STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225668	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadows of Central Massachusetts (the)	111 Huntoon Memorial Highway Rochdale, MA 01542

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 47901 Based on observation, interview, record and policy review, the facility failed to identify and notify the Physician/Nurse Practitioner (NP) timely of a change in urinary catheter (also known as a Foley catheter - a flexible tube inserted into the bladder to drain urine outside of the body) condition for one Resident (#210) out of a total sample of 17 residents. Specifically, Resident #210, the facility failed to monitor and assess bleeding from the urinary catheter and notify the Physician/NP timely for required interventions, resulting in hospitalization for gross hematuria (excessive blood in the urine). Findings include: Review of the facility's policy titled Urinary Catheter Insertion, Maintenance and Removal, revised August 2024, indicated: -Indwelling urinary catheters may be beneficial to patients to assist with draining of urine. -To reduce the risk of infection and other negative outcomes, urinary catheters must be placed with care on the correct patients, maintained with appropriate technique, and removed when no longer necessary. Review of the facility's policy untitled and undated, indicated: -The facility shall promptly notify the resident and/or the resident representative and his or her Physician of changes in the resident's condition or status to obtain orders for appropriate treatment and monitoring and promote the resident's right to make choices about treatment and care preferences. -The Nurse will immediately notify the Resident, Resident's Physician and the Resident Representatives for the following (list not all inclusive): a) significant change in the Resident's physical, mental, or psychosocial status that is deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) a need to alter treatment significantly (a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment). c) a decision to transfer or discharge the resident from the facility. -The Nurse will notify the Resident, Resident's Physician and the Resident Representatives(s) for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician. -Document the notification and record any new orders in the resident's medical record. -Educate the Resident and/or Representative about the proposed plan to treat, manage or monitor the Resident's change in condition. -Update the Resident's care plan, transcribe and implement the Provider's orders. Resident #210 was admitted to the facility in September 2024, with diagnoses including Urinary Retention (difficulty urinating and completely emptying the bladder) and ataxic gait (type of walking characterized by a lack of coordination and balance, resulting in unsteady, irregular and wide-based gait), acute embolism (a clot that breaks loose and travels to another part of the body, blocking blood flow in a large artery or branch) and Thrombosis (a blood clot that forms in a vein, artery, or the heart, narrowing the vessel and restricting blood flow) of unspecified deep veins of lower extremity (legs). On 10/8/24 at 10:19 A.M., the surveyor observed Resident #210 ambulating in the hallway with the Physical Therapist (PT). The surveyor observed that the Resident had a urinary catheter tubing that went down through his/her pants and was hung on the base of the walker (mobility device) while the Resident was ambulating. On 10/8/24 at 4:16 P.M., the surveyor observed Resident #210 ambulating in the hallway with the Physical Therapist and the Resident had a urinary catheter tubing that was observed down through his/her pants and hung on the base of the Resident's walker while he/she was ambulating. The surveyor observed that the urine in the urinary catheter tubing was bloody. Review of Resident #210's October 2024 Physician's orders did not indicate any orders for the care and maintenance of the Foley catheter. Further review of the Physician's orders indicated that the Resident was prescribed Eliquis (anticoagulant/blood thinner medication) 5 mg (milligrams) tablet two times a day, ordered on 10/1/24. Review of the Resident's Discharge Record from the hospital dated 9/30/24, indicated: -Urinary retention with history of Chronic Kidney Disease (CKD - when the kidneys are damaged and cannot filter blood the way that it should), Parkinson's Disease (a progressive degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination), Foley catheter was placed in the ICU - Intensive Care Unit. -Foley was removed on 9/23/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Trial voiding was attempted on 9/24/24 but due to persistent retention and patient preference to avoid intermittent straight catheterization (insertion of a flexible tube through the urinary opening into the bladder; after the bladder is drained of urine the tube is removed), Foley was replaced. -Outpatient follow-up with Urology (medical and surgical specialty that manages the health of the urinary system) is recommended for voiding trial. -Foley catheter was last exchanged on 9/24/24. -Continue Flomax (alpha blocker medication that relaxes the muscles of the bladder to allow urine to flow more easily). During an interview on 10/8/24 at 4:38 P.M., the surveyor and Nurse #3 reviewed Resident #210's Physician's orders. Nurse #3 said that a Certified Nurses Aide (CNA) had reported to Nurse #3 that the Resident had blood in the urine. Nurse #3 said she would call the Physician for Foley catheter care orders and would also report the bleeding to the Physician. During an observation and interview on 10/9/24 at 8:15 A.M., Resident #210 said he/she could not understand why he/she was not getting better. The surveyor observed that the Foley catheter tubing remained with bloody urine. Review of Resident #210's October 2024 Medication Administration Record (MAR) indicated the Resident was administered the Eliquis medication at 8:00 A.M. on 10/9/24. During an interview on 10/9/24 at 11:30 A.M., Nurse #3 said she did not have time on 10/8/24 to notify the Physician about Resident #210's bloody urine observed in the Foley catheter tubing, and that she had asked a CNA to inform the Nurse working on the medication cart. During an interview at the same time, Nurse #2 said he was the Nurse that took care of Resident #210 on 10/8/24 from 7:00 A.M. to 11:00 P.M., but he was not aware that the Resident had a Foley catheter and had bloody urine. During an interview on 10/9/24 at 11:35 A.M., Unit Manager (UM) #1 said she was not aware Resident #210 had a Foley catheter and she had not been made aware that the Resident had bloody urine. During an interview on 10/10/24 at 11:45 A.M., the facility's NP said she was aware that Resident #210 had a Foley catheter on admission. The NP said she received a text message from UM #1 informing her that Resident #210 had hematuria on 10/9/24, and she gave an order to hold (not administer) the Resident's Eliquis for two days. The NP said she did not order any laboratory workup because UM #1 did not make it clear that the Resident had gross hematuria. The NP further said she gave an order on 10/10/24 for the Resident to be sent out to the hospital when UM #1 notified her that Resident #210 had gross hematuria. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/24 at 12:08 P.M., UM #1 said Nurse #3 had called a covering Physician on 10/9/24 during the 7:00 A.M. to 3:00 P.M. (Day) shift for Resident #210's Foley catheter to be changed, to obtain urine for urinalysis and sensitivity (laboratory test) but Nurse #3 passed the order on to the 3:00 P.M. -11:00 P.M. (Evening) Nurse Supervisor. UM #1 said the Evening Nurse Supervisor said he did not have time to follow through with the Physician's orders for Resident #210 and passed the orders on to the 11:00 P. M. to 7:00 A.M. (Night) shift. UM#1 further said the Night shift Nurse was able to re-insert a new Foley catheter at 4:00 A.M. on 10/10/24, after the Night shift Nurse noted that Resident #210's abdomen was distended. UM #1 said the newly inserted Foley catheter drained 1000 ml (milliliters) of bloody urine. UM #1 said she notified the NP when she (UM #1) came in for the morning shift at 7:00 A.M. and obtained orders from the NP to transfer Resident #210 to the hospital. During an interview of 10/10/24 at 12:52 P.M., the facility's Physician said he was aware the Resident had a Foley catheter, but it was up to nursing to ensure the care and services was provided. The facility Physician said he was not aware the Resident had bleeding in his urine.