STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225653	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copley at Stoughton Nursing Care Center	380 Sumner Street Stoughton, MA 02072

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 50740 Based on record review and interview, the facility failed to ensure one Resident's (#93) representative, as designated by the Resident, was able to make medical decisions for the Resident, in a sample of 22 records reviewed. Specifically, the facility failed to ensure that the Resident's representative was able to formulate the Resident's Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) form. Findings include: Review of the facility's policy titled Advance Directives, revised September 2022, indicated but was not limited to the following: -Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. -The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. -If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the residents legal representative. -Upon admission the interdisciplinary team assesses the resident's decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity. -The interdisciplinary team conducts ongoing review of the resident's decision-making capacity and invokes the resident representative or health care agent if the resident is determined not to have decision-making capacity. Resident #93 was admitted to the facility in February 2024 with a diagnosis of dementia. (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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	225653	A. Building B. Wing	10/08/2024

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #93 indicated a Physician completed a Health Care Activation Form on 2/7/24. The form indicated the physician determined Resident #93 lacked the capacity to make and/or communicate health care decisions related to cognitive impairment dementia and the duration was undetermined. Review of Resident #93's Care Plan indicated but was not limited to the following: -Focus: Resident has a MOLST: DNR (do not resuscitate) DNI (do not intubate) Do not use invasive ventilation No CPAP (continuous positive airway pressure) DNH (do not hospitalize) No dialysis No artificial nutrition No artificial hydration -Interventions 1) Communicate with hospital/EMTs (emergency medical technician) code status 2) MOLST form/copy of MOLST form in front of chart 3) Review MOLST form quarterly with resident and/or HCP 4) If changes made by resident and/or HCP use new MOLST form. Review of the medical record indicated that the Resident signed a MOLST form on 5/14/24 indicating the Resident was not to be resuscitated, not to be intubated and ventilated, not to use non-invasive ventilation, not transferred to the hospital unless needed for comfort, and not to be treated with dialysis, artificial nutrition, or artificial hydration. The MOLST form was signed by the provider on 5/14/24, effecting the orders for life-sustaining treatment immediately as indicated on the MOLST form completed by the Resident. The record failed to indicate that the Resident's representative reviewed and signed the Resident's MOLST form. During an interview on 10/8/24 at 11:10 A.M., Unit Manager (UM) #3 and surveyor reviewed that Resident #93's HCP had been activated in February 2024 and that the Resident, not the HCP, had signed the MOLST form in May 2024. UM #3 said that hospice staff had assisted the Resident with completing the MOLST form but that the HCP should have reviewed and signed the MOLST form at that time since the Resident's HCP was activated.

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 48695 Based on record review and interview, the facility failed to complete a discharge assessment to ensure timely coding and transmitting of a Minimum Data Set (MDS) assessment for two Residents (#25 and #42), out of two resident assessments reviewed, resulting in a delay in the encoding and transmission of an MDS post-discharge from the facility. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) 3.0 Manual Chapter 2: Assessments for the RAI, dated October 2023, indicated but was not limited to: -The MDS must be transmitted (submitted and accepted into iQIES) electronically no later than 14 calendar days after the care plan completion date (V0200C2 + 14 calendar days). 1. Resident #25 was admitted to the facility in April 2024 for short-term skilled rehabilitation services and discharged to the community in May 2024. Review of the medical record indicated the discharge MDS was not completed until 9/30/24 approximately four months following the Resident's discharge from the facility. During an interview on 10/8/24 at 10:08 A.M., MDS Nurse #1 reviewed Resident #25's medical record and said Resident #25's MDS assessment was not submitted for over 120 days and should have been submitted in a timely manner. 2. Resident #42 was admitted to the facility in May 2024 for short-term skilled rehabilitation services and discharged to the hospital in May 2024. Review of the medical record indicated the discharge MDS was not completed until 9/30/24 approximately four months following the Resident's discharge from the facility. During an interview on 10/8/24 at 10:08 A.M., MDS Nurse #1 reviewed Resident #42's medical record and said Resident #42's MDS assessment was not submitted for over 120 days and should have been submitted in a timely manner. During an interview on 10/8/24 at 2:32 P.M., the Director of Nursing (DON) said the expectation was for MDS assessments for Resident #25 and Resident #42 to have been encoded and transmitted in a timely manner.

