

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Care One at New Bedford		STREET ADDRESS, CITY, STATE, ZIP CODE 221 Fitzgerald Drive New Bedford, MA 02745	
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 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695</p> <p>Based on record review and interview, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for five Residents (#127, #11, #133, #13, and #141), out of 25 sampled residents. Specifically, the facility failed:</p> <ol style="list-style-type: none"> 1. For Resident #127, to ensure a formal assessment instrument/tool was accurately coded on the MDS; 2. For Resident #11, to ensure an antianxiety medication was accurately coded on the MDS; 3. For Resident #133, to ensure a diuretic medication was accurately coded on the MDS; 4. For Resident #13, to ensure an antipsychotic medication was accurately coded on the MDS; and 5. For Resident #141, to ensure the accurate discharge location was accurately coded on the MDS. <p>Findings include:</p> <p>Review of the facility's policy titled Certifying Accuracy of the Resident Assessment, last revised 2019, indicated but was not limited to:</p> <ul style="list-style-type: none"> - Policy Statement: Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. - Policy Interpretation and Implementation <ol style="list-style-type: none"> 2. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. 3. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. <p>1. Resident #127 was admitted to the facility in April 2024 with diagnoses including diabetes mellitus and traumatic arthropathy (joint capsule injury).</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #127's Admission Resident Evaluation, dated 4/26/24, indicated a [NAME] Assessment (a tool used to assess risk for developing a pressure ulcer) had been completed.</p> <p>Review of the MDS assessment, dated 5/2/24, Section M, failed to indicate Resident #11 had a formal assessment instrument/tool (e.g., Braden, [NAME], or other) completed.</p> <p>During an interview on 5/21/24 at 4:04 P.M., MDS Nurse #1 said Resident #127 had a [NAME] Assessment completed as part of his/her admission assessment. MDS Nurse #1 said Resident #127's MDS assessment should have indicated he/she had a formal assessment instrument/tool (e.g., Braden, [NAME], or other) completed.</p> <p>2. Resident #11 was admitted to the facility in April 2024 with diagnoses including anxiety disorder and depression disorder.</p> <p>Review of Resident #11's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - Clonazepam (antianxiety medication) 0.5 milligrams (mg) three times a day (4/28/24) <p>Review of Resident #11's April and May Medication Administration Record (MAR) indicated Clonazepam was administered as ordered.</p> <p>Review of the MDS assessment, dated 5/3/24, Section N, failed to indicate Resident #11 had received an antianxiety medication.</p> <p>During an interview on 5/21/24 at 2:17 P.M., MDS Nurse #1 said Resident #11's MDS assessment should have indicated that he/she had received an antianxiety medication.</p> <p>3. Resident #133 was admitted to the facility in April 2024 with diagnoses including chronic kidney disease and atrial fibrillation.</p> <p>Review of Resident #133's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - Furosemide (diuretic) 40 mg tablet one time a day (4/6/24) <p>Review of Resident #133's April and May Medication Administration Record (MAR) indicated the Furosemide was administered as ordered.</p> <p>Review of the MDS assessment, dated 5/3/24, Section N, failed to indicate Resident #133 had received a diuretic medication.</p> <p>During an interview on 5/21/24 at 2:02 P.M., MDS Nurse #2 said Resident #133's MDS assessment should have indicated that he/she had received diuretic medication.</p> <p>34145</p> <p>4. Resident #13 was admitted to the facility in July 2020 with a diagnosis of Parkinson's disease.</p> <p>Review of the medical record indicated the following Physician's Order:</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>-Nuplazid (antipsychotic) 34 mg, give one capsule one time a day for delusions related to Parkinson's disease (3/13/24)</p> <p>Review of March 2024 through May 2024 MARs indicated Nuplazid was administered as ordered by the physician.