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 42761 Based on observation, interview, record and policy review, the facility failed to provide a homelike environment, relative to accessibility of the call bell, for one Resident (#108) out of a total sample of 17 residents. Specifically, for Resident #108, the facility failed to ensure ready access to his/her call device when the Resident was dependent on staff for his/her care needs and was able to use an alternate call pad device (altered device for a call light that is activated by being tapped rather than pressed by a finger or thumb), which increased the Resident's risk for not having his/her care needs met timely and appropriately. Findings include: Review of the facility's policy titled Call Devices for Patients, dated March 2018 and last reviewed December 2023, indicated the following: -Appropriate devices shall be made available to help facilitate patient communication needs. -If the patient cannot demonstrate appropriate use of the standard call light, the Nurse shall evaluate the patient's ability to use alternative call devices, . -If the patient demonstrates appropriate use of an alternative call device, the Nurse shall secure the device proximal to the patient. Resident #108 was admitted to the facility in August 2024 with diagnoses including Unspecified Cord Compression (pressure on the spinal cord that can affect one's body movements and function). Review of Resident #108's Spinal Injury Care Plan, dated 8/13/24, indicated the Resident had Quadriplegia (complete paralysis of the body from the neck down) related to a surgical spinal injury. Review of Resident #108's Activities of Daily Living (ADL) Care Plan, dated 8/5/24, indicated the Resident had a self-care performance deficit related to Quadriplegia. Further review of the Resident's ADL Care Plan indicated: -The Resident was totally dependent on staff for eating and oral care. -The Resident required assistance of two staff to turn and reposition in bed. -Staff were to encourage the Resident to use his/her call device for assistance. Review of Resident #108's Minimum Data Set (MDS) Assessment, dated 8/15/24, indicated the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total possible points. -The Resident demonstrated no rejection of care. -The Resident had limited functional range of motion in both of his/her upper and lower extremities. -The Resident required substantial/maximal assistance from staff for eating. -The Resident was dependent on staff for oral hygiene, bathing, dressing, bed mobility, and transfers. -The Resident did not walk and required the use of a wheelchair. -The Resident had frequent pain at a level of eight out of 10. On 10/8/24 at 10:20 A.M., the surveyor observed the following: -Resident #108 was positioned in bed, lying on his/her back, with both lower extremities elevated. -Quarter length side rails were in the up position on both sides of the bed. -The cord to the Resident's call device was attached to the wall and secured to the top of the side rail on the Resident's left side. -The cord was positioned between the Resident's side rail and mattress and the call pad device was observed to be dangling below the level of the Resident's bed, just above the floor. During an interview at the time, Resident #108 said he/she was thirsty, having pain, and could not locate his/her call pad device. Resident #108 said he/she needed the call pad device to alert staff when he/she needed assistance, because his/her ability to care for him/her self was very limited since his/her spinal injury. The Resident also said that his/her call device was supposed to be positioned on the mattress, near his/her left hand so that he/she could tap the call pad using the back of his/her hand. The Resident further said this was the only way he/she could activate the call pad device. During an interview on 10/8/24 at 10:37 A.M., Nurse #1 said that Resident #108's call pad device needed to be positioned so that the Resident could access the device and that use of the call pad device was how the Resident was able to alert staff when he/she needed something. On 10/9/24 at 8:45 A.M., the surveyor observed Resident #108 positioned in bed, lying on his/her back. The surveyor observed the Resident's call pad device was positioned on the mattress between the Resident's body and left arm, just below the Resident's left elbow. The surveyor observed Resident #108 rotate his/her arm outward two times consecutively, hitting the mattress with the back of his/her hand, then sigh loudly. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at the time, Resident #108 said he/she was rotating his/her arm in an attempt to activate the call pad device, but he/she could not locate the call pad. Resident #108 said staff needed to position the call pad device so that he/she could rotate his/her arm outward in order to tap the device with the back of his/her hand, but the call pad was not in the right place. During an interview on 10/9/24 at 10:19 A.M., the Assistant Director of Nursing (ADON) said that Resident #108 was unable to position his/her own call pad device and that Resident #108 was dependent on staff to position the device for the Resident. The ADON said Resident #108 required the use of the call pad device in order to alert staff when he/she needed assistance. Please Refer to F697.

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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** 48206 Based on record and policy review, observation, and interview, the facility failed to develop a plan of care for appropriate treatment and services related to limited range of motion for one Resident (#42), out of a total sample of 17 Residents. Specifically, for Resident #42, the facility failed to develop a plan of care relative to positioning for the Resident after he/she was assessed and recommendations made by Rehabilitative Services for a specialty wheelchair and molded lateral supports (fitted equipment that help reinforce body support and reduce postural deformity). Findings include: Review of the facility policy titled Comprehensive Resident Centered Care Plans, last revised December 2021, indicated: -Updating care plans: 1. Care plans are modified between care plan conference when appropriate to meet the resident's current needs, problems, and goals. 2. Stand up meetings of the Director of Nursing (DON), Social Services Coordinator, MDS coordinator, Registered Dietician, Activities Director, and Therapy Professional are held to review the current status of skilled residents and determine needed interventions to meet resident goals. 3. The Care Plan will be updated and/or revised for the following reasons: >Significant change in the resident's condition >A change in planned interventions >Goals are obtained and new goals established to meet current resident needs and/or goals 4. Any revision, additions, or deletion to the plan of care will be dated and initialed. 5. Revisions involving the care of other disciplines are done through consultative and collaborative efforts and documented as above. Resident #42 was admitted to the facility in August 2022, with diagnoses including Traumatic Brain Injury (TBI - a form of acquired brain injury that occurs when a sudden trauma causes damage to the brain), Contracture (a permanent shortening [as of muscle, tendon, or scar tissue] producing deformity or distortion) of right hand, Contracture of left hand, Contracture of left wrist, and Contracture of left elbow. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #42: (continued on next page)

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	225668	A. Building B. Wing	10/11/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was rarely to never understood and severely cognitively impaired as evidenced by a staff assessment. -was dependent on staff for all ADLs (ADLS- activities related to personal care which include bathing, dressing, grooming and eating). -had abnormal posture, left and right foot drop (difficulty lifting the front part of the foot), and contracture to his/her left elbow. -that no therapies had been provided since the last comprehensive assessment. On 10/10/24 at 8:52 A.M., the surveyor observed Resident #42 seated in Geri chair (large padded recliner wheeled chair) with the head of the chair angled backwards with a pillow underneath his/her head, a pillow underneath his/her right arm, and a bolster (a long, thick pillow that is placed under other pillows for support) underneath his/her legs which were elevated. Review of Resident #42's Plan of Care relative to ADLs, initiated 9/1/22 and last revised 6/7/24, indicated: -Resident #42 had an ADL self care performance deficit related to diagnosis of TBI and contractures, initiated 9/1/22. -Resident able to answer yes/no questions, utilize his/her fingers. 1 finger means yes and 2 fingers means no, initiated 6/7/24. -Mobility: wheelchair assistance of (1) staff, initiated 11/10/22. -Bed Mobility: is totally dependent on two staff for repositioning and turning in bed, initiated 9/1/22 -Transfer: [Resident] is totally dependent on (2) staff and a mechanical lift for transfers, initiated 11/10/22. -PT/OT evaluation and treatment as per MD orders, initiated 9/1/22. Review of the Plan of Care relative to risk for falls, initiated 9/1/22 and last revised 12/1/23, indicated: -Resident #42 was at moderate risk for falls due to deconditioning, initiated 9/1/22. -Intervention: Bolsters to be in the chair when [Resident] in it [chair], last revised 12/1/23. -PT evaluate and treat as ordered or PRN, last revised 9/20/22. Review of Resident #42's Physician's orders indicated: -Physical Therapy Eval of [Resident's] recliner chair, initiated 6/7/24 and discontinued 6/21/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Referral/Screen to Rehab Services form, dated 6/7/24, indicated: -Resident #42 was leaning to the side when he/she is in the chair. -Rehab results documented that no triggers were indicated to support skilled rehab intervention at this time. -Resident in Geri chair appears Resident unable to reposition self. -Tilt-in-space with molded lateral supports or lateral support on backside and leg positioner is appropriate. Review of the Nursing Progress Note, dated 6/7/24, indicated: -[Physical Therapy] had evaluated Resident #42 in Geri chair. -Resident was unable to reposition self. -Tilt-in-space with molded lateral support or lateral support on backside and leg positioner is appropriate. Further review of the medical record did not indicate that the Plan of Care relative to ADLs or positioning was reviewed or revised for Resident #42 after new interventions were recommended by Rehabilitative Services on 6/7/24. During an interview on 10/10/24 at 12:08 P.M., the Rehabilitation Director said that Resident #42 was screened by rehab as staff were not positioning him/her well in his/her chair. The Rehab Director said that Rehab Department completes the screening form after they have evaluated a Resident and then the Rehab Director will communicate the screening results to the Nursing department and it is nursing's responsibility to implement the rehab recommendations. On 10/10/24 at 1:10 P.M., the surveyor and the Rehab Director observed Resident #42 seated in a Geri chair with the head of the chair reclined, feet elevated with a bolster underneath the feet, and pillows under his/her head, and left and right arms. During an interview at the time, the Rehab Director said that the Resident was in a Geri Chair, not a Tilt-in-space chair. The Resident was observed to have a leg positioner in place. The Rehab director said that based on her observation of the Resident, she would not consider Resident #42's current position to be effective and that the interventions recommended on the 6/7/24 screening were not in place. During an interview on 10/10/24 at 1:24 P.M., Nurse #6 said when a Resident has specific positioning needs, therapy/rehab staff would put in Physician's orders, and nursing staff would then document those positioning needs under the Physician's order and in the Medication Administration Record (MAR). Nurse #6 said that Rehab staff and the Nursing Supervisors would educate the CNAs (Certified Nurses Aides) and the Nursing staff when new positioning devices were needed. Nurse #6 said that he was not aware of Resident #42 having any specialty positioning devices. (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 10/10/24 at 1:34 P.M., Unit Manager (UM) #1 said that the Rehab Department would normally provide a Rehabilitation Screening Form with recommendations for a Resident and that she would then provide education to the Nursing staff on the rehab recommendations. UM #1 said that Resident #42's family had wanted him/her in a tilt-in-space chair and the rehab department would be responsible for ordering a specialty wheelchair. UM #1 said that she was unable to recall if any bolsters were in place for Resident #42 or if a tilt-in-space chair was ever ordered for the Resident. During an interview at the same time, the Rehab Director said she had molded lateral supports available in the facility but she was unsure if a tilt-in-space chair had been ordered. The Rehab Director said that she would complete a rehab screen today, evaluate if a tilt-in-space chair was necessary, and would start the process to add molded lateral supports for Resident #42.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on observation, interview, record and policy review, the facility failed to provide urinary catheter (also known as a Foley catheter - a flexible tube inserted into the bladder to drain urine outside of the body) care and services according to professional standards of practice for three Residents (#210, #44 and #42) out of a total sample of 17 residents, which increased the Residents' risk for urinary catheter complications. Specifically, the facility failed to: 1. For Resident #210, identify that the Resident was admitted to the facility with a urinary catheter, resulting in delayed monitoring and assessment of the Resident's urinary catheter and obtaining Physician orders to implement catheter care and management when hematuria (blood in urine) was identified. 2. For Resident #42, obtain a Physician's order for a specific type of external urinary catheter. 3. For Resident #44, insert the right size of Foley catheter ordered by the Physician. Findings include: Review of the facility's policy titled Urinary Catheter Insertion, Maintenance and Removal. revised August 2024, indicated: -Indwelling urinary catheters may be beneficial to patients to assist with draining of urine. To reduce the risk of infection and other negative outcomes, urinary catheters must be placed with care on the correct patients, maintained with appropriate technique, and removed when no longer necessary. -Patients admitted with an indwelling catheter should be reviewed for need of catheter upon admission. Whenever available, the date of the catheter insertion should be noted in the electronic medical record. -Patients should be assessed daily for need of the urinary catheter and determine whether removal with the nurse-drive protocol may be followed. -Maintain proper securement of the catheter for the duration of dwell. Change securement device every seven days following manufacturer instructions. -Review catheter necessity and goal for discontinuation daily, and with each hand off. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225668	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadows of Central Massachusetts (the)	111 Huntoon Memorial Highway Rochdale, MA 01542

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #210 was admitted to the facility in September 2024, with diagnoses including Urinary Retention (condition that occurs when a person is unable to empty their bladder completely or partially of urine), Ataxic Gait (type of walking characterized by a lack of coordination and balance, resulting in unsteady, irregular and wide-based gait), acute embolism (a clot that breaks loose and travels to another part of the body, blocking blood flow in a large artery or branch) and Thrombosis (a blood clot, forms in a vein, artery, or the heart, narrowing the vessel and restricting blood flow) of Unspecified Deep Veins of lower extremity. On 10/8/24 at 4:16 P.M., the surveyor observed Resident #210 ambulating with the Physical Therapist in the hallway. The surveyor observed that the Resident had a urinary catheter tubing that went down through his/her pants and was hung on the base of the walker (mobility device) while he/she was ambulating. The surveyor observed that the urine in the urinary catheter tubing was bloody. Review of Resident #210's October 2024 Physician's orders did not indicate any orders for the care and maintenance of the Foley catheter. Review of the Resident's Discharge Record from the hospital dated 9/30/24, indicated: -Urinary retention with history of Chronic Kidney Disease (CKD - when the kidneys are damaged and cannot filter blood the way that it should), Parkinson's Disease (a progressive degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination), Foley catheter was placed in the ICU - Intensive Care Unit. -Foley was removed on 9/23/24. -Trial voiding was attempted on 9/24/24 but due to persistent retention and patient preference to avoid intermittent straight catheterization (insertion of a flexible tube through the urinary opening into the bladder; after the bladder is drained of urine the tube is removed), Foley was replaced. -Outpatient follow-up with Urology (medical and surgical specialty that manages the health of the urinary system) is recommended for voiding trial. -Foley catheter was last exchanged on 9/24/24. -Continue Flomax (alpha blocker medication that relaxes the muscles of the bladder to allow urine to flow more easily). During an interview on 10/8/24 at 4:38 P.M., the surveyor and Nurse #3 reviewed Resident #210's Physician orders and found no evidence of orders for urinary catheter care and maintenance. Nurse #3 said Resident #210 had no Physician orders for Foley catheter care and services because the Resident was not admitted with a Foley catheter, but the Resident had a Foley catheter while he/she was at the hospital. The surveyor and Nurse #3 reviewed the Discharge Record from the hospital for the Resident which indicated he/she had a Foley catheter on admission to the facility. During an interview on 10/8/24 at 5:00 P.M., the Assistant Director of Nursing (ADON) said she had been made aware that Resident #210 had no Physician orders for care and services of the Foley catheter and she would follow-up pertaining to the orders. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/8/24 at 5:02 P.M., the Director of Nursing Services (DNS) said she knew Resident #210 was admitted to the facility with a Foley catheter but was not aware that the Resident did not have Physician orders for the care and services of the Foley catheter and would follow-up pertaining to the orders. During an interview on 10/9/24 at 8:00 A.M., the MDS Nurse said she was made aware that Resident #210 had no Physician orders for the care and management of the Foley catheter and that she had obtained orders from the Physician and entered the orders into the Electronic Medical Record (EMR) on 10/9/24 at 7:41 A.M. On 10/9/24 at 8:15 A.M., the surveyor observed that the urine in Resident #210's Foley catheter tubing remained bloody. During an interview on 10/9/24 at 11:30 A.M., Nurse #3 said she did not have time to notify the Physician the previous day (10/8/24) about Resident #210's need for care and services of Foley catheter and or his/her bleeding. Nurse #3 said she had asked a Certified Nurses Aide (CNA) to inform the Nurse on the medication cart about the bloody urine in the Resident's urinary catheter. During an interview at the time, Nurse #2 said he was the Nurse that took care of Resident #210 on 10/8/24 from 7:00 A.M. to 11:00 P.M., but he was not aware that the Resident had a Foley catheter and had hematuria. During an interview on 10/9/24 at 11:35 A.M., Unit Manager (UM) #1 said she was not aware Resident #210 had a Foley catheter and she had not been made aware that the Resident had blood in his/her urine. During an interview of 10/10/24 at 12:52 P.M., the facility's Physician said he was aware the Resident had a Foley catheter, but it was up to nursing to ensure the urinary care and services was provided. 2. Resident #42 was admitted to the facility in August 2022, with diagnoses including Diffuse Traumatic Brain Injury (TBI - a form of acquired brain injury that occurs when a sudden trauma causes damage to the brain) and Tracheostomy (a medical procedure that involves creating an opening in the neck in order to place a tube into a person's trachea, or windpipe). On 10/9/24 at 9:58 A.M., the surveyor and Nurse #1 observed Resident #42. Nurse #1 said Resident #42 had an external type urinary catheter attached to a drainage bag. The surveyor and Nurse #1 reviewed the Resident's October 2024 Physician's orders and Nurse #1 said Resident #42 did not have orders for an external type urinary catheter. Nurse #1 said Resident #42 should have had orders for the external type urinary catheter. 3. Resident #44 was admitted to the facility in October 2022, with diagnoses including Traumatic Subarachnoid Hemorrhage (bleeding in the space between the brain and the tissue covering the brain) with Loss of Consciousness of Unspecified Duration and Acute Pyelonephritis (bacterial infection of the kidneys). Review of Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #44: -had cognitive loss and never understood others (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was dependent on staff for bathing, dressing, grooming and toileting. Review of Resident #44's October 2024 Physician's orders indicated: -suprapubic catheter (a thin, flexible tube that drains urine from the bladder through a small incision in the lower abdomen) secondary to neurogenic bladder (a urinary dysfunction in which the bladder does not empty properly) Depending on the type of neurological disorder causing the problem, the bladder may empty spontaneously (incontinence) or may not empty at all (retention with overflow leakage), 16 French with 30 ml (milliliters) of balloon (retention balloon- a tiny balloon at the end of the indwelling urinary catheter that is inflated with water to prevent the indwelling urinary catheter from sliding out of the body) ordered on 10/8/24. On 10/9/24 at 9:41 A.M., the surveyor and Nurse #1 observed that Resident #44 had a 20 French suprapubic urinary catheter with 30 ml balloon. Nurse #1 said the suprapubic urinary catheter size did not match the Physician's order. During an interview on 10/9/24 at 10:30 A.M., the Director of Nursing (DON) said all Residents are required to have Physician's orders for urinary catheter usage and Residents #210 and #42 should have Physician orders but they did not. The DON further said the facility staff should have followed the Physician's order for a 16 French (not 20 French) urinary catheter inserted for Resident #44, but they did not.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 42761 Based on observation, interview, record and policy review, the facility failed to provide care and services for assisted nutrition and hydration in accordance with the Physician order for one Resident (#46), who required Total Parenteral Nutrition (TPN: method of providing nutrition where a liquid formula is given into a vein through an intravenous catheter (IV) to provide most of the nutrients a resident needs, used when a resident cannot or should not eat or drink by mouth) of one resident who required TPN, out of a total sample of 17 residents. Specifically, the facility failed to provide Clinimix E (IV nutritional product containing amino acids [building blocks of protein] with electrolytes [electrically charged minerals that play important roles in the body] in Dextrose [simple sugar] with Calcium [mineral needed by the body]) and SMOFlipids (IV nutritional product containing calories and essential fatty acids) infusions to Resident #46 in accordance with the Physician's order, increasing the Resident's risk for malnutrition. Findings include: Resident #46 was admitted to the facility in August 2024, with diagnoses including Unspecified Intestinal Obstruction and Gastro-Esophageal Reflux Disease (GERD-gastro-esophageal reflux disease, a condition that causes heartburn or acid indigestion). Review of Resident #46's Hospital Discharge Summary, dated 8/11/24, indicated the following: -The Resident had been admitted to the hospital with a small bowel obstruction (SBO). -The Resident required TPN indefinitely due to concern and high risk for re-obstruction given complicated abdominal surgery history. -The Resident would require outpatient surgery follow-up for advancement of diet. -Nutrition was required to be administered via TPN through a PICC (Peripherally Inserted Central Catheter: long, thin tube that's inserted through a vein in one's arm and passed through to the larger veins near the heart) line. Review of Resident #46's Parenteral Nutrition Prescription Order Form, dated 9/26/24, indicated the following: -The Resident required Clinimix E 5% Amino/15% Dextrose 1 L (Liter). -The Resident was to receive a total volume of 2000 mL (milliliters; 2000 mL = 2 L) of Clinimix E, infused over 18 hours (56 mL/hour for one hour, then increase to 118 mL/hour for 16 hours, then decrease to 56 mL/hour for one hour, then stop for six hours). -The Resident required 50 G (grams) of SMOFlipids. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The SMOFlipids were to be infused separately from the Clinimix E at a rate of 20.8 mL/hour, infused over 12 hours. Review of Resident #46's active Care Plan indicated the following: -The Resident was at potential nutrition risk due to need for TPN. -The Resident was at potential risk for dehydration due to need for TPN. -Staff were required to provide medications as ordered. -Staff were required to provide IV fluids/TPN as ordered. Review of Resident #46's October 2024 Physician orders indicated the following: -Clinimix E 5% Dex (Dextrose) 15%. Infuse Clinimix 2000 mL IV cycled over 18 hours at initial rate of 56 mL x 1 hour. Then increase to 118 mL/hour x 16 hours. Then decrease to 56 mL/hour x 1 hour. Then stop for 6 hours ., initiated 9/30/24 with no stop date. -Document amount of TPN administered every shift, initiated 5/15/24 with no stop date. -Infuse SMOFlipid IV continuously at 20.8 mL/hour x 12 hours at room temperature. Infuse in a different line from TPN, initiated 9/26/24 with no stop date. Review of Resident #46's October 2024 Medication Administration Record (MAR) indicated the following: -The Resident received the total ordered dose of 2000 mLs Clinimix E that was ordered to be administered starting at 6:00 P.M. on 10/9/24 and ending at 12:00 P.M. on 10/10/24. -The Resident received the total ordered dose of SMOFlipids that were ordered to be administered starting at 6:00 P.M. on 10/9/24 and ending at 6:00 A.M. on 10/10/24 at 20.8 mL/hour (total dose of 249.6 mLs). On 10/10/24 at 1:22 P.M., the surveyor observed the following in Resident #46's room: -The Resident was positioned on the bed. -One 2000 mL bag of Clinimix E hung on an IV pole and the tubing from the bag was connected to one of the ports on the Resident's PICC line. -The IV pump administering the Clinimix E was running at a rate of 56 mL/hour. -The bag of Clinimix E was approximately one quarter full. -One 250 mL bag of SMOFlipids hung on another IV pole in the room. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The bag of SMOFlipids was not connected to the Resident's PICC line and the IV pump was not running. -The bag of SMOFlipids was approximately one third full. During an interview at the time, Resident #46 said the Clinimix E was still being infused from the prior evening but should have been done around noon time that day. Resident #46 also said he/she was unsure whether the SMOFlipids should have been infusing at that time. During an interview and observation on 10/10/24 at 1:50 P.M., Nurse #7 said he worked the prior evening (10/9/24) and hung Resident #46's Clinimix E and SMOFlipids for administration. Nurse #7 said he knew the Resident had a lab draw in the morning on 10/10/24 and that the infusions needed to be stopped in order to prepare for the lab to draw the Resident's blood. Nurse #7 said he reconnected the Clinimix E to continue the infusion for Resident #46 after the lab collected the blood sample, but he did not reconnect the SMOFlipids. Nurse #7 said that the SMOFlipids were not to be reconnected once they stopped infusing, but he did not know why. At this time, the surveyor and Nurse #7 observed Resident #46 and the bags of Clinimix E and SMOFlipids. Nurse #7 said there were approximately 400 mLs left in the Clinimix E bag that had not yet been infused and approximately 40 mLs left in the SMOFlipids bag that had not been infused from the prior evening. Nurse #7 said the Clininmix E was scheduled to be infused from 6:00 P.M. for 18 hours, and would be completed around 12:00 P.M. Nurse #7 also said the SMOFlipids were scheduled to be infused from 6:00 P.M. for 12 hours, and should have been completed around 6:00 A.M. Nurse #7 then turned to Resident #46 and said You're done. At this time, the surveyor observed Nurse #7 stop the Clinimix E infusion and disconnect the IV tubing from the Resident's PICC line port. Nurse #7 then removed the bags of Clinimix E and SMOFlipids from the IV poles and turn toward the room exit. Nurse #7 said that the Resident should not have left over Clinimix E and leftover SMOFlipids, but that the Resident was due for another infusion at 6:00 P.M. Nurse #7 said he needed to disconnect the Clinimix E because the Resident was supposed to have six hours between infusions and the Clinimix infusion was already stopped too late. Nurse #7 said that there was nothing he could do about the leftover Clinimix E and SMOFlipids other than discard it and that he would just need to let the Nurse coming in for the evening (3:00 P.M. through 11:00 P.M.) shift to start the Resident's next infusion late. Review of Resident #46's Comprehensive Metabolic Panel (CMP: blood test that measures proteins, enzymes, electrolytes, minerals and other substances in one's body) indicated the Resident's total protein level was 6.4 grams (g)/deciliter (dL) (normal reference range 6.6 - 8.7 g/dL). Review of a Physician's order, dated 10/10/24, indicated Dietitian Consult related to low protein. (continued on next page)

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	225668	A. Building B. Wing	10/11/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/11/24 at 7:57 A.M., the Assistant Director of Nursing (ADON) said Resident #46 required TPN and required infusions of Clinimix E and SMOFlipids to be administered according to the Physician's orders. The ADON said if the Resident did not receive the ordered infusions within the scheduled time frame, the Nurse was required to call the Pharmacy to identify the shelf life of the Clinimix E and SMOFlipids after being removed from the refrigerator and opened, to determine whether it would be safe to continue to administer the infusions past the ordered timeframes. The ADON also said the Nurse was required to call the Physician and obtain orders whether to continue the infusions beyond the scheduled infusion timeframes and to obtain orders if the timeframes for the next infusions needed to be altered. The ADON said that there should not have been leftover Clinimix E or SMOFlipids on 10/10/24 from the Resident's infusions that were administered starting at 6:00 P.M. on 10/9/24. During an interview on 10/11/24 at 10:18 A.M., the Dietitian said that facility staff were responsible to alert her if a Resident's assisted nutrition and hydration was not being administered as ordered so that she could assess the Resident and coordinate with the Physician to ensure the Resident's nutrition and hydration needs were met. The Dietician said she worked in the facility on 10/10/24 and that no staff alerted her that Resident #46 did not receive his/her assisted nutrition as ordered. The Dietician said that as of the time of this interview with the surveyor, no facility staff had communicated to her that a new order had been placed for a Dietitian consult. During an interview on 10/11/24 at 11:46 A.M., the Nurse Practitioner (NP) said that the Physician was on vacation this same week. The NP said that staff at the facility were required to contact her or, if after hours, the on-call Practitioner relative to Resident needs. The NP said that Resident #46 received his/her primary nutritional needs via TPN. The NP also said she received no communication from facility staff on 10/10/24 relative to Resident #46 not having received the ordered doses of Clinimix E and SMOFlipids. The NP said that staff should have contacted her, or the on-call Provider/Practitioner if after 5:00 P.M., when the infusions of Clinimix E and SMOFlipids were not administered as ordered so that appropriate orders could have been obtained to ensure the Resident received proper nutrition. The NP said if she had been notified, she would have contacted the Pharmacy to identify the shelf life of the Clinimix E and SMOFlipids in order to determine whether the infusions could continue to run safely. The NP also said she would have reviewed the timing of the Resident's next infusion to determine whether the next infusion time needed to be altered.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 42761 Based on observation, record and policy review, and interview, the facility failed to ensure that care and services for pain management consistent with professional standards of practice were provided in a timely manner for one Resident (#108) out of a total sample of 17 residents. Specifically, the facility failed to provide pain management interventions in a timely manner for Resident #108 when the Resident was experiencing severe pain and was dependent on staff to receive pharmacological (medication) and non-pharmaceutical interventions to treat pain. Findings include: Review of the facility's policy titled Pain Assessment and Management, dated March 2016 and last reviewed December 2023, indicated the following: -Pain is an unpleasant sensory and emotional experience . -Breakthrough pain is pain that increases above the pain addressed by the ongoing analgesics (drug used to treat pain). -Management of a patient's pain includes individualized assessment, intervention, and evaluation of pain and pain relief. -A patient's self-report of pain will be accepted as the most reliable indicator of pain. -Pain assessments are conducted using a numeric pain scale from zero to ten. -Numeric pain level of one to three is interpreted as mild pain. -Numeric pain level of four to six is interpreted as moderate pain. -Numeric pain level of seven to 10 is interpreted as severe pain. -Pharmacological and non-pharmacological interventions may be used to treat a patient's pain. Resident #108 was admitted to the facility in August 2024, with diagnoses including: Unspecified Cord Compression (pressure on the spinal cord that can affect one's body movements and function), Muscle Spasm (sudden, uncontrollable muscle contractions that are usually painful), Cutaneous Abscess (localized collection of pus in the skin characterized by pain and swelling) of Right and Left Lower Limbs, Anxiety Disorder (group of mental disorders characterized by anxiety and fear), and Major Depressive Disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy). Review of Resident #108's Pain Care Plan, initiated 8/5/24 and revised 8/13/24, indicated the following: (continued on next page)

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	225668	A. Building B. Wing	10/11/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident was at risk for breakthrough pain related to Quadriplegia (complete paralysis of the body from the neck down), Cutaneous Left lower Limb, Chronic Disability, and Wounds. -The Resident's pain was alleviated by PRN (as needed) and scheduled medications. -Administer analgesia as per orders. -Meet the Resident's need for pain relief and respond immediately to any complaint of pain. Review of Resident #108's Spinal Injury Care Plan, dated 8/13/24, indicated the following: -The Resident had Quadriplegia related to Spinal Injury. -Give medications as ordered. -Pain management as needed . provide alternative comfort measures PRN. Review of Resident #108's Minimum Data Set (MDS) Assessment, dated 8/15/24, indicated the following: -The Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total possible points. -The Resident reported having frequent pain. -The Resident reported a pain level of eight out of 10 (severe). -The Resident was on a scheduled pain medication regime. -The Resident received PRN pain medications and non-medication interventions for pain. Review of Resident #108's October 2024 Physician orders indicated the following: -Pain scale zero to 10 every shift for monitoring, initiated 8/2/24 with no stop date. -Acetaminophen Tablet 325 milligrams (mg), give two tablets by mouth every six hours as needed for Pain. Not to exceed three grams (3g) per 24 hours, initiated 8/2/24 with no stop date. -Baclofen (medication used to relieve muscle spasms, cramping, and tightness caused by medical problems, including . certain spinal injuries) Oral Tablet, give 25 mg by mouth three times a day related to Muscle Spasm, initiated 8/2/24 with no stop date. -Diclofenac Sodium (Non-Steroidal Anti-Inflammatory Drug [NSAID] used to treat pain) External Gel 1% (one percent) Topical (apply to the skin), apply to right shoulder topically two times a day for pain, initiated 8/5/24 with no stop date. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Gabapentin (anti-seizure medication that can also be used to treat pain) Oral Tablet, give 900 mg by mouth three times a day related to Cutaneous Abscess of Left Lower Limb, initiated 8/2/24 with no stop date. -Hydromorphone (opioid medication used to treat moderate to severe pain) HCl Oral Tablet 2 mg, give 4 mg by mouth every four hours as needed for moderate to severe pain, initiated 10/4/24 with no stop date. -Lidocaine (medication to treat pain) External Patch, apply to right shoulder topically one time a day for pain, initiated 8/3/24 with no stop date. -Tizanidine (short acting muscle relaxer used to relieve . muscle spasms caused by medical problems such as certain injuries to the spine) HCl Oral Tablet 2 mg, give 1.5 tablets by mouth two times a day for Muscle Spasm, initiated 10/4/24 with no stop date. On 10/8/24 between 10:20 A.M. and 10:40 A.M., the surveyor observed the following: -Unit Manager (UM) #1 was standing at the medication cart in the hallway on the Unit. -Resident #108 positioned in bed, on his/her back, and was crying. -Resident #108's call device was out of reach of the Resident. During an interview at the time, Resident #108 said he/she was experiencing pain and that he/she had not had any of his/her pain medications that was scheduled to be administered that morning. Resident #108 said that he/she knew medications were scheduled to be administered between 8:00 A.M. and 9:00 A.M., but that he/she had not received any of those medications as yet. -The surveyor activated Resident #108's call device for him/her. -Nurse #1 responded to the call device at 10:30 A.M. -Resident #108 told Nurse #1 that he/she was in pain and had not received his/her morning medications. -Nurse #1 said she would alert UM #1 that the Resident was in pain and requesting his/her medication. -Nurse #1 exited Resident #108's room, then returned with the Assistant Director of Nursing (ADON). Nurse #1 and the ADON assisted the Resident to reposition in bed. -The surveyor observed Nurse #1 tell Resident #108 that UM #1 was aware the Resident had not yet received his/her medication and that UM #1 was working on preparing the medications at that time. Review of Resident #108's Medication Administration Audit Report for 10/8/24 indicated the following: (continued on next page)

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	225668	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadows of Central Massachusetts (the)	111 Huntoon Memorial Highway Rochdale, MA 01542

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Baclofen Oral Tablet 25 mg was due for administration at 8:00 A.M. and was not administered until 11:06 A.M. -Gabapentin 900 mg was due for administration at 8:00 A.M. and was not administered until 11:08 A.M. -Tizanidine HCl Oral Tablet 2 mg was due for administration at 9:00 A.M. and was not administered until 11:09 A.M. -Diclofenac Sodium External Gel 1% was due for administration at 9:00 A.M. and was not administered until 11:10 A.M. -Lidocaine External Patch was due for administration at 9:00 A.M. and was not administered until 11:09 A.M. During an interview on 10/8/24 at 5:02 P.M., Resident #108 said he/she did not receive his/her scheduled pain medications this morning until around 11:00 A.M. and that his/her pain did improve after receiving the medications. During an interview on 10/9/24 at 7:50 A.M., UM #1 said she was the Nurse responsible for administering medications to Resident #108 during the day shift on 10/8/24. UM #1 said that when she completed Resident #108's Pain Assessment prior to administering the ordered pain medications, the Resident reported a pain level of eight out of 10 (severe pain). UM #1 said she administered Resident #108's pain medications late on 10/8/24 and that once the pain medications were administered, the Resident reported that the medications were effective. During an interview on 10/9/24 at 10:10 A.M., the ADON said that Resident #108 experienced pain frequently and that all medications provided to Resident #108 for treatment of pain were time critical. The ADON said that the Resident's pain medications should have been administered within a total of one hour of when the medications were ordered, so the medications should have been administered within the timeframe of a half hour before or after the medications' scheduled order time. The ADON said Resident #108 received Baclofen and Tizanidine for muscle spasms, which was a component of the Resident's pain, and also received Gabapentin, Diclofenac Sodium External Gel, and Lidocaine External Patches to treat his/her pain. The ADON further said it was important for Resident #108's medications to be administered timely in order to treat the Resident's pain. Please Refer to F760.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47646 Based on the record review and interview, the facility failed to to utilize the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week, as required placing all residents at risk for not having their clinical needs met either directly by the RN or indirectly by the Licensed Practical Nurse (LPN) or Certified Nurses Aides (CNA) that the RN was responsible for overseeing with provision of resident care. Specifically, the facility failed to: 1. Provide the services of a RN for at least eight consecutive hours a day, seven days a week when no staffing waivers were in place for three days for the period of 4/1/24 to 6/30/24. 2. Designate a Registered Nurse to serve as the Director of Nursing (DON) on a full time basis when no staffing waivers were in place. Findings include: 1. Review of the PBJ Staffing Data Report, dated Quarter 3: 2024 (April 1 - June 30), indicated the following: -One Star Staffing Rating Triggered = Star Staffing Rating Equals 1 -Excessively Low Weekend Staffing Triggered = Submitted Weekend Staffing data is excessively low -No RN Hours Triggered = Four or More Days Within the Quarter with no RN Hours Review of the as worked nursing schedule provided by the facility failed to indicate that a Registered Nurse worked for eight hours in the facility on the following days: -4/27/24 -5/12/24 -6/21/24 During an interview on 10/10/24 at 2:53 P.M., the Administrator said he was not employed at the facility as the Administrator until July, 2024 so if there were no RNs on the as worked schedule for the dates in question, then a RN did not work on those days. The surveyor and the Administrator reviewed the as worked schedules, and he said that no RNs worked on 4/27/24, 5/12/24, and 6/21/24. The Administrator said the facility does not have any staffing waivers. The Administrator said he could not provide any documentation indicating that a RN worked on those days and there should be a RN working at least 8 hours every day. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During an interview at the Entrance Conference on 10/8/24 at 8:19 A.M., with the Administrator and the Director of Nursing, they said that the Director of Nursing (DON), who is a RN, did not work full time. The Administrator said the DON's working schedule was Monday, Tuesday, Wednesday, and Thursday and she worked 32 hours per week. The Administrator said the Assistant Director of Nursing (ADON), who is not a RN, covers on the other days (Friday, Saturday and Sunday). The Administrator said that the facility does not have any waivers for staffing in place. During an interview on 10/10/24 at 12:46 P.M., the ADON (a Licensed Practical Nurse [LPN]) said that the DON only worked 4 days a week, never more than 32 hours. The ADON said that staff would come to her with any clinical problems or questions on the days that the DON was not there (in the facility).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47901 Based on observation, record and policy review, and interview, the facility failed to ensure that one Resident (#6) out of a total sample of 17 resident was free of medication errors. Specifically, the facility failed to: -ensure that antibiotic medication (Clindamycin) ordered for Resident #6 was administered for seven days as ordered and not 12 days as indicated on the Medication Administration Record (MAR). Findings include: Review of the facility's policy titled Medication Management Administration of Medications, revised October 2024, indicated: -Licensed personnel may only administer medications that have been dispensed by the pharmacy, including those stocked in the automated drug distribution cabinet (ADC). -Medications will be obtained from the ADC or medication storage area for one patient at a time, then administered to that patient. Resident #6 was admitted to the facility in August 2024, with diagnosis of Stage 4 Pressure Ulcer (full thickness tissue loss that exposes bone, muscle, or tendon) of the left buttock. Review of Resident #6's October 2024 Physician orders indicated the following ordered medications: -Clindamycin (antibiotic used to treat bacterial infection) 150 mg (milligrams) four times a day for wound infection, ordered on 10/7/24 for 7 days. Review of the October 2024 Medication Administration Record (MAR) indicated: -Clindamycin medication was to be administered for 12 days from 10/7/24 to 10/19/24. During an interview on 10/9/24 at 8:53 A.M., Nurse #4 said the Clindamycin medication had not been delivered from the pharmacy. During an interview on 10/9/24 at 8:58 A.M., Nurse #2 said he had administered the Clindamycin medication four times on 10/8/24. Nurse #2 said the medication had not been delivered from the pharmacy therefore he borrowed the Clindamycin from another resident's medication. Nurse #2 said that he was not aware he could not borrow medications from another resident. During an interview on 10/9/24 at 2:46 P.M., Nurse #1 said the nursing staff are not expected to borrow medications from other residents. Nurse #1 further said the Clindamycin medication had been marked to be administered for 12 days on Resident #6's MAR. Nurse #1 said the Clindamycin medication should have been marked to be administered for 7 days as ordered.