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	225653	A. Building B. Wing	10/08/2024

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 50740 Based on record review and interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) assessments were completed for three Residents (#80, #93, and #76), out of a total sample of 22 residents. Specifically, the facility failed to: 1. For Resident #80, accurately code the Resident's prognosis of less than six months on the 9/4/24 MDS; 2. For Resident #93, a. Accurately code hospice care on the 3/1/24 MDS, b. Accurately code a fall with injury on the 5/29/24 MDS, and c. Accurately code the Resident's prognosis of less than six months on the 8/28/24 MDS; and 3. For Resident #76, accurately code the Resident's use of antipsychotic medication on the 8/21/24 MDS. Findings include: Review of the facility's policy titled Electronic Transmission of the MDS, revised October 2023, indicated but was not limited to the following: - All staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the Resident Assessment Instrument (RAI) User's Manual, before being permitted to use the MDS information system. - The MDS coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data and that feedback and validation reports from each transmission are maintained for historical purposes and for tracking. Review of the facility's policy titled MDS Error Correction, revised October 2023, indicated but was not limited to the following: - If an error is discovered after the encoding period and the record in error is an OBRA (Omnibus Budget Reconciliation Act, regulations that defined a schedule of assessments that will be performed for a nursing facility resident at admission, quarterly, annually, and whenever the resident experiences a significant change in condition) comprehensive or quarterly assessment, determine if the error is significant or minor. -A minor error is one related to the coding of the MDS. For minor errors, correct the record and submit to the iQIES system. (continued on next page)

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	225653	A. Building B. Wing	10/08/2024

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	-A significant error is one that inaccurately reflects the resident's clinical status and/or may result in an inappropriate plan of care. For major errors: (1) correct the original assessment to reflect the resident's status as of the original assessment reference date and submit the record; and (2) perform a new significant change in status (if this has occurred) or a new significant correction to a prior assessment with a current observation period and assessment reference date. 1. Resident #80 was admitted to the facility in December 2022 with diagnoses including heart failure, cerebral infarction, and dementia. Review of the Hospice Certification of Terminal Illness signed by the Hospice Physician on 9/5/24 indicated that the life expectancy for Resident #80 was less than six months and that hospice care was initiated on 8/26/24. Review of the 9/4/24 Significant Change MDS assessment for Resident #80 indicated that he/she received hospice care. The 9/4/24 MDS assessment failed to indicate that the Resident had a condition or chronic disease that may result in a life expectancy of less than six months. During an interview on 10/8/24 at 8:24 A.M., MDS Nurse #1 reviewed the MDS assessments for Resident #80. The MDS Nurse said that the facility has a difficult time getting a copy of the signed Hospice Certification of Terminal Illness in the time needed to complete the MDS accurately. The MDS Nurse said that if she does not have a copy of the signed Hospice Certification of Terminal Illness or a progress note from the physician indicating that a resident has a life expectancy of less than six months, then she cannot include that information on the MDS. 2. Resident #93 was admitted to the facility in February 2024 with diagnoses including heart failure and dementia. a. Review of the Hospice Certification of Terminal Illness signed by the Hospice Physician on 5/20/24 indicated that hospice care was initiated on 2/24/24 and the prognosis/life expectancy for Resident #93 was less than six months. Review of the 3/1/24 Significant Change MDS for Resident #93 failed to indicate that the Resident received hospice care. During an interview on 10/8/24 at 8:24 A.M., MDS Nurse #1 reviewed the MDS assessments for Resident #93. MDS Nurse #1 said that the facility has a difficult time getting a copy of the signed Hospice Certification of Terminal Illness in the time needed to complete the MDS accurately. MDS Nurse #1 said that if she does not have a copy of the signed Hospice Certification of Terminal Illness or a progress note from the physician indicating that a resident has a life expectancy of less than six months, then she cannot include that information on the MDS. b. Review of Resident #93's Progress Notes indicated that the Resident sustained a fall at the facility on 4/24/24 and 4/25/24. As a result of the fall sustained on 4/24/24, the Resident acquired an injury (skin tears to each elbow) which required treatment with dressings. (continued on next page)

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	225653	A. Building B. Wing	10/08/2024