</p> <p>Review of section N-Medications of the MDS assessment, dated 4/20/24, indicated sections N0145 High Risk Drug Class and section N0450 Antipsychotic Medication Review did not reflect the Resident's use of antipsychotic medication.</p> <p>During an interview on 5/22/24 at 4:57 P.M., MDS Nurse #2 reviewed the 4/20/24 MDS and said was not aware Nuplazid was an antipsychotic medication and did not code it as such on the MDS.</p> <p>5. Resident #141 was admitted to the facility in February 2024 for short-term rehabilitation following an acute hospitalization . The Resident had diagnoses including bladder cancer.</p> <p>Review of the medical record indicated a care conference meeting was held on 2/28/24. Review of care conference notes indicated Resident #141 would be discharged home on 3/2/24, and a referral for services had been made.</p> <p>Review of a Nursing Note, dated 3/2/24, indicated Resident #141 was discharged home with medications and services.</p> <p>Review of the MDS assessment, dated 3/2/24, indicated Resident #141 was discharged to an acute hospital and not discharged home with services.</p> <p>During an interview on 5/22/24 at 2:02 P.M., MDS Nurse #2 reviewed the Resident's medical record and confirmed the 3/2/24 discharge MDS was inaccurate and needed to be modified to reflect that the Resident was discharged home with services.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>48695</p> <p>Based on record review, interview, and policy review, the facility failed to act promptly upon recommendations made by the Consultant Pharmacist during the monthly Medication Regimen Reviews (MRR) for one Resident (#133), out of a total sample of 25 residents. Specifically, for Resident #133 the Pharmacist failed to review and report irregularities related to the administration of a medication.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Consultant Pharmacist Reports, effective date February 2019, indicated but was not limited to:</p> <ul style="list-style-type: none"> -Comments and recommendations concerning medication therapy and apparent irregularities will be reported in a timely manner to ensure the resident's safe and appropriate medication utilization. <p>Resident #133 was admitted to the facility in April 2024 with diagnoses including chronic kidney disease and diabetes with diabetic neuropathy.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 4/13/24, indicated Resident #133 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15.</p> <p>Review of Resident #133's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> -Oxycodone (opioid used to treat pain) 5 milligrams (mg), give half a tab by mouth every 4 hours as needed for severe pain (5/6/24) -Oxycodone 5 mg, give one tablet by mouth every 4 hours as needed for severe pain (5/6/24) -Pain Score every shift 0=No Pain, 1,2,3,4= Mild Pain, 5,6,7= Moderate Pain, 8,9,10= Severe pain every shift for Pain (4/2/24) <p>Review of the May 2024 Medication Administration Record (MAR) for Resident #133 indicated Oxycodone had been administered 34 times.</p> <p>Review of Resident #133's MRR, dated 5/17/24, failed to indicate any irregularities with his/her Oxycodone parameters.</p> <p>During an interview on 5/21/24 at 2:17 P.M., MDS Nurse #1 said Resident #133 should have a pain scale parameter for each Oxycodone order.</p> <p>During an interview on 5/21/24 at 2:40 P.M., Nurse #3 said Resident #133 should have had a range on his/her Oxycodone order. Nurse #3 said both orders for Oxycodone should not say for severe pain.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/21/24 at 2:52 P.M., Resident #133 said he/she was offered a choice between taking Oxycodone 2.5 mg and Oxycodone 5 mg. Resident #133 said he/she would request the Oxycodone 5 mg dose.</p> <p>During an interview on 5/21/24 at 3:53 P.M., the Director of Nursing (DON) said for Resident #133 there should not have been two orders for Oxycodone for severe pain. The DON said the order for Oxycodone 2.5 mg should have been for moderate pain and for Oxycodone 5 mg should have been for severe pain. The DON said both orders should have included a pain range.</p> <p>During a telephonic interview on 5/22/24 at 1:20 P.M., Pharmacist #1 said he electronically reviews each residents' medication orders monthly. Pharmacist #1 said he reviews the Resident orders for things such as the use, correct diagnosis, appropriate dose, interactions, indications for use and accurate order entry. Pharmacist #1 said when there was a recommendation to distinguish between two different doses based on a pain scale he would provide the facility with a written recommendation. Pharmacist #1 said, with his review on 5/17/24, he did not make a reference to the dose of Oxycodone for Resident #133, but he should have.