and that it was an error. The DON further said she would report to the MD about Resident #4 receiving Metoprolol without a blood pressure and heart rate reading, that the Resident #4 received Vitamin B12 100 mcg instead of 500 mcg and the Resident did not rinse his/her mouth after orally inhaling Breo Ellipta Medication and that these are medication errors.<br><br>Please Refer to F760 and F880 |

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| | 225615 | A. Building<br>B. Wing | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Riverbend of South Natick | 34 South Lincoln Street<br>S Natick, MA 01760 |

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|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>47901<br><br>Based on observation, interview, record and policy review, the facility failed to ensure that the facility residents were free of significant medication errors for one Resident (#4) out of five residents observed, out of a total sample of 13 residents, during the medication pass process.<br><br>Specifically, for Resident #4, the facility staff failed to assess blood pressure and heart rate parameters as ordered prior to administering Metoprolol (used to treat high blood pressure) medication.<br><br>Findings include:<br><br>Review of the facility policy titled Administering medications, revised 2012, indicated the following:<br><br>-Vital signs must be checked/verified for each resident prior to administering medications, if necessary.<br><br>-The individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time, and right method of administration before giving the medication.<br><br>-Medication must be administered in accordance with the orders, including any required time frame.<br><br>Resident #4 was admitted to the facility in February 2024 with a diagnosis including Hypertension (high blood pressure), Heart Failure (HF: when the heart is unable to pump blood as it should resulting in fluid buildup in the feet, arms, lungs and other organs), and Coronary Artery Disease (CAD: heart condition that occurs when fatty deposits of plaque build up in the coronary arteries causing them to narrow and restrict blood flow to the heart).<br><br>Review of Resident #4's May 2024 Physician's orders indicated:<br><br>-Artificial Tears: one drop into each eye, ordered 2/15/24<br><br>-Breo Ellipta: 100-25 mcg one puff inhale into lungs once daily, rinse mouth after each use, ordered 2/20/24<br><br>-Buspirone: 15 mg tablet, ordered 2/20/24<br><br>-Creon: 6,000-unit capsule, ordered 2/20/24<br><br>-Famotidine: 29 mg tablet, ordered 4/24/24<br><br>-Furosemide: 40 mg tablet, ordered 2/20/24<br><br>-Magnesium Oxide: 400 mg tablet, ordered 2/15/24<br><br>(continued on next page) |

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|---|---|---|---|
| | 225615 | A. Building<br>B. Wing | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverbend of South Natick | 34 South Lincoln Street<br>S Natick, MA 01760 |

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|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Metoprolol: 50 mg tablet, ordered 4/24/24<br><br>-Senna: 8.6 mg (2) tablets, ordered 2/15/24<br><br>-Sertraline: 100 mg tablet, ordered 2/20/24<br><br>-Sertraline: 25 mg (3) tablets, ordered 2/20/24<br><br>-Vitamin B12: 500 mcg tablet, ordered 2/15/24<br><br>Review of Resident #4's May 2024 Medication Administration Record indicated:<br><br>-8:00 A.M., Artificial Tears 1 drop into each eye<br><br>-8:00 A.M., Breo Ellipta 100-25 mcg inhaler, one puff into lungs once daily, rinse mouth after each use.<br><br>-8:00 A.M., Buspirone 15 mg, 1 tablet<br><br>-8:00 A.M., Creon 6,000 IU, 1 capsule<br><br>-8:00 A.M., Famotidine 20 mg, 1 tablet<br><br>-8:00 A.M., Furosemide 40 mg, 1 tablet<br><br>-8:00 A.M., Magnesium 400 mg, 1 tablet<br><br>-8:00 A.M., Metoprolol 50 mg, 1 tablet, hold for systolic blood pressure less than 100 and heart rate less than 50<br><br>-8:00 A.M., Senna 8.6 mg, 2 tablets<br><br>-8:00 A.M., Sertraline 100 mg, 1 tablet<br><br>-8:00 A.M., Sertraline 25 mg, 3 tablets<br><br>-8:00 A.M., Vitamin B12 500 mcg, 1 tablet<br><br>On 5/31/24 at 7:50 A.M., the surveyor observed Nurse #1 prepare and administer the following medications to Resident #4:<br><br>-Vitamin B12 (used to strengthen immune system)100 mcg, 1 tablet<br><br>-GERI KOT (used to soften stool) 8.6 mg, 2 tablets<br><br>-Magnesium Oxide 400 mg, 1 tablet<br><br>-Fluticasone furoate/Vilanterol Ellipta Inhalation powder (Breo Ellipta) 100 mcg/25 mcg<br><br>(continued on next page) |

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| | 225615 | A. Building<br>B. Wing | 06/05/2024 |

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|---|---|
| Riverbend of South Natick | 34 South Lincoln Street<br>S 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) |
|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Buspirone (used to treat depression) 15 mg, 1 tablet<br><br>-Sertraline (used to treat depression )100 mg, 1 tablet<br><br>-Sertraline 25 mg, 3 tablets<br><br>-Famotidine (used to treat acid reflux) 20 mg, 1 tablet<br><br>-Metoprolol (used to control blood pressure) 50 mg, 1 tablet<br><br>-Creon 6 (helps to digest food) 6000 international unit (IU), 1 capsule<br><br>-Refresh eye drops<br><br>The surveyor did not observe Nurse #1 obtaining an appropriate blood pressure measurement or heart rate parameters before administering the Metoprolol medication to Resident #4.<br><br>During an interview on 5/31/24 at 11:03 A.M., Unit Manager (UM) #1 said Nurse #1 should have obtained Resident #4's blood pressure and heart rate before she administered the Metoprolol medication to the Resident.<br><br>During an interview on 5/31/24 at 11:47 a.m., the Director of Nursing (DON) said she would report to the Medical Doctor (MD) about Resident #4 receiving the Metoprolol medication without the blood pressure and heart rate measurements. The DON further said that Nurse #1 had been sent home. |

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| | 225615 | A. Building<br>B. Wing | 06/05/2024 |

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| Riverbend of South Natick | 34 South Lincoln Street<br>S Natick, MA 01760 |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>47901<br><br>Based on observation, interview and policy review, the facility failed to ensure that infection control standards of practice were followed by Nurse #1 to prevent the spread of infections during the medication administration process for two Residents (#9 and #4) out of five residents observed, out of a total sample of 13 residents.<br><br>Specifically, the facility failed to ensure that Nurse #1 performed appropriate hand hygiene before and after the medication administration process for Resident #9 and before and after the administration of eye drops for Resident #4.<br><br>Findings include:<br><br>Review of the Centers for Disease Control (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised April 12, 2024 (reference CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings \| Infection Control \| CDC) indicated the following:<br><br>-Use Standard Precautions to care for all patients in all settings.<br><br>-Standard Precautions include: hand hygiene<br><br>-Standard Precautions are the basic practices that apply to all patient care, regardless of the patient's suspected or confirmed infectious state, and apply to all settings where care is delivered.<br><br>-These practices protect healthcare personnel and prevent healthcare personnel or the environment from transmitting infections to other patients.<br><br>Review of the facility policy titled Employees' Responsibilities for Infection Prevent and Control, not dated, indicated All employees of this facility are responsible for practicing good infection prevention and control measures and for carrying out the policies and procedures instituted by the facility, such as hand hygiene and personal hygiene.<br><br>Review of the facility policy titled Be Involved in [Resident] Care, undated, indicated:<br><br>-Be aware that germs can spread on the hands of healthcare workers.<br><br>-Practicing good hand washing can reduce [Resident] risk of infection.<br><br>-Know that all healthcare workers are expected to use hand hygiene before they touch [a Resident], [Resident's] surroundings, and afterwards.<br><br>Review of the facility policy titled, Administering Medications, revised December 2012 indicated:<br><br>-Staff shall follow established facility infection control procedures for the administration of medications including eye drops .<br><br>(continued on next page) |

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| | 225615 | A. Building<br>B. Wing | 06/05/2024 |