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the 5/29/24 Quarterly MDS for Resident #93 indicated that since the prior assessment on 3/1/24, Resident #93 sustained only one fall with no injury. During an interview on 10/08/24 at 1:25 P.M., MDS Nurse #1 said that she obtains information about falls from multiple places in the Residents' medical records. MDS Nurse #1 said she must have missed the documentation indicating that Resident #93 sustained a fall with injury while completing her review. c. Review of the Hospice Certification of Terminal Illness signed by the Hospice Physician on 8/16/24 indicated that the prognosis/life expectancy for Resident #93 was less than six months. Review of the 8/28/24 Quarterly MDS indicated that the Resident received hospice services but failed to indicate that the Resident had a condition or chronic disease that may result in a life expectancy of less than six months. During an interview on 10/8/24 at 8:24 A.M., MDS Nurse #1 reviewed the MDS assessments for Resident #93. MDS Nurse #1 said that the facility has a difficult time getting a copy of the signed Hospice Certification of Terminal Illness in the time needed to complete the MDS accurately. MDS Nurse #1 said that if she does not have a copy of the signed Hospice Certification of Terminal Illness or a progress note from the physician indicating that a resident has a life expectancy of less than six months, then she cannot include that information on the MDS. 34145 3. Resident #76 was admitted to the facility in August 2021 with diagnoses including psychotic disorder. Review of the Physician's Orders indicated but was not limited to: -Olanzapine (antipsychotic) 2.5 milligrams (mg), give 2.5 mg by mouth one time a day (11/14/22) -Olanzapine 5 mg at bedtime (4/9/24) Review of the August 2024 Medication Administration Record (MAR) indicated Olanzapine was administered to Resident #76 as ordered by the physician. Review of the MDS assessment, dated 8/21/24, indicated that section N0450 Antipsychotic Medication Review A. Did the resident receive antipsychotic medication since admission/entry or reentry or the prior OBRA assessment, whichever is more recent. A check mark was noted in the box corresponding to the response: No- Antipsychotics were not received. During an interview on 10/8/24 at 10:08 A.M., MDS Nurse #1 said Resident #76's 8/21/24 MDS should have indicated he/she was receiving an antipsychotic medication daily, but it was not coded correctly.

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	225653	A. Building B. Wing	10/08/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50740 Based on observation, interview, and record review, the facility failed to develop and implement an individualized, person-centered care plan to meet the physical, psychosocial, and functional needs for two Residents (#93 and #37), out of a total sample of 22 residents. Specifically, the facility failed: 1. For Resident #93, to develop and implement interventions to address the Resident's risk for falls; and 2. For Resident #37, to ensure the care plan was updated when a Foley catheter (small flexible tube inserted into the urethra to drain urine from the bladder) used to manage the Resident's urinary retention was ineffective and changed to a larger size catheter in response following two episodes of urinary incontinence. Findings include: Review of the facility's policy titled Falls - Clinical Protocol, revised September 2012, indicated but was not limited to the following: -Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. -If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation. -If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions. Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, revised March 2022, indicated but was not limited to the following: -The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. -The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; c. includes the resident's stated goals upon admission and desired outcomes; (continued on next page)

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	225653	A. Building B. Wing	10/08/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. builds on the resident's strengths; e. reflects currently recognized standards of practice for problem areas and conditions -Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. -The IDT reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS (Minimum Data Set) assessment. Review of the facility form titled Resident Incident/Accident Report indicated but was not limited to: -Identify what new intervention was put into to prevent a reoccurrence [sic]. The form indicates that the area must be completed. Resident #93 was admitted to the facility in February 2024 with diagnoses including repeated falls, concussion (a brain injury that occurs when the brain is forced to move rapidly within the skull), difficulty walking, weakness, and dementia. Review of Resident #93's Minimum Data Set (MDS) assessment, dated 8/28/24, indicated that the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. Review of the medical record indicated Resident #93 sustained four falls after his/her admission to the facility: -On 4/24/24 at 5:30 P.M., the Resident fell from his/her wheelchair. -On 4/25/24 at 11:00 A.M., the Resident was found on the floor. -On 7/10/24 at 6:20 A.M., the Resident was found sitting on the floor. -On 8/3/24 at 11:10 P.M., the Resident was found sitting on the floor. (continued on next page)

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	225653	A. Building B. Wing	10/08/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Resident Incident/Accident Reports for the falls occurring on 4/25/24, 7/10/24, and 8/3/24 did not indicate new interventions put into place to prevent falls. The Resident Incident/Accident Report for the fall occurring on 4/24/24 indicated the intervention put into place was Call for assistance. Review of Resident #93's Progress Notes indicated but was not limited to the following: -On 4/24/24 at 5:30 P.M., the Resident was found lying on the floor near his/her wheelchair. The Resident had been sitting in the wheelchair prior. When asked what happened, the Resident stated he/she leaned forward to pick up something and slipped out of the chair. -On 4/25/24 at 11:00 A.M., the Resident was found on the floor in his/her room and stated he/she had to use the bathroom. -On 7/10/24 just before 6:30 A.M., the Resident was found sitting on his/her buttocks next to his/her bed. -On 8/3/24 at 11:10 P.M., the Resident slipped from his/her bed with his/her buttocks on the floor. The Resident was confused and having hallucinations and Ativan (an antianxiety medication) was administered at 1:00 A.M. -On 8/4/24 at 6:29 A.M., the Resident was evaluated by a Nurse Practitioner (NP) via telemedicine visit. The NP indicated that the Resident's fall interventions were reviewed and additional fall prevention precautions were to be added per center protocol. Review of Resident #93's Care Plans indicated but was not limited to the following: -Focus: The resident has had an actual fall with serious injury poor balance and unsteady gait (2/5/24) -Goal: a) The resident will resume usual activities without further incident through the review date (2/5/24) b) The resident's Facial Concussion and bruises will resolve without complication by review date (2/5/24) -Interventions: a) Bed at lowest position. (2/5/24) b) Continue interventions on the at-risk plan. (2/5/24) c) Ensure call light is within reach. (2/5/24) d) Ensure patient is wearing slip resistant shoes or socks with grips. (2/5/24) (continued on next page)

