STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225663	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Concord	57 Old Road to Nine Acre Corner W Concord, MA 01742

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 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** 43807 Based on record review and interviews, the facility failed to develop personalized care plans for two Residents (#87 and #92) out of a sample of 26 residents. Specifically: 1. For Resident #87, the facility failed to develop personalized care plans after the Speech Therapist made recommendations after two speech evaluations. 2. For Resident #92, the facility failed to develop a personalized history of substance abuse care plan. Findings include: A review of the facility policy titled, 'Care Plans, Comprehensive Person-Centered' with a revision date of December 2016 indicated the following: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. -The comprehensive care plan will: -Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. -Incorporate identified problem areas. -Incorporate risk factors associated with identified problems. -Aid in preventing or reducing decline of the resident's functional status and or/functional levels. 1.) Resident #87 was admitted to the facility in October 2023 with diagnoses including dementia and dysphagia (difficulty swallowing). (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15 indicating moderate cognitive impairment. A review of the Situation, Background, Assessment, and Recommendation (SBAR) dated 2/10/24 indicated the following: -Change in condition noted related to Around 1:35 pm, patient was in the hallway between his/her room and dining when staff notice his/her briefly unresponsive, mouth cyanotic (bluish coloring) and eyes fixed while trying to hand over a bottle of drink to that staff. While assessing him/her further, we notice he/she had something in his/her mouth which looks like smuchy blueberry muffins. Apparently, his/her family brought donuts to him/her and he/she must have eating it too fast and it did not go down the digestive track easily. This change in condition started on 2/10/24. Since this started, it has stayed the same. Other relevant information: Patient has a history of eating too fast [sic] A review of a speech evaluation dated 2/15/24 indicated the following: -Patient noted one time pocketing (holding food in one's mouth without swallowing it) and patient independently cleared with liquids. Discussed with nursing, continue to assist with cutting into small bites, encourage slow rate of intake and alternating with liquids and checking oral cavity at the end of PO (by mouth) intake. Suspected that a diet change will not make a difference with behaviors/pocketing, and patient appears to tolerate regulars with no overt signs and symptoms of aspiration. They (nursing) expressed understanding, agreement with the plan. Discussed to continue with regular thin, if they (family) are here during lunch, encourage washing all food down with liquids at the end of the meal, if they want to bring outside food from home, have the nurses store it in the kitchen for patient and then supervise when eating. [sic] A review of the SBAR dated 12/2/24 indicated the following: - Change in condition noted related to Resident was observed coughing/choking on a piece of waffle, residents' mouth was cleared of any food, but food was still lodged in throat, Heimlich maneuver (abdominal thrusts used as a first aid technique used to dislodge foreign objects that obstruct the upper airway) was performed with good effect. Residents 02 (oxygen) after incident was 86, but went up to 92% RA (Room Air) after a few minutes. This change in condition started on 12/2/24. Since this started, it has gotten better. Treatment for the last episode: resident sent out.[sic] A review of a speech evaluation dated 12/2/24 indicated the following: -Patient seen in the dining room today, speech therapist was initially sitting with a different patient at his/her table. Speech therapist noted patient with an overstuffed oral cavity of waffles. Speech therapist instructed patient to remove the waffles, which he/she followed, he/she then started pointing at his/her throat. When asked if he/she felt food was stuck in his/her throat, he/she nodded yes. Speech therapist called for help, Heimlich maneuver completed. At this time, downgraded diet, discussed diet change and incident with Nursing. [sic] (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/25 at 9:28 A.M., the Speech Therapist said she completed a speech evaluation with Resident #87 on 2/15/24 after the Resident pocketed a muffin that was brought in by family. She said she met with the Resident's family and provided education, she said she made a verbal recommendation to the Unit Manager #1 that food brought in from family should be stored in the kitchen and the Resident should only eat it with staff supervision. The Speech therapist also said she verbally explained the following to Unit Manager #1, the Resident has a history of fast paced eating, and his/her mouth should always be checked for pocketing prior to exiting the dining area after meals. The Speech Therapist said she completed another speech evaluation with Resident #87 on 12/2/24 after he/she choked and received the Heimlich maneuver. She said she met with the Unit Manager #1 and made the following verbal recommendations, check for pocketing prior to leaving the dining area after meals, change the Resident's seating in the dining room so that the Resident is visible to all staff, and Resident #87 has a history of fast-paced eating. The Speech Therapist said she makes verbal recommendations to the Unit Manager and expects her to develop a personalized care plan, so all staff are aware of Resident #87's needs during meals. A review of Resident #87's care plan failed to indicate that the Speech Therapist's recommendations were developed and implemented into Resident #87's care plan after the evaluations on 2/15/24 and 12/2/24. During an interview and record review on 1/23/25 at 9:42 A.M., Unit Manger #1 said she was aware of the verbal recommendations made by the Speech Therapist on 2/15/24 and 12/2/24. She said she did not develop personalized care plans based on the recommendations but should have. Unit Manger #1 added that Resident #87 gets very anxious on Fridays before his/her family member visits and tends to eat in a very fast paced manner. She said the fast-paced eating could be triggered by anxiety. Unit Manager #1 said this information should also be added and personalized in Resident #87's care plan. During an interview on 1/23/25 at 1:20 P.M., the Director of Nurses said she expects all verbal recommendations from the Speech Therapist to be addressed by the Unit Manager and added in the care plan. The DON said the verbal recommendations and information provided by the Speech Therapist on 2/15/24 and 12/2/24 should have been care planned. 2.) A review of the facility policy titled, 'Substance Use Disorder' dated November 2022 indicated the following: -Residents who are admitted to the facility with substance use disorder (SUD) will receive the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being, provided by the facility and in accordance with the comprehensive assessment and care plan. -The resident's history of substance use disorder and risk for using substances which could lead to an overdose while in the facility are identified to the extent possible and documented in the medical record. Resident #92 was admitted to the facility in August 2024 with diagnoses including alcohol abuse and schizoaffective disorder. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 4 out of a possible 15 indicating cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #92's Nutritional care plan initiated 8/28/24 indicated the following: -Diagnosis of encephalopathy and ETOH (alcohol) abuse. A review of the behavioral medication management progress notes dated 12/30/24 indicated the following: -Substance Use/Addiction History-History of ETOH (Alcohol) use disorder. During an interview and medical review on 1/23/25 at 10:30 A.M., the Social Worker reviewed the medical record and said a history of ETOH abuse care plan should be added even though Nutrition has addressed the ETOH abuse in the care plan. The Social Worker said a personalized ETOH abuse care plan should be developed and address the interventions from a mood and behavior perspective. During an interview on 1/23/25 at 1:20 P.M., the Director of Nurses said Resident #92 should have a personalized history of substance use care plan.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41105 Based on record review and interview, the facility failed to ensure accurate documentation in the medical record for one Resident (#88) out of a total sample of 26 residents. Specifically, for Resident #88, nursing documentation in the Medication Administration Record (MAR) regarding the Resident's wanderguard was inaccurate. Findings include: Review of the facility policy titled Charting and Documentation, dated as revised July 2017, indicated the following: -Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. Resident #88 was admitted to the facility in September 2023 and has diagnoses that include dementia and Parkinson's disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/22/24, indicated that on the Brief Interview for Mental Status exam Resident #88 scored a 4 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #88 had behavior of wandering 4-6 days in the previous 7 days. Review of Resident #88's current care plan indicated the following: Focus: Elopement/wandering risk related to cognitive impairment, initiated 1/2/24. Interventions include: -Check for placement and function of security bracelet as indicated, initiated 1/2/24. -Wanderguard to left ankle, initiate 1/2/24. Review of Resident #88's current Physician's orders indicated the following order: -Wanderguard, Expiration Date 5/26, every shift Wanderguard to left ankle. Check placement and function every shift. Start date of 11/13/24. Review of the January 2025 Medication Administration Record (MAR) indicated that in January 2025 nursing had documented 19 times no that Resident #88's wanderguard was not in place or functioning. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/25 at 10:00 A.M., with Nurse #2 she said that she is Resident #88's nurse on a regular basis. Nurse #2 said that Resident #88 wears a wanderguard due to behavior of trying to elope. She said that the Resident has no behavior of removing the wanderguard and that she should be documenting yes in the MAR, to indicate that the wanderguard is in place and functioning. Nurse #2 and the surveyor reviewed the MAR where Nurse #2 documented 15 of the 19 no entries that were in the MAR and she said that needed to be fixed. During an interview on 1/23/25 at 11:02 A.M., with the Director of Nursing she said that it is her expectation that the documentation in the MAR be accurate