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	225668	A. Building B. Wing	10/11/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 42761 Based on observation, interview, record and policy review, the facility failed to ensure one Resident (#108) out of a total sample of 17 residents, was free of significant medication errors. Specifically, for Resident #108, the facility failed to ensure that: -pain medications were administered timely as ordered by the Physician, when the Resident experienced pain and scheduled pain medications were ordered, which increased the Resident's risk for prolonged pain. -intravenous (IV: administered directly into a vein) antibiotics (medications used to treat infection) were administered timely as ordered by the Physician, when the Resident required IV antibiotics to treat an active infection, which increased the Resident's risk for illness. -anticoagulant (blood thinner) medication was administered timely as ordered by the Physician, when the Resident had a diagnosis of chronic embolus (a blood clot, air bubble, piece of fatty deposit, or other object which has been carried in the bloodstream lodges in a blood vessel) and Thrombosis (blood clot that forms inside a vessel and obstructs normal blood flow) of bilateral femoral veins (large blood vessels in the upper thighs and pelvic region that carries blood from the legs to the heart) which increased the Resident's risk for embolus and thrombosis related complications. -anticonvulsant (used to treat seizures) medication was administered timely as ordered by the Physician, which increased the Resident's risk for convulsions (medical event that occurs when the brain's nerve cell activity is disrupted, causing the muscles to contract and relax uncontrollably). Findings include: Review of the facility's policy titled Medication Administration - General Guidelines, dated February 2019, indicated the following: -Medications are administered as prescribed . -Right resident, right drug, right dose, right route, right time are applied for each medication being administered. -Medications are administered in accordance with written orders of the Prescriber. -Medications are administered within 60 minutes of scheduled time. Review of the facility's policy titled Pain Assessment and Management, dated March 2016 and last reviewed December 2023, indicated the following: -Pain is an unpleasant sensory and emotional experience . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Breakthrough pain is pain that increases above the pain addressed by the ongoing analgesics (drug used to treat pain). -Management of a patient's pain includes . intervention . -A patient's self-report of pain will be accepted as the most reliable indicator of pain. -Pain assessments are conducted using a numeric pain scale from zero to ten. -Numeric pain level of one to three is interpreted as mild pain. -Numeric pain level of four to six is interpreted as moderate pain. -Numeric pain level of seven to 10 is interpreted as severe pain. Resident #108 was admitted to the facility in August 2024, with diagnoses including: Unspecified Cord Compression (pressure on the spinal cord that can affect one's body movements and function), Muscle Spasm (sudden, uncontrollable muscle contractions that are usually painful), Cutaneous Abscess (localized collection of pus in the skin characterized by pain and swelling) of Right and Left Lower Limbs, Chronic Embolism and Thrombosis of Bilateral Femoral Veins, and Unspecified Convulsions. Review of Resident #108's Pain Care Plan, initiated 8/5/24 and revised 8/13/24, indicated the following: -The Resident was at risk for breakthrough pain related to Quadriplegia (condition where all four limbs and body from the neck down are paralyzed. Can be caused by spinal cord injury or medical conditions), Cutaneous [Abscess] Left lower Limb, Chronic Disability, and Wounds. -The Resident's pain was alleviated by PRN (as needed) and scheduled medications. -Administer analgesia as per orders. -Meet the Resident's need for pain relief and respond immediately to any complaint of pain. Review of Resident #108's Spinal Injury Care Plan, dated 8/13/24, indicated the following: -The Resident had Quadriplegia related to Spinal Injury. -Give medications as ordered. -Pain management as needed . provide alternative comfort measures PRN. Review of Resident #108's Impaired Immunity Care Plan indicated the Resident was at risk for contracting infections due to impaired immune status. Review of Resident #108's Minimum Data Set (MDS) Assessment, dated 8/15/24, indicated the following: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total possible points. -The Resident reported having frequent pain. -The Resident reported a pain level of eight out of 10 (severe). -The Resident was on a scheduled pain medication regime. Review of Resident #108's clinical record indicated the Resident was transferred to the hospital on 9/21/24 and returned to the facility 10/4/24 with a diagnosis of Aspiration Pneumonia (infection of the lungs caused by accidentally inhaling saliva, food, liquid, vomit and even small foreign objects). Review of Resident #108's October 2024 Physician orders indicated the following: -Baclofen (medication used to relieve muscle spasms, cramping, and tightness caused by medical problems, including . certain spinal injuries) Oral Tablet, give 25 mg (milligrams) by mouth three times a day related to Muscle Spasm, initiated 8/2/24 with no stop date. -Gabapentin (anti-seizure medication that can also be used to treat pain) Oral Tablet, give 900 mg by mouth three times a day related to cutaneous abscess of left lower limb, initiated 8/2/24 with no stop date. -Lidocaine (medication to treat pain) External Patch, apply to right shoulder topically one time a day for pain, initiated 8/3/24 with no stop date. -Tizanidine (short acting muscle relaxer used to relieve . muscle spasms caused by medical problems such as certain injuries to the spine) HCL Oral Tablet 2 mg, give 1.5 tablets by mouth two times a day for Muscle Spasm, initiated 10/4/24 with no stop date. -Apixaban (anticoagulant medication) Oral Tablet 5 mg, give 5 mg by mouth two times a day for anticoagulant, initiated 10/5/24 with no stop date. -Cefepime (antibiotic medication used to treat infection) HCL IV Solution Reconstituted, use one Gram (g) IV every six hours for Aspiration Pneumonia until 11/5/24, initiated 10/5/24. -Lamotrigine (anticonvulsant medication used to treat seizures) Oral Tablet 25 mg by mouth one time a day related to unspecified convulsions, initiated 8/3/24 with no stop date. -Vancomycin (antibiotic medication used to treat infection) HCL IV Solution, use 1250 mg IV every 12 hours for Aspiration Pneumonia until 10/9/24 . Trough (blood test used to monitor the use of Vancomycin) drawn 10/7/24 was less than 4.0. Dose increased from 1000 mg every 12 hours to 1250 mg every 12 hours. Next trough to be drawn 10/10/24. On 10/8/24 between 10:20 A.M. and 10:40 A.M., the surveyor observed the following: -Unit Manager (UM) #1 was standing at the medication cart in the hallway on the Unit. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #108 positioned in bed, on his/her back, and was crying. -An IV pole and pump were positioned by the head of the Resident's bed. The surveyor did not observe any IV medications in use at this time. -The Resident had a PICC (Peripherally Inserted Central Catheter: long, thin tube that's inserted through a vein in one's arm and passed through to the larger veins near the heart) line present in his/her right upper arm. During an interview at the time, Resident #108 said he/she was experiencing pain and had not received any of his/her pain medication that was scheduled to be administered that morning. Resident #108 said that he/she knew medications were scheduled to be administered between 8:00 A.M. and 9:00 A.M., but that he/she had not received any of those medications yet. Resident #108 also said that he/she was supposed to receive IV antibiotic medication for an infection through his/her PICC line that morning but the IV antibiotic medication had not been administered as yet. -The surveyor activated Resident #108's call device as the call device was out of reach of the Resident. -Nurse #1 responded at 10:30 A.M., and Resident #108 told Nurse #1 that he/she was in pain and had not received his/her morning medications. -Nurse #1 said she would alert UM #1 that the Resident was in pain and requesting his/her medications. -Nurse #1 exited Resident #108's room, then returned with the Assistant Director of Nursing (ADON) to assist the Resident to reposition in bed. -Nurse #1 told Resident #108 that UM #1 was aware the Resident had not yet received his/her medication and that UM #1 was working on preparing the medications at that time. Review of Resident #108's Medication Administration Audit Report for 10/8/24 indicated the following: -Baclofen Oral Tablet 25 mg was scheduled for administration at 8:00 A.M. and was not administered until 11:06 A.M. -Gabapentin 900 mg was scheduled for administration at 8:00 A.M. and was not administered until 11:08 A.M. -Tizanidine HCL Oral Tablet 2 mg was scheduled for administration at 9:00 A.M. and was not administered until 11:09 A.M. -Lidocaine External Patch was scheduled for administration at 9:00 A.M. and was not administered until 11:09 A.M. -Lamotrigine Oral Tablet 25 mg was scheduled for administration at 8:00 A.M. and was not administered until 11:08 A.M. (continued on next page)

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	225668	A. Building B. Wing	10/11/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Vancomycin HCL IV Solution 1250 mg was scheduled for administration at 9:00 A.M. and was not administered until 10:42 A.M. -Apixaban Oral Tablet 5 mg was scheduled for administration at 9:00 A.M. and was not administered until 11:08 A.M. -Cefepime HCL IV Solution 1g was scheduled for administration at 11:00 A.M. and was not administered until 12:35 P.M. During an interview on 10/8/24 at 5:02 P.M., Resident #108 said he/she did not receive his/her scheduled pain medications that morning until around 11:00 A.M. and his/her pain did improve after receiving the medications. Resident #108 also said that he/she had received an antibiotic medication through his/her PICC line that morning and that the antibiotic was not administered on time. During an interview on 10/9/24 at 7:50 A.M., UM #1 said she was the Nurse responsible for administering medications to Resident #108 during the day shift on 10/8/24. UM #1 said she thought that all scheduled medications were required to be administered within one hour before or after their scheduled times and that the Resident's scheduled 8:00 A.M. and 9:00 A.M. medications could be administered at the same time. UM #1 said when she completed Resident #108's pain assessment prior to administering the ordered pain medications on 10/8/24, the Resident reported a pain level of eight out of 10 (severe pain). UM #1 said she did not administer Resident #108's pain medications until somewhere around 11:00 A.M. on 10/8/24 and that these medications were administered late. UM #1 also said she administered IV Vancomycin to Resident #108 that same morning and that the IV Vancomycin was not administered until 10:42 A.M. During an interview on 10/9/24 at 10:10 A.M., the ADON said that Resident #108 experienced pain frequently, required IV antibiotics to be administered, required anticoagulation therapy, and required anticonvulsant medications. The ADON said that Resident #108 also experienced muscle spasms and that the muscle spasms were a component of the Resident's pain. The ADON said that all medications provided to Resident #108 for treatment for his/her pain, infection, anticoagulation, and anticonvulsant were time critical and should have been administered within a total of one hour of when the medications were ordered, so the medications should have been administered within the timeframe of a half hour before or after the medications' scheduled order time.