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	225653	A. Building B. Wing	10/08/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e) Ensure proper use of assistive devices. (2/5/24) f) For no apparent acute injury, determine and address causative factors of the fall. (8/4/24) g) Keep residents [sic] personal possessions within reach. (2/5/24) h) Monitor/document/report PRN (as needed) x 72h (hours) to MD for s/sx (signs and symptoms): Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. (2/5/24) i) Pharmacy consult to evaluate medications. (2/5/24) j) Provide activities that promote exercise and strength building where possible Provide 1:1 activities if bedbound. (2/5/24) k) PT consult for strength and mobility. (8/4/24). Further review of Resident #93's Care Plans failed to identify a separate at-risk plan as identified in the actual fall care plan interventions noted above. Review of the medical record failed to indicate that Resident #93's comprehensive care plan was reviewed/updated to identify and/or add additional fall prevention interventions after the Resident's falls on 4/24/24, 4/25/24, and 7/10/24. During an interview on 10/8/24 at 12:59 P.M., Nurse #11 said that when a resident has a fall, an incident report is done, the physician and family are notified, the resident is assessed, a fall assessment is completed in the electronic medical record. Nurse #11 said that the Charge Nurse usually updates the Resident's care plan and the completed incident report is given to the Director of Nursing (DON) for review. During an interview on 10/08/24 at 1:00 P.M., the surveyor and DON reviewed the Resident Incident/Accident Reports for Resident #93's falls. The DON said that the reports did not indicate interventions put into place after each fall but that the care plan should have been updated. During an interview on 10/08/24 at 1:25 P.M., MDS Nurse #1 said that no care plan updates were made to Resident #93's fall care plan after the Resident fell on [DATE] and 4/25/24. 34145 2. Resident #37 was admitted to the facility in August 2023 with diagnoses including neuromuscular dysfunction of the bladder. Review of the MDS assessment, dated 9/11/24, indicated Resident #37 had severe cognitive impairment as evidenced by a BIMS score of 4 out of 15, and had an indwelling urinary catheter. (continued on next page)

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	225653	A. Building B. Wing	10/08/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record indicated Resident #37 was admitted to the hospital in March 2024 and was treated for a urinary tract infection. The Resident had a Foley catheter in place at the time of admission to the hospital, but it was removed prior to discharge. Physician's orders upon return to the facility included, but was not limited to: -Post void residual (PVR) bladder scan every shift. Insert Foley catheter (FC) for greater than 350 milliliters (ml), every shift for 2 Days (4/1/2024) Review of a Skilled Nurse's Note, dated 4/2/24, indicated a bladder scan was performed with a post-void residual (PVR) volume of 438 ml. A Foley Catheter 16 French (Fr) 10 ml balloon was inserted. Review of Resident #37's comprehensive care plans indicated but was not limited to: -Focus: The resident has an indwelling Foley catheter related to neurogenic bladder (10/20/23) -Interventions: Catheter: The resident has 16 French catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door (4/12/24) -Goal: The resident will show no signs/symptoms of urinary infection through review date (4/12/24) Review of a Skilled Nurse's Note, dated 9/13/24, indicated Resident #37 was incontinent of a large amount of urine and the FC 16 Fr 10 ml balloon was changed (with the same size catheter). Review of a Skilled Nurse's Note, dated 9/30/24, indicated Resident #37 was incontinent of a large amount of urine and the FC was changed to a 22 Fr 30 ml balloon. During an interview with observation on 10/7/24 at 10:33 A.M., Nurse #12 confirmed that Resident #37 had a Foley catheter, but did not know the size of the catheter or the retention balloon as there was no physician's order and said she was going to look at the catheter itself to obtain that information. Nurse #12 walked down the hallway and entered Resident #37's room, and proceeded to reposition the Resident while he/she was reclined in bed, remove the Resident's pants and examine the Foley catheter. She said the catheter was a 22 Fr with a 30 ml retention balloon. Further review of comprehensive care plans indicated the care plan for indwelling catheter was not revised to reflect the discontinuation of the FC 16 Fr 10 ml balloon due to its ineffectiveness and initiation of the larger size Foley catheter 22 Fr 30 ml balloon. During an interview on 10/8/24 at 11:25 A.M., Unit Manager #2 said the care plan should have been updated when the 16 Fr Foley catheter failed to effectively manage the Resident's urinary retention and a new, larger catheter was inserted on 9/30/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225653	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copley at Stoughton Nursing Care Center	380 Sumner Street Stoughton, MA 02072

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on observation, interviews, and record review, the facility failed to ensure residents were provided care in accordance with professional standards of practice for two Residents (#77 and #37), out of a total sample of 22 residents. Specifically, the facility failed: 1. For Resident #77, to identify and provide care for an implanted central line catheter (port, type of central line that allows for long-term access to a patient's bloodstream); and 2. For Resident #37, to ensure physician's orders for insertion of indwelling Foley catheters, including the size of the device, was obtained/documented in the medical record on three occasions. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated but was not limited to: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Review of the facility's policy titled Admission Assessment and Follow Up: Role of the Nurse, last revised September 2012, indicated but was not limited to: - Purpose: The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instructions, including the MDS (Minimum Data Set). -Steps in the Procedure: 7. Conduct an admission assessment (history and physical), including: a. A summary of the individual's recent medical history, including hospitalization s, acute illnesses, and overall status prior to admission. b. Relevant medical, social, and family history. c. A list of active medical diagnoses and patient problems. - Documentation: The following information should be recorded in the resident's medical record: 3. All relevant assessment data obtained during the procedure. (continued on next page)

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	225653	A. Building B. Wing	10/08/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Implanted Venous Port Flushing and Locking, last revised 2022, indicated but was not limited to: -Purpose: the purposes of this procedure are to maintain patency of the implanted port. -Frequency 4. Flush implanted venous ports not accessed for infusion at least 10 mL (milliliters) with preservative-free 0. 9% sodium chlorine and 3-5 mL heparin (anticoagulant medication, used to prevent clots) every 3 months for maintenance flushing, or refer to manufacturer's instructions. Review of the National Library of Medicine (NLM), dated 5/15/23, indicated but was not limited to: - A central line is a thin, flexible, large-bore tube inserted into a client's large vein, also referred to as a central venous access device (CVAD). -CVADs are commonly guided into the superior vena cava so the distal tip is located in the superior vena cava near the junction with the right atrium. -Complications: -Occlusion due to clot formations: -Flush the catheter routinely as recommended and according to agency policy. -Skin erosion: -Assess the skin at and around the CVAD insertion site. Note any skin separation from the catheter exit site, drainage, contusions, or any indication of skin involvement. https://www.ncbi.nlm.nih.gov/books/NBK594495/ Resident #77 was admitted to the facility in June 2024 with diagnoses including ovarian cancer, colon cancer, and weakness. Review of Resident #77's hospital discharge paperwork, dated 6/11/24, indicated but was not limited to: -Patient Lines/Drains/Airway Status -Implanted Port Chest Wall Review of Resident #77's intial admission assessment, dated 6/11/24, failed to indicate he/she had an implanted central line catheter. Review of Resident #77's hospital discharge paperwork, dated 7/3/24, indicated but was not limited to: (continued on next page)

