STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 45429 Based on record review, policy review, and interview, the facility failed to accurately execute Advance Directives (legal documents that provide instructions for medical care and only go into effect if you are unable to communicate your own wishes) for one Resident (#94) out of a total sample of 23 residents. Specifically, for Resident #94, the facility failed to ensure that the MOLST (Massachusetts Medical Order for Life-Sustaining Treatment) form was valid and reflected the signature of Resident #94's invoked (made active by a Physician) Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself). Findings include: Review of the facility policy for Advance Directives, last revised February 2022, indicated: -capacity to make health care decisions is the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision. -In Massachusetts, the determination of a patient's lack of capacity must be made by a Physician in writing before a health care proxy can be put into effect. -health care decision made by an agent under the healthcare proxy is a decision which . is consistent with any limitations in the healthcare proxy and is consistent with responsible medical practice. Resident #94 was admitted to the facility in May 2024, with diagnoses including Dementia (a group of symptoms affecting memory, thinking and social abilities). Review of Resident #94's clinical record revealed: -a MOLST form signed on 2/5/23 by Resident #94's HCP prior to the Resident's admission to the facility. -a HCP activation form dated 5/4/24 after the MOLST form had been signed by the HCP. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-no evidence that the MOLST form had been re-addressed with Resident #94's HCP after their facility admission and before the surveyor brought t it to the attention of the facility. During an interview on 10/29/24 at 9:50 A.M., Social Worker (SW) #2 said that the MOLST form was not valid as it had been signed by the HCP before the Resident had been deemed incapacitated by his/her Physician. SW #2 also said that a new MOLST form should have been completed upon the Resident's admission to the facility and it was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 37400 Based on observation, interview, and record review, the facility failed to ensure that one Resident (#98), was free from physical restraints, out of a total sample of 23 residents. Specifically, for Resident #98, the facility failed to: -appropriately assess and re-assess the use and need of wedge cushions (a triangular shaped cushion used to aid in positioning for health issues or comfort) as a restraint that was being used in the place of an ordered scoop mattress (a mattress with raised edges on all four sides to prevent accidental rolling out of bed). -obtain informed consent and review the risk/benefits with the Resident's Representative for the use of wedge cushions while the Resident was in bed to prevent him/her from exiting the bed, increasing the potential risk of accidental falls and injury. Findings include: Review of the facility policy titled Guidelines for the Use of a Restraint, revised 11/2016, indicated it was the policy of the facility to provide care and services to assist each resident to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has a medical symptom that warrants the use of restraints. The policy also included the following: -every resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience . -when the use of restraints is indicated, the facility will use the least restrictive alternative for the least amount of time and document ongoing evaluation of the need for the restraints. -physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. -physical restraints may include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays that the resident cannot remove easily. -also included as restraints are facility practices that meet the definition of a restraint, such as: >using the side rails that keep a resident from voluntarily getting out of bed; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>tucking in or using velcro to hold a sheet, fabric, or clothing tightly so that a resident's movement is restricted >placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or voluntarily getting out of the bed -removes easily means that the manual method, device, material, or equipment can be removed intentionally by the same manner as it was applied by the staff (e.g., side rails are put down, not climbed over) considering the resident's physical condition and ability to accomplish the objective . -convenience is defined as any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by a facility and not in the resident's best interest. -freedom of movement means any change in place or position for the body or any part of the body that the person is physically able to control -before initiating any device that has a potential to act as a restraint, the facility will conduct a comprehensive assessment utilizing the Restraint/Positioning Assessment form -the assessment should include: -resident diagnoses and prior medical history -problem for which restraint use is being considered -falls history -behaviors -physical functioning status -evaluate the risks and benefits of ALL options -the order must be specific to: -the type of restraint to be used -time limitations for the use of the restraint -the diagnosis and specific medical symptoms to warrant the restraint -the frequency of observing and assessing the resident -the periodic removal/release of the restraint -in order to be fully informed, the facility will explain to the resident or resident representative, in terms specific to the resident's condition: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the specific medical symptoms/conditions that would require the use of the restraints -how the use of the restraint would treat the medical symptoms and assist the resident in attaining his/her highest level of physical/psychological well-being -the risks and benefits of restraint use -After reviewing the terms of the restraint use and being given the opportunity to discuss the risks, benefits and alternatives, the resident or, in the case of a resident who is incapable of making a decision, the legal surrogate or resident representative will give their permission by signing the Consent to the Use of Restraints form. Resident #98 was admitted to the facility in May 2024, with diagnoses including Severe Dementia (a group of symptoms that affects memory, thinking and interferes with daily life) with agitation, Adjustment Disorder (a disorder characterized by a group of symptoms such as stress, anxiety, feeling sad or hopeless, and physical symptoms that can occur after a stressful life event) with Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations) and muscle weakness. Review of the Minimum Data Set (MDS) Assessment, dated 8/2/24, indicated Resident #98: -had a Brief Interview of Mental Status (BIMS) score of 1 out of 15. -had other behaviors that occurred towards others (hitting, physical, throwing things, disruptive sounds). -was dependent on staff for activities of daily living (ADLs: basic skills you need to perform daily life activities, such as bathing, dressing, and eating) and had two or more falls since the previous assessment. Review of Resident #98's clinical record indicated: -Sustained a fall 5/10/24 out of his/her wheelchair in the dining room, and sustained falls on 6/1/24 and 6/13/24 out of his/her bed. -Falls Care Plan, initiated 5/7/24, included the following intervention: >scoop mattress (mattress with raised edges on the bottom and/or top and a space in the middle to allow access in/out of the bed which assists a resident to define the edges of the bed) while in bed (initiated 6/6/24). Review of the Restraint/Positioning Assessment, completed on 9/9/24, indicated the following: -the problem/diagnosis for which the restraint or positioning device was being considered: falls out of bed -Resident was severely cognitively impaired (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-had agitation and history of falls -had left upper extremity range of motion impairments -was dependent on staff for ADLs, transfers and mobility -type of restraint/positioning device being considered: scoