STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225615	A. Building B. Wing	08/07/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that appropriate infection prevention and control measures were followed for one Resident (#18) out of a total sample of 13 residents. ^ Specifically, for Resident #18, the facility failed to implement and adhere to Contact Precautions to reduce the potential spread of infection when the Resident was diagnosed with Scabies (skin infection/rash caused by a parasitic mite, that can be spread by skin-to-skin contact) putting staff, other residents, and visitors at risk for the spread of infection.^ ^ Findings include:^ Review of the facility policy titled Transmission Based Precautions, undated, indicated but was not limited to the following:^ -Use Personal Protective Equipment (PPE) appropriately, including gloves and gown.Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens.^ ^ Review of the facility policy titled Infections-Clinical Protocol, revised July 2016, indicated but was not limited to the following:^ -Skin/Soft Tissue Infection (SSTI): .Consider scabies in any resident with unexplained generalized rash. It may be helpful to consult a dermatologist and/or obtain scrapings for evaluation of mites, eggs, or mite feces.^^ ^ Review of the U.S. Centers for Disease Control and Prevention (CDC) Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions, updated 2/7/25, indicated that the Scabies infection should have Contact plus Standard precautions implemented until 24 hours after initiation of effective therapy.^ ^ Resident #18 was admitted to the facility in September 2023, with diagnoses including hemiplegia (weakness or paralysis of one side of the body) and hemiparesis (partial paralysis of one side of the body) following cerebral infarction (stroke), chronic kidney disease, and Scabies.^ ^ Review of Resident #18's current Care Plan dated 7/16/25, indicated:^ -Resident had actual skin impairment due to Scabies rash.^ ^ Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #18:^ -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) exam score of 15 out of a possible 15.^^ -had ointments or medications applied to areas of the body other than to his/her feet.^ ^ Review of Resident #18's Report of Consultation dated 8/4/25, indicated:^ -consulted with a dermatologist on 8/4/25 at 3:40 P.M. due to rash to back, arms and chest with ongoing itching and rash, with last treatment performed on 7/31/25.^ -was diagnosed with Scabies on 8/4/25, with positive findings under the microscope.^ -was recommended for treatment, including Ivermectin (anti-parasite medication).^ During an interview on 8/5/25 at 8:13 A.M., Resident #18 said he/she attended a dermatology appointment on 8/4/25 and had been diagnosed with a Scabies infection.^ The surveyor observed that there was no signage present regarding transmission-based precautions on the Resident's bedroom door or outside of the Resident's bedroom door.^ Review of Resident #18's clinical record indicated that the Resident was not placed on Contact Precautions until 8/5/25.^^^ ^ During an interview on 8/5/25 at 8:32 A.M. with the Assistant Director of Nurses (ADON) and the Director of Nursing (DON), the ADON said that Resident #18 attended a dermatology appointment on 8/4/25 due to recent treatment for a Scabies infection. The DON said that the Resident should have been placed on Contact Precautions upon return to the facility following the dermatology appointment on 8/4/25 due to a diagnosis of Scabies but had not been placed on Contact Precautions at that time.^ On 8/5/25 at 8:58 A.M., the surveyor (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed the ADON hang a STOP sign on Resident #18's room door. During an interview at the time, the ADON said she had placed the Contact Precautions sign and the bin containing PPE outside the Resident's door that morning (after the surveyor's observation at 8:13 A.M.). The surveyor observed the Contact Precautions sign was published by the CDC and indicated that everyone must clean their hands, including before entering and when leaving the room. The Contact Precautions sign also indicated that Providers and staff must also: 1) Put on gloves before room entry. Discard gloves before room exit. 2) Put on gown before room entry. Discard gown before room exit.3) Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. The ADON said that there was a potential risk for the spread of infection when transmission-based precautions were not implemented and should have been.ˆ On 8/5/25 at 8:40 A.M., the surveyor observed Nurse #2 walk into Resident #18's room to deliver the Resident's breakfast meal and did not don PPE prior to entering the Resident's room.ˆ Nurse #2 was observed delivering the Resident's breakfast meal and then exiting the Resident's room.