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	225653	A. Building B. Wing	10/08/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Patient Lines/Drains/Airway Status - Single Lumen Implantable Port Right Chest Review of Resident #77's re-admission assessment, dated 7/3/24, failed to indicate he/she had an implanted central line catheter. Review of Resident #77's chest x-ray (obtained because of an elevated white blood cell count), dated 9/27/24, indicated he/she had a right implanted central line catheter. Further review of Resident #77's medical record failed to indicate he/she had orders for care and maintenance of the implanted central line catheter. During an interview on 10/7/24 at 3:00 P.M., Nurse #2 said she completed Resident #77's admission assessment on 7/3/24. Nurse #2 said she completed an admission assessment but had not reviewed Resident #77's hospital discharge paperwork because another nurse did. Nurse #2 said she did not identify Resident #77 had an implanted central line catheter but should have. During an interview on 10/8/24 at 10:49 A.M., Nurse #10 said she had completed Resident #77's admission assessment dated [DATE]. Nurse #10 said she was aware Resident #77 had an implanted central line catheter, but she did not mark it off on his/her admission assessment and did not pass it on. During an interview on 10/7/24 at 2:58 P.M., Unit Manager (UM) #3 said residents who have implanted central line catheters should have orders for care and maintenance of them. UM #3 said she was unaware Resident #77 had an implanted central line catheter. UM #3 said Resident #77 should have orders for care and maintenance of his/her implanted central line catheter but does not. During an interview on 10/8/24 at 11:32 P.M., the Director of Nursing (DON) said for any resident who had an implanted central line catheter the expectation is that he/she had orders for care and maintenance of it, but Resident #77 did not. 34145 2. Review of the facility's policies titled Medication and Treatment Orders, last revised July 2016, and Verbal Orders, last revised February 2014, indicated but was not limited to: - Verbal orders are those given by an authorized practitioner directly to a person authorized to receive and transcribe orders on his or her behalf. A telephone order is a verbal order given over the telephone. - Text messaging is not an acceptable method of communicating an order. - The individual receiving the verbal order must write it on the physician's order sheet as v.o. (verbal order) or t.o. (telephone order). - The individual receiving the verbal order will: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. read the order back to the practitioner to ensure that the information is clearly understood and correctly transcribed; b. record the ordering practitioner's last name and his or her credentials (MD, NP, PA, etc.); and c. record the date and time of the order. Resident #37 was admitted to the facility in August 2023 and has diagnoses including neuromuscular dysfunction of the bladder. Review of the Minimum Data Set (MDS) assessment, dated 9/11/24, indicated Resident #37 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 4 out of 15, and had an indwelling urinary catheter. Review of the medical record indicated Resident #37 was admitted to the hospital in March 2024 and was treated for a urinary tract infection. The Resident had a Foley catheter in place at the time of admission to the hospital, and it was removed prior to discharge. Review of the Physician's Orders upon return to the facility included but was not limited to: -Post-void residual (PVR) bladder scan every shift. Insert Foley catheter for greater than 350 milliliters (ml), every shift for 2 Days (4/1/24 - 4/2/24) The physician's order failed to identify the size of the Foley catheter and retention balloon to be inserted. Review of a Skilled Nurse's Note, dated 4/2/24, indicated a bladder scan was performed with a PVR volume of 438 ml and a Foley catheter 16 French (Fr) 10 ml retention balloon was inserted. Review of the medical record indicated the following physician's orders were initiated on 4/2/24: -Foley catheter care every shift -Maintain enhanced precautions related to Foley catheter every shift -Foley Catheter Output every shift Document amount -Change catheter drainage bag (CD) weekly and label/date every night shift every Wednesday Further review of the entire medical record failed to indicate a physician's order was obtained and documented that included the Foley catheter size and retention balloon size to be inserted. Review of a Skilled Nurse's Note, dated 9/13/24, indicated Resident #37 was incontinent of a large amount of urine and the Foley catheter 16 Fr 10 ml retention balloon was changed (with the same size catheter). Further review of the entire medical record failed to indicate a physician's order was obtained and documented to remove and insert a new Foley catheter 16 Fr 10 ml retention balloon. (continued on next page)

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	225653	A. Building B. Wing	10/08/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Skilled Nurse's Note, dated 9/30/24, indicated Resident #37 was incontinent of a large amount of urine, 100 ml in Foley drainage bag, and the Foley catheter was changed with a 22 Fr 30 ml retention balloon. Nurse Practitioner (NP #1) aware. Further review of the entire medical record failed to indicate a physician's order was obtained and documented to remove the Foley catheter 16 Fr 10 ml retention balloon and insert a new FC 22 Fr 30 ml retention balloon. During an interview on 10/7/24 at 10:33 A.M., Nurse #12 reviewed Resident #37's medical record and said she could not find any information about the size of the Foley catheter and retention balloon. Said there should be a physician's order that includes the type and size of the catheter and retention balloon and there is no order. She said there were only orders for catheter care every shift and to change the CD bag. Nurse #12 said it is important to have physician's orders with information about the size of the catheter and retention balloon available in the medical record because if something happens, they need to have that information to change the catheter with the proper size device. During an interview on 10/7/24 at 10:55 A.M., Unit Manager #2 reviewed Resident #37's medical record and said there should have been an order for insertion of the Foley catheter on 4/2/24 that included the size of the catheter and retention balloon and there is not. She said there should also have been orders obtained and documented for the catheter changes with sizes of the catheter on 9/13/24 and 9/30/24 and there were no orders documented as required. During an interview on 10/7/24 at 2:15 P.M., NP #1 said she doesn't recall getting any messages or hearing anything about Resident #37's Foley catheter insertions on 4/2/24, 9/13/24, and 9/30/24, but may have. During a subsequent interview on 10/7/24 at 2:31 P.M., NP #1 said she just reviewed her cell phone messages and found a message from a Nurse regarding Resident #27 dated 9/30/24. She read the message aloud to the survey team and it indicated the Resident was incontinent of urine and a 22 Fr catheter was inserted and it was working, draining clear yellow urine. She said she still did not recall giving an order for the new catheter, but she must have. During an interview on 10/8/24 at 11:25 A.M., Nurse #4 reviewed Resident #37's medical record and said on 9/13/24, the Resident was incontinent of a large amount of urine and she changed the Foley catheter. She said she couldn't remember who she spoke to and did not write/transcribe a telephone order for the Foley catheter change in the medical record. Nurse #4 said on 9/30/24, Resident #37 was incontinent and she notified NP #1 and was given a verbal order to change the catheter, but did not transcribe the order into the medical record. She said she should have written the order and included the size of the catheter and retention balloon and written a note documenting NP notification and that an order was given. During an interview on 10/8/24 at 1:35 P.M., the DON said the nurse should have documented contacting the NP and transcribed the orders for the Foley catheters, including the size of the catheter and retention balloon, when they were inserted on 4/2/24, 9/13/24, and 9/30/24.