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	225668	A. Building B. Wing	10/11/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47646 Based on observation, interview, and document review, the facility failed to ensure all medications used in the facility were stored and labeled in accordance with currently accepted professional principles of practice. Specifically, the facility failed to ensure staff properly labeled all medications stored in one of three medication carts reviewed. Findings include: Review of the facility's policy titled Medication Labeling and Storage, dated 2001, indicated but was not limited to the following: 1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 2. The medication label includes, at a minimum: a. medication name (generic and/or name brand); b. prescribed dose; c. strength; d. expiration date, when applicable; e. resident's name; f. route of administration; and g. appropriate instructions and precautions. On 10/9/24 at 11:46 A.M., the surveyor and Nurse #5 reviewed the medication cart on the First Floor and observed the following: -One Albuterol Sulfate inhalation aerosol unit (inhaler) in a ziplock bag with no pharmacy label affixed to indicate the prescribed dose, strength, expiration date, route of administration or instructions and precautions for the medication. -A resident's name and room number were handwritten in black marker on the bag and the side of the inhaler. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/9/24 at 11:50 A.M., Nurse #5 said she did not know when the inhaler was opened. Nurse #5 said there was no label or date on the bag or inhaler. Nurse #5 said she knew which resident the inhaler was for, but there should be a pharmacy label with instructions on the inhaler. Nurse #5 said she was not sure when the inhaler was used or how long it had been there for. Nurse #5 said she had not administered the inhaler and she was going to dispose of the medication. During an interview on 10/10/24 at 10:15 A.M., the Assistant Director of Nursing (ADON), said the inhaler should have been labeled with the pharmacy label that has the required information about the medication. The ADON said the inhaler should not have been on the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225668	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadows of Central Massachusetts (the)	111 Huntoon Memorial Highway Rochdale, MA 01542

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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 - Few	Provide and implement an infection prevention and control program. 47901 Based on observation, interview, record and policy review, the facility failed to implement infection control measures to stop the spread of infection for two Residents (#6 and #46) out of 17 sampled residents, and on one Unit out of two units. Specifically, the facility failed to: 1. Ensure that Enhanced Barrier Precautions (EBP) and Infection control practice were maintained for Resident #6. 2. Ensure that infection control practices were adhered to during a PICC (peripherally inserted central catheter - a long flexible tube that is inserted into a vein in the arm and threaded into a large vein near the heart) line dressing change for Resident #46. 3. Ensure that a glucometer machine (glucose meter: a small, portable device that measure the amount of glucose (sugar) in the blood) was appropriately disinfected between Resident use. Findings include: Review of the facility's policy titled Enhanced Barrier Precautions, revised August 2022, indicated: -Enhanced barrier precautions (EBP's) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. -EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. -Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room. -EBPs are indicated (when contact precautions do not otherwise apply) 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 precautions and PPE required. Review of the facility's policy titled Central Line Dressing Change, revised June 2016, indicated: -During dressing change, don (put on) non-sterile gloves, carefully open central line dressing kit and remove mask and sterile gloves, remove non-sterile gloves and perform hand hygiene . -After dressing change remove gloves and perform hand hygiene . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #6 was admitted to the facility in August 2024 with diagnoses including Stage 4 Pressure Ulcer (full thickness tissue loss that exposes bone, muscle, or tendon) of the left buttock. On 10/9/24 at 2:32 P.M., the surveyor observed Nurse #4 perform a wound dressing change for Resident #6. The surveyor observed: -Nurse #4 don gloves, and remove the old dressing from Resident #6's pressure area, discard the old dressing, and doff (remove) her gloves. -Nurse #4 then donned new gloves, cleansed the wound with wound cleanser, doffed her gloves, put on new gloves, and applied a new wound dressing to the wound bed. -Nurse #4 then reached into her pocket with the gloved hand and retrieved scissors. -Nurse #4 did not wear a gown, sanitize or clean her hands before donning gloves or after doffing gloves during the wound care observation. During an interview on 10/9/24 at 2:42 P.M., Nurse #4 said she was not aware Resident #6 was on Enhanced Barrier Precautions and that she needed to wear a gown because there was no sign at the door with instructions. Nurse #4 further said she forgot to bring hand sanitizer into the room and did not remember to sanitize hands after removing soiled gloves and before putting on clean gloves during the wound care. During an interview on 10/10/24 at 12:46 P.M. the Assistant Director of Nursing (who is also the facility Infection Preventionist[IP]) said the expectation is that when a Resident has a wound, Enhanced Barrier Precautions including wearing gowns and hand hygiene should be performed during wound care. 2. Resident #46 was admitted to the facility in August 2024, with a diagnosis of Unspecified Intestinal Obstruction (gastrointestinal condition in which digested material is prevented from passing normally through the intestines). Review of Resident #46's October 2024 Physician's orders indicated that the Resident was due for a PICC line dressing change on 10/8/24. On 10/8/24 at 1:11 P.M., the surveyor observed a dressing change being done by Unit Manager (UM) #1. The surveyor observed: -UM #1 remove the old PICC line dressing from Resident #46's left arm. -The Resident reminded UM #1 that she forgot to wear a mask. -UM #1 went to the door, donned a mask and a gown and then took the old dressing off the Resident's PICC line. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-UM #1 doffed the gloves, and opened the central line kit that contained supplies for the dressing change. -UM #1 dropped the sterile gloves from the central line dressing kit. -UM #1 removed her gown, walked out of the Resident's room to the hallway to her medication cart and returned with another pair of gloves. -UM #1 donned the sterile gloves, cleaned the PICC line site and applied new dressings to the area. -UM #1 did not don another gown upon entering the Resident's room the second time. During an interview on 10/8/24 at 1:33 P.M., UM #1 said she forgot to sanitize her hands between donning and doffing gloves. UM #1 said she forgot to clean her hands when she left the Resident's room, and she forgot to wear a new gown when she re-entered the Resident's room, but she should have. During an interview on 10/10/24 at 12:46 P.M., the Assistant Director of Nursing (ADON: who is also the Infection Preventionist [IP]) said that PICC Line dressing changes should be done according to the facility policy. 3. On 10/10/24 at 8:05 A.M., during a medication administration pass, the surveyor observed Nurse #7 perform finger stick blood glucose check (a common way to measure blood sugar levels using a lancet and glucose meter/ glucometers) on a resident. Nurse #7 returned the blood glucose meter to the top of his medication cart, removed his gloves and sanitized his hands. The surveyor observed Nurse #7 continued to administer medications to other residents. -At 8:29 A.M., another Nurse came and retrieved the blood glucose meter from Nurse #7. During an interview at the time, Nurse #7 said he did not disinfect the blood glucose meter after he used it. Nurse #7 said that he would disinfect the blood glucose meter after he completed administering medications to all his assigned residents. During an interview on 10/10/24 at 8:51 A.M., UM #1 said the Nurses are expected to disinfect the glucose meter machine after each use. During an interview on 10/10/24 at 12:46 P.M. the ADON/ IP said that glucometers should be cleaned between residents per manufacturer's guidelines.