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>49428</p> <p>Based on interviews, record review, and policy review, the facility failed to ensure for three Residents (#11, #73, and #133), out of a total sample of 25 residents, that the Residents were free from significant medication errors. Specifically, the facility failed to ensure pain medicine was administered according to the pain scale indicated in the physician's orders.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Pain - Clinical Protocol, revised October 2022, indicated but was not limited to:</p> <p>-Staff will use a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level.</p> <p>Review of the facility's policy titled Administering Medications, revised April 2019, indicated but was not limited to:</p> <p>-Medications are administered in accordance with prescriber orders.</p> <p>-If a dosage is believed to be inappropriate or excessive for a resident, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns.</p> <p>Standard of Practice Reference: Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of registered nurse and practical nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered nurse and Practical nurse respectively. The regulations stipulate that both the registered nurse and practical nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the registered nurse and practical nurse incorporate into the plan of care, and implement prescribed medical regimens. A nurse licensed by the Board shall not administer any prescription drug or non-prescription drug to any person in the course of nursing practice except as directed by an authorized prescriber. A nurse licensed by the Board shall document the handling, administration, and destruction of controlled substances in accordance with all federal and state laws and regulations and in a manner consistent with accepted standards of practice.</p> <p>1. Resident #73 was admitted to the facility in May 2021 with diagnoses including morbid obesity, acute on chronic congestive heart failure, and generalized anxiety disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #73, dated 2/28/24, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the Resident was cognitively intact.</p> <p>Review of Resident #73's active Physician's Orders indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Acetaminophen (pain reliever), give 30 milliliters (ml) by mouth three times a day for pain, 30 ml to equal 1000 milligrams (mg). Active 3/13/24. Discontinued 5/15/24.</p> <p>- Acetaminophen (pain reliever), give 30 ml by mouth three times a day for pain, 500 mg/15 ml, give 30 ml to equal 1000 mg. Active 5/15/24.</p> <p>- Oxycodone tablet 5 mg, give 5 mg by mouth every 6 hours as needed for moderate-severe pain. Active 6/23/21.</p> <p>- Pain score every shift, 0 = no pain; 1, 2, 3, 4 = mild pain; 5, 6, 7 = moderate pain; 8, 9, 10 = severe pain. Active 5/20/21.</p> <p>Review of Resident #73's Medical Administration Record (MAR) for the months of April and May 2024 indicated Oxycodone was administered to the Resident outside of the physician's ordered pain parameters for the following dates:</p> <p>4/1/24, pain score = 4, administered by Nurse #11</p> <p>4/3/24, pain score = 3, administered by Nurse #12</p> <p>4/6/24, pain score = 4, administered by Nurse #12</p> <p>4/6/24, pain score = 4, administered by Nurse #11</p> <p>4/7/24, pain score = 4, administered by Nurse #11</p> <p>4/7/24, pain score = 4, administered by Nurse #12</p> <p>4/8/24, pain score = 4, administered by Nurse #11</p> <p>4/11/24, pain score = 4, administered by Nurse #11</p> <p>4/11/24, pain score = 4, administered by Nurse #12</p> <p>4/12/24, pain score = 4, administered by Nurse #11</p> <p>4/18/24, pain score = 4, administered by Nurse #11</p> <p>4/19/24, pain score = 4, administered by Nurse #11</p> <p>4/25/24, pain score = 4, administered by Nurse #12</p> <p>5/1/24, pain score = 4, administered by Nurse #11</p> <p>5/4/24, pain score = 4, administered by Nurse #12</p> <p>5/5/24, pain score = 4, administered by Nurse #11</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5/7/24, pain score = 4, administered by Nurse #12</p> <p>5/9/24, pain score = 4, administered by Nurse #12</p> <p>5/18/24, pain score = 4, administered by Nurse #13</p> <p>5/21/24, pain score = 4, administered by Nurse #11</p> <p>Additional review of Resident #73's MAR for the months of April and May 2024, indicated the Resident received Acetaminophen per physician's orders.