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	225653	A. Building B. Wing	10/08/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 50740 Based on interview and record review, the facility failed to act promptly upon recommendations made by the Consultant Pharmacist during the monthly Medication Regimen Reviews (MRR) for one Resident (#93), out of a total sample of 22 residents. Specifically, the facility failed to act on the consultant pharmacist's recommendation to add a stop date to the Resident's as needed Ativan (an antianxiety medication) order. Findings include: Resident #93 was admitted to the facility in February 2024 with diagnoses including dementia and anxiety. Review of Resident #93's medical record indicated he/she was seen by the Consultant Pharmacist in July 2024 and recommendations were made. The surveyor was unable to locate the July 2024 Consultant Pharmacist's recommendation in Resident #93's record. After inquiry, the facility provided Resident #93's July 2024 Summary of all Doctor Recommendations, dated 7/11/24, provided by the consultant pharmacist. The document indicated but was not limited to: -Resident #93 had an order for as needed Ativan without a stop date and that after 14 days, the use of the as needed psychoactive medication may be continued if it is determined that the benefit of treatment outweighs the potential/actual risk of continued as needed therapy. -The Consultant Pharmacist recommended that if the medication was continued as needed, a stop date should be added to the order. Further review of the July 2024 recommendation form indicated the physician/prescriber response section was blank. During an interview on 10/8/24 at 10:40 A.M., Unit Manager #2 said that she had not been aware of the pharmacist's recommendations from July. Unit Manager #2 said the July recommendations should have been addressed. During an interview on 10/9/24 at 8:42 A.M., the Consultant Pharmacist said that she had provided the facility with a recommendation in July 2024 regarding the lack of stop date on Resident #93's as needed Ativan order. The Consultant Pharmacist said that after a recommendation is made but not addressed when she returns for subsequent months' reviews, it goes on a list of pending recommendations that is given to the facility. The Consultant Pharmacist said that the recommendation she had made in July 2024 for Resident #93 was on the list of pending recommendations that had not been addressed and given to the facility in both August 2024 and September 2024.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 50740 Based on record review and interview, the facility failed to ensure one Resident's (#93) drug regimen was free from unnecessary psychotropic medications, out of a total sample of 22 residents. Specifically, the facility failed to ensure as needed antianxiety medications were limited to 14 days or extended beyond 14 days with a documented clinical rationale and duration. Findings include: Review of the facility's policy titled Psychotropic Medication Use, dated July 2022, indicated but was not limited to the following: 12. Psychotropic medications are not prescribed or given on a PRN (as needed) basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. (1) For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. Resident #93 was admitted to the facility in February 2024 with diagnoses including dementia and anxiety. Review of Resident #93's Physician's Orders indicated but was not limited to the following: -Alprazolam (an antianxiety medication) Oral Tablet 0.25 milligrams (mg) Give 0.25 mg by mouth every 12 hours as needed for anxiety (start date 2/5/24, no end date) -Ativan (an antianxiety medication) Oral Tablet 0.5 mg Give 1 tablet sublingually every 4 hours as needed for anxiety (start date 7/7/24, no end date) Review of Resident #93's Medication Administration Record (MAR) indicated that as needed Ativan was administered on: -7/18/24 at 2:04 A.M. -7/20/24 at 1:15 A.M. -7/25/24 at 1:25 A.M. -7/30/24 at 1:42 A.M. (continued on next page)

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	225653	A. Building B. Wing	10/08/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/4/24 at 1:33 A.M. -8/10/24 at 5:04 P.M. -8/21/24 at 1:01 A.M. -8/22/24 at 12:58 A.M. -8/25/24 at 2:12 A.M. -9/4/24 at 1:07 A.M. and 3:44 P.M. -9/20/24 at 4:17 P.M. Review of the MAR for July through October 2024 did not indicate that Resident #93 was administered as needed Alprazolam. Review of Resident #93's medical record failed to indicate that the use of antianxiety medications on an as needed basis was limited to 14 days or extended beyond 14 days with a documented clinical rationale and duration. During an interview on 10/8/24 at 10:40 A.M., Unit Manager #2 said she was aware that the Resident's as needed psychotropic medication orders needed stop dates.