ˆDuring an interview at the time, Nurse #2 said Resident #18 attended a dermatology appointment on 8/4/25 and had a rash, but Nurse #2 was not aware of what caused the rash.ˆNurse #2 said the Contact Precautions sign outside of the Resident's room indicated that gloves and a gown must be worn when caring for the Resident.ˆNurse #2 said that she did not need to put on gloves or a gown when delivering the Resident his/her breakfast meal because she did not have to touch the Resident.ˆ On 8/5/25 at 2:24 P.M., the surveyor observed Laundry Personnel #1 walk into Resident #18's room and did not don PPE prior to entering the Resident's room. Laundry Personnel #1 was observed opening the Resident's closet, prior to exiting the Resident's room.ˆDuring an interview at the time, Laundry Personnel #1 said she put Resident #18's clean clothes into his/her closet. Referring to the Contact Precautions sign outside of the Resident's room, Laundry Personnel #1 said she should have put on PPE prior to entering the Resident's room. At that time, Laundry Personnel #1 was observed removing a gown from the PPE bin and entering the Resident's bedroom without donning the gown or any PPE and demonstrated to the surveyor how she would discard a PPE gown in the Resident's trash can.ˆLaundry Personnel #1 said she did not don PPE when she put clothes into the Resident's closet because she did not feel it was bad not to wear the PPE.ˆLaundry Personnel #1 said the purpose of the PPE was to protect herself and to prevent the spread of infection to other residents.ˆ On 8/5/25 at 3:15 P.M., Certified Nurse Aide (CNA) #1 was observed to walk into Resident #18's room and did not don PPE prior to entering the Resident's bedroom. CNA #1 was observed to pick up a cup in the Resident's bedroom and hand it to the Resident and then place her hand on the Resident's shoulder prior to exiting the Resident's bedroom. During an interview at the time, CNA #1 referring to the Contact Precautions sign outside Resident #18's door, said that she should wear a mask and gown prior to entering the Resident's room, however it was not necessary to wear gloves unless she was going to touch the Resident.ˆCNA #1 said there was a potential risk for contracting the scabies infection and for spreading the infection to another resident when she did not wear the required PPE.ˆ During an interview on 8/5/25 at 4:23 P.M., the DON said Resident #18 was placed on Contact Precautions on 8/5/25 and the expectation was that staff don the appropriate PPE before entering Resident #18's room and that the PPE was removed before exiting the Resident's room. The DON said that there was a potential risk for the spread of infection when staff did not use the required PPE.ˆˆˆ During an interview on 8/6/25 at 3:18 P.M., the DON said the facility follows CDC guidance for all infection control protocols, including standard and transmission-based precautions.ˆ

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observations, and interviews, the facility failed to post the required nurse staffing data daily in a prominent place, readily accessible to residents, staff and visitors on three out of three days observed.ˆ Specifically, the facility failed to:ˆ -Post nurse staffing data on 8/5/25, 8/6/25, and 8/7/25 in a prominent place in the facility as required. -Post nurse staffing data including the facility name, the current date, the total number and the actual hours worked by Registered Nurses, Licensed Practical Nurses, Certified Nurse Aides, in addition to the resident census. Findings include:ˆ During the facility survey, the surveyor failed to observe any evidence of the nurse staffing data that included the facility name, the current date, the resident census, the total number and the actual hours worked by Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nurse Aides (CNAs), posted in the facility on 8/5/25, 8/6/25 and 8/7/25. During an interview on 8/7/25 at 10:26 A.M., the Assistant Director of Nurses (ADON) said the nurse staffing data was typically posted in the front entrance lobby, however the nurse staffing data was not posted at that time. During an interview on 8/7/25 at 10:29 A.M., the Director of Nursing (DON) said the nurse staffing data was typically posted in the front entrance lobby, however the nurse staffing data was not posted at that time. During an interview on 8/7/25 at approximately 10:40 A.M., the Administrator said the nurse staffing data should be posted in the front entrance lobby, however the nurse staffing data was not posted at that time. During an interview on 8/7/25 at 12:58 P.M., the DON said the Nurse who was responsible for posting the nurse staffing data had not posted the nurse staffing data on 8/5/25, 8/6/25, and 8/7/25, because she was unable to locate the protective sleeve in which the nurse staffing data sheet was placed in and typically posted.