</p> <p>During an interview on 5/22/24 at 10:38 A.M., Nurse #12 said she did not know what the pain scale was off the top of her head. Nurse #12 said on a scale from 1-10, she counts a pain rating of 4-7 as moderate. Nurse #12 said per the physician's order for pain score, pain at 5-7 is considered moderate. Nurse #12 said Resident #73 should not receive Oxycodone when the Resident reports pain of 4 or less on the pain scale. Nurse #12 said she did not contact the physician in regard to administering the Oxycodone outside of the ordered pain parameters but she should have.</p> <p>During an interview on 5/22/24 at 12:07 P.M., the Director of Nursing (DON) said pain levels 5-10 are considered moderate to severe. The DON said the physician should have been called when Resident #73 requested Oxycodone for a pain level of 4 or below. The DON could not provide the Surveyor documentation that the physician was specifically notified or aware of Oxycodone being administered to Resident #73 for a pain level of 4 or below.</p> <p>48695</p> <p>2. Resident #11 was admitted to the facility in April 2024 with diagnoses including muscle weakness and atrial fibrillation.</p> <p>Review of the MDS assessment, dated 4/13/24, indicated Resident #133 was cognitively intact as evidenced by a BIMS score of 13 out of 15.</p> <p>Review of Resident #11's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - Acetaminophen (pain reliever) 500 mg give 2 tablets (1000 mg) by mouth every 8 hours as needed for mild pain (4/28/24) - Oxycodone 5 mg give one tab every six hours as needed for severe pain (7-10), dated 5/8/24 - Pain Score every shift 0=No Pain, 1,2,3,4= Mild Pain, 5,6,7= Moderate Pain, 8,9,10= Severe pain every shift for Pain (4/27/24) <p>Review of Resident #11's May MAR indicated that Oxycodone was administered 21 times.</p> <p>Further Review of the MAR indicated that 10 out of 21 times Oxycodone had been administered out of the Physician's parameters as follows:</p> <ul style="list-style-type: none"> - 5/8/24 at 8:45 P.M. Pain Score: 4 by Nurse #8 <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 5/9/24 at 8:18 A.M. Pain Score: 5 by Nurse #7</p> <p>- 5/9/24 at 4:50 P.M. Pain Score: 2 by Nurse #8</p> <p>- 5/9/24 at 10:27 P.M. Pain Score: 3 by Nurse #8</p> <p>- 5/10/24 at 8:36 A.M. Pain Score: 6 by Nurse #7</p> <p>- 5/11/24 at 1:49 A.M. Pain Score: 5 by Nurse #5</p> <p>- 5/11/24 at 9:29 A.M. Pain Score: 6 by Nurse #14</p> <p>- 5/13/24 at 1:35 P.M. Pain Score: 5 by Nurse #1</p> <p>- 5/14/24 at 9:46 A.M. Pain Score: 6 by Nurse #7</p> <p>- 5/20/24 at 3:00 A.M. Pain Score: 2 by Nurse #15</p> <p>Review of Resident #11's care plan titled Pain (back) related to chronic pain syndrome, last revised 4/28/24, indicated but not limited to:</p> <p>- Administered (sic) pain medication per physician orders (initiated 4/27/24)</p> <p>During an interview with medical record review on 5/20/24 at 1:43 P.M., Nurse #1 and the surveyor reviewed Resident #11's MAR. Nurse #1 said Resident #11 should have only been administered the Oxycodone for a pain score of 7 or higher. If the Oxycodone was administered for a pain score of less than 7, then the Physician/Nurse Practitioner (NP) should have been called and notified.</p> <p>During an interview on 5/20/24 at 1:53 P.M., Physician #1 said if a pain medication is administered for a pain level below the prescribed parameter, then, prior to administration, the Physician/NP should be called.</p> <p>During an interview on 5/20/24 at 4:23 P.M., Nurse #2 said pain medications should be administered per physician's orders and parameters. If a Resident requests pain medication outside of physician's orders, then the Physician/NP should be called prior to administration and a nurse's note should be written to document the conversation.</p> <p>During an interview on 5/21/24 at 11:28 A.M., the DON said that the nurses should have called the Physician/NP when administering a pain medication outside of the physician's orders. The DON said she could not find any documentation that the Physician/NP were notified of the Oxycodone being administered outside of the Physician's orders' parameters.