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| Riverbend of South Natick | 34 South Lincoln Street<br>S Natick, MA 01760 |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #9 was admitted to the facility in February 2024, with diagnoses including CVA (cerebrovascular accident or stroke: [damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area]), Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations), Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and Diabetes (disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in elevated blood glucose [sugar] levels in the blood).<br><br>On 5/31/24 at 7:36 A.M., the surveyor observed Nurse #1 prepare and administer medications to Resident #9. The surveyor did not observe Nurse #1 performing hand hygiene before or after the medication administration process.<br><br>Resident #4 was admitted to the facility in February 2024, with diagnoses including Hypertension (high blood pressure), Heart Failure (HF: when the heart is unable to pump blood as it should resulting in fluid buildup in the feet, arms, lungs and other organs), Coronary Artery Disease (CAD: heart condition that occurs when fatty deposits of plaque build up in the coronary arteries causing them to narrow and restrict blood flow to the heart) and Depression.<br><br>On 5/31/24 at 7:50 A.M., the surveyor observed Nurse #1 prepare and administer medications including eye drops to Resident #4. The surveyor observed that Nurse #1 did not perform hand hygiene before and after the eye drop administration. The surveyor further observed that Nurse #1 removed a tissue from her pocket, instill one drop of the eye drop medication to each eye of the Resident, then wiped both of the Resident's eyes with the same tissue, and discarded the tissue.<br><br>During an interview on 5/31/24 at 8:40 A.M., Nurse #1 said she had been very busy and forgot to perform hand hygiene during the medication administration process.<br><br>During an interview on 5/31/24 at 12:44 P.M., the Director of Nursing (DON) said Nurse #1 had been sent home. The DON said Nurse #1 should have washed and/or sanitized her hands before and after administering the eye drop medication for Resident #4. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 225615 | A. Building<br>B. Wing | 06/05/2024 |

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| Riverbend of South Natick | 34 South Lincoln Street<br>S Natick, MA 01760 |

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|---|---|
| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206<br><br>Based on interview, record review, and policy review, the facility failed to offer the Pneumococcal Vaccination as recommended for three Residents (#5, 10, and #18) out of five applicable Residents, in a total sample of 13 Residents, putting the residents at risk for developing facility acquired Pneumonia.<br><br>Specifically, the facility failed to ensure that:<br><br>1. Resident #5's immunization consent form was complete and accurate, and the Resident was offered any eligible Pneumococcal Vaccination after admission to the facility.<br><br>2. Resident #10 was offered, received or declined any eligible Pneumococcal Vaccination after admission to the facility.<br><br>3. Resident #18 was offered, received, or declined any Pneumococcal Vaccination after admission to the facility.<br><br>Findings include:<br><br>Review of the CDC (Centers for Disease Control) website: Pneumococcal Vaccine Timing for Adults greater than or equal to [AGE] years (cdc.gov), dated 3/15/23 indicated but was not limited to the following:<br><br>-For adults 65 and over who have not had any prior Pneumococcal Vaccines, then the patient and provider may choose Pneumococcal Conjugate Vaccine (PCV) 20 or PCV15 followed by Pneumococcal Polysaccharide Vaccine (PPSV) 23 one year later.<br><br>-For adults 65 and over who has had Pneumococcal Conjugate Vaccine 13 (PCV13) and Pneumococcal Polysaccharide Vaccine 23 (PPSV23), and it has been 5 years or greater since the last Pneumococcal Vaccination, then the patient and the vaccine provider may choose to administer the 20-Valent Pneumococcal Conjugate Vaccine (PCV20).<br><br>Review of the facility policy titled Pneumococcal Vaccination of Residents last revised 9/2022, indicated the following:<br><br>-Each Resident or their responsible party will be asked on admission if they have previously received either the Prevnar 13/15 or the Polysaccharide 23 or the Prevnar 20 Pneumococcal vaccine.<br><br>-The records that accompany the Resident will be used to determine immunization status.<br><br>-The facility will contact the Resident's PCP to obtain all previous vaccination records on file.<br><br>-If there is no evidence of vaccination, the Resident will be offered the appropriate vaccine at that time.<br><br>(continued on next page) |