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	225653	A. Building B. Wing	10/08/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 34145 Based on observation, interview, and policy review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to ensure: 1. For Resident #31, who has an indwelling urinary catheter, that staff implemented Enhanced Barrier Precautions (EBP-an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities); and 2. An effective water management program was in place from 7/31/23 to 9/18/24 to prevent the potential growth of Legionella (bacteria that can cause legionellosis [illness caused by Legionella] including a pneumonia-type illness called Legionnaires' disease and a mild flu-like illness called Pontiac fever) and other opportunistic waterborne pathogens. Findings include: 1. Review of the Centers for Medicare and Medicaid Services (CMS) guidance titled Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, indicated but was not limited to: - Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. - EBP are used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing - EBP are indicated for residents with any of the following: a. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO - EBP should be used for any residents who meet the above criteria, wherever they reside in the Facility Review of the facility's policy titled Enhanced Barrier Precautions, dated August 2022, indicated but was not limited to: - EBPs are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms to residents. (continued on next page)

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	225653	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply a. gloves and gown are applied prior to performing the high contact resident care activity - Examples of high contact resident care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care - EBP are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization - Signs are posted in the door or wall outside the resident room indicating the type of precaution and PPE required - PPE is available outside of the residents' rooms Resident #37 was admitted to the facility in August 2023 and had diagnoses including neuromuscular dysfunction of the bladder. Review of the Minimum Data Set (MDS) assessment, dated 9/11/24, indicated Resident #37 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 4 out of 15, and had an indwelling urinary catheter. On 10/2/24 at 8:58 A.M., the surveyor observed an EBP sign posted at the door of Resident #37's room indicating the Resident was on EBP. During an interview with observation on 10/7/24 at 10:33 A.M., Nurse #12 confirmed that Resident #37 had a Foley catheter, but did not know the size of the catheter or the retention balloon and said she was going to look at the catheter itself to obtain that information. Nurse #12 removed two gloves from a box at the nursing desk and walked down the hallway to the Resident's room. The surveyor observed an EBP sign posted at the door of Resident #37's room and a hanging organizer mounted to the closet door inside the Resident's room that stored gowns. The surveyor observed Nurse #12 don gloves without first performing hand hygiene and did not put on a gown before entering the Resident's room and proceeded to reposition the Resident while he/she was reclined in bed. The surveyor observed the Nurse remove the Resident's pants and examine the Foley catheter. Following the observation, Nurse #12 said she did not perform hand hygiene before donning gloves and no one told her the Resident was on precautions. She said she didn't notice the EBP sign posted at the Resident's doorway, and the hanging PPE organizer that was mounted to the closet door just inside the Resident's room. Nurse #12 read the EBP sign posted at the Resident's doorway and said she should have worn a gown when providing high contact care and did not. During an interview on 10/7/24 at 10:55 A.M., Unit Manager #2 said that Nurse #12 should have performed hand hygiene prior to donning gloves and should have worn a gown when removing Resident #37's clothing and examining his/her Foley catheter because it is high contact care. (continued on next page)

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	225653	A. Building B. Wing	10/08/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/8/24 at 1:35 P.M., the Infection Preventionist said Nurse #12 should have performed hand hygiene prior to donning gloves and followed EBP while providing high contact care for Resident #37. 49428 2. Review of the facility's policy titled Legionella Water Management Program, dated as revised September 2022, indicated but was not limited to: - As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. - The water management team consists of at least the following personnel: a. the infection preventionist; b. the administrator; c. the medical director (or designee); d. the director of maintenance; and e. the director of environmental services. - The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. - The water management program includes the following elements: a. an interdisciplinary water management team. b. a detailed description of and diagram of the water system in the facility, including the following: (1) Receiving; (2) Cold water distribution; (3) Heating; (4) Hot water distribution; (5) Waste. c. the identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria. d. the identification of situations that can lead to Legionella growth, such as: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225653	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(5) water temperature fluctuations; (6) water pressure changes; (7) water stagnation; and (8) inadequate disinfection. f. the control limits or parameters that are acceptable and that are monitored; h. a system to monitor control limits and the effectiveness of control measures; j. documentation of the program. - The water management program is reviewed at least once a year, or sooner, if any of the following occur: a. the control limits are consistently not met. During an interview on 10/4/24 at 3:42 P.M., the Director of Maintenance (DOM) said he was new to the facility and had been DOM for about one month. The DOM said he could not provide documentation that a water management program had been implemented prior to his hire. During an interview on 10/7/24 at 2:04 P.M., the Administrator provided a binder of the water management program that was to be in place from 7/31/24 to 9/18/24, but said he could not provide any testing or monitoring documentation during that time. During an interview on 10/7/24 at 3:41 P.M., the Infection Preventionist (IP) said she had not previously participated in the water management program.