</p> <p>3. Resident #133 was admitted to the facility in April 2024 with diagnoses including chronic kidney disease and diabetes with diabetic neuropathy.</p> <p>Review of the MDS assessment, dated 4/13/24, indicated Resident #133 was cognitively intact as evidenced by a BIMS score of 15 out of 15.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #133's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> -Acetaminophen 650 mg give 2 tablets (650 mg) by mouth every 8 hours as needed for pain (4/28/24) -Oxycodone 5 mg, give half a tab by mouth every 4 hours as needed for severe pain (5/6/24) -Oxycodone 5 mg, give one tablet by mouth every 4 hours as needed for severe pain (5/6/24) -Pain Score every shift 0=No Pain, 1,2,3,4= Mild Pain, 5,6,7= Moderate Pain, 8,9,10= Severe pain every shift for Pain (4/2/24) <p>Review of Resident #133's April and May MAR indicated that Oxycodone was administered 34 times.</p> <p>Further Review of the MAR for Resident #133 indicated 24 out of 34 times Oxycodone 5 mg had been administered outside of the Physician's parameters:</p> <ul style="list-style-type: none"> - 5/6/24 at 6:10 P.M., Pain Score: 7 by Nurse #5 - 5/7/24 at 8:40 P.M., Pain Score: 6 by Nurse #6 - 5/8/24 at 8:55 A.M., Pain Score: 6 by Nurse #7 - 5/8/24 at 4:38 P.M., Pain Score: 4 by Nurse #8 - 5/8/24 at 9:10 P.M., Pain Score: NA (not applicable) Nurse #8 - 5/9/24 at 11:46 A.M., Pain Score: 5 by Nurse #7 - 5/9/24 at 5:03 P.M., Pain Score: 2 by Nurse #8 - 5/9/24 at 9:08 P.M., Pain Score: 3 by Nurse #8 - 5/10/24 at 12:44 P.M., Pain Score: 6 by Nurse #7 - 5/11/24 at 2:38 A.M., Pain Score: 0 by Nurse #6 - 5/14/24 at 1:54 A.M., Pain Score: 7 by Nurse #9 - 5/14/24 at 8:54 A.M., Pain Score: 6 by Nurse #7 - 5/14/24 at 9:46 P.M., Pain Score: 7 by Nurse #5 - 5/15/24 at 9:36 A.M., Pain Score: 0 by Nurse #4 - 5/15/24 at 9:10 P.M., Pain Score: 7 by Nurse #10 - 5/16/24 at 6:04 A.M., Pain Score: 7 by Nurse #17 <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Care One at New Bedford		STREET ADDRESS, CITY, STATE, ZIP CODE 221 Fitzgerald Drive New Bedford, MA 02745	
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 5/16/24 at 8:31 P.M., Pain Score: 7 by Nurse #9</p> <p>- 5/17/24 at 1:01 A.M., Pain Score: 7 by Nurse #9</p> <p>- 5/17/24 at 8:00 A.M., Pain Score: 5 by Nurse #1</p> <p>- 5/17/24 at 2:32 P.M., Pain Score: 6 by Nurse #1</p> <p>- 5/18/24 at 5:59 A.M., Pain Score: 5 by Nurse #6</p> <p>- 5/20/24 at 3:00 A.M., Pain Score: 7 by Nurse #2</p> <p>- 5/21/24 at 1:05 A.M., Pain Score: 7 by Nurse #9</p> <p>- 5/21/24 at 1:23 P.M., Pain Score: 7 by Nurse #9</p> <p>Review of Resident #133's care plan titled Pain (generalized related to fibromyalgia (a condition that involves widespread body pain), last revised 4/8/24, indicated but was not limited to:</p> <p>-Administered (sic) pain medication per physician orders (initiated 4/8/24)</p> <p>During an interview on 5/21/24 at 2:10 P.M., Nurse #4 said, in order to give a pain medication, the nurse should have assessed the resident's pain and administered the medication per physician's order. Nurse #4 said Resident #133 would ask for Oxycodone 5 mg. Nurse #4 said the Physician/NP should have been called if Resident #133 was having less than severe pain.</p> <p>During an interview on 5/21/24 at 2:40 P.M., Nurse #3 said Resident #133 should have had a range on his/her Oxycodone order. Nurse #3 said if a resident rates their pain below what the physician's order says, then prior to administering the medication, the Physician/NP should be called to get clarification of the order.</p> <p>During an interview on 5/21/24 at 2:52 P.M., Resident #133 said he/she was offered a choice between taking Oxycodone 2.5 mg and Oxycodone 5 mg. Resident #133 said he/she would request the Oxycodone 5 mg dose.</p> <p>During a telephonic interview on 5/22/24 at 12:56 P.M., Nurse #2 said she had administered the Oxycodone on 5/20/24 at 17:42 (5:42 P.M.) to Resident #133 for pain of 7 out 10. Nurse #2 said she should have called the Physician to get an order to administer the Oxycodone but did not.</p> <p>During an interview on 5/22/24 at 1:54 P.M., the DON said the expectation was for pain medications to be administered per physician's orders and per the pain scale.</p>		