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|---|---|---|---|
| | 225615 | A. Building<br>B. Wing | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverbend of South Natick | 34 South Lincoln Street<br>S 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) |
|---|---|
| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The Resident and/or their responsible party will be educated on the risks and benefits of the pneumococcal vaccine.<br><br>-Pneumococcal candidates for vaccination:<br><br>>[AGE] years or older<br><br>>Serious long term health problems<br><br>>Resistance to Infection<br><br>-Procedure:<br><br>>Obtain consent<br><br>>Educate Resident and/or responsible party<br><br>>Document vaccination in IMAR (Medication Administration Record)<br><br>1. Resident #5 was admitted to the facility in September 2023, and was over the age of 65.<br><br>Review of the MIIS (Massachusetts Immunization Information System) record provided by the facility indicated that Resident #5 had his/her last Pneumococcal Vaccination (PCV13) in July 2018.<br><br>Review of the Consent for Immunization Form, dated 10/10/23, indicated the Pneumococcal (PPV23) Vaccine was already received this season, but the form failed to indicate the date the Resident received the PPV23 Vaccine.<br><br>Review of the Consent for Immunization Form, dated 5/31/24, indicated a verbal consent was obtained from the Responsible Party consenting to the PCV13 Pneumococcal Vaccination.<br><br>Review of the CDC Pneumovax Advisor tool indicated the following recommendation for Resident #5 based on his/her history of Pneumococcal vaccination:<br><br>-Based on shared clinical decision-making, decide whether to administer one dose of PCV20 at least 5 years after the last pneumococcal vaccine dose.<br><br>Review of the Medical Record failed to indicate Resident #5 had a medical contraindication to or had been offered, received, or declined the appropriate Pneumococcal Vaccination on admission to the facility when the Resident was eligible for an updated dose prior to 5/31/24.<br><br>2. Resident #10 was admitted to the facility in January 2023, and was over the age of 65.<br><br>Review of the MIIS record provided by the facility indicated Resident #10 had his/her last Pneumococcal Vaccination (PCV13) in June 2015.<br><br>Review of the Consent for Immunization Form, dated 5/31/24, indicated a verbal consent was obtained from the Responsible Party consenting to the PCV13 Pneumococcal Vaccination.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225615 | A. Building<br>B. Wing | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverbend of South Natick | 34 South Lincoln Street<br>S 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.

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|---|---|
| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the CDC Pneumovax Advisor tool indicated the following recommendation for Resident #10 based on his/her history of Pneumococcal vaccination:<br><br>-Give one dose of PCV20 at least 1 year after PCV13 or give one dose of PPSV23 at least 8 weeks after PCV13.<br><br>Review of the Medical Record failed to indicate Resident #10 had a medical contraindication to or had been offered, received, or declined a Pneumococcal Vaccination on admission to the facility when the Resident was eligible for an updated dose prior to 5/31/24.<br><br>3. Resident #18 was admitted to the facility in July 2023 and was over the age of 65.<br><br>Review of the MIIS record provided by the facility indicated that Resident #18 had his/her last Pneumococcal Vaccination (PPSV23) in December 2008.<br><br>Review of the Consent for Immunization Form, dated 6/3/24, indicated a verbal consent was obtained from the Responsible Party consenting to PCV13 Pneumococcal Vaccination.<br><br>Review of the CDC Pneumovax Advisor tool indicated the following recommendation for Resident #18 based on his/her history of Pneumococcal Vaccination:<br><br>-Give one dose of PCV15 or PCV20 at least 1 year after the last dose of PPSV23.<br><br>Review of the Medical Record failed to indicate Resident #18 had a medical contraindication to or had been offered, received, or declined a Pneumococcal Vaccination on admission to the facility when the Resident was eligible for an updated dose prior to 6/3/24.<br><br>During an interview on 6/4/24 at 1:36 P.M., the Director of Nursing (DON), who also served as the facility Infection Preventionist (IP), said that the facility should have offered Pneumococcal Vaccinations to Residents #5 and #10 prior to 5/31/24, and to Resident #18 prior to 6/3/24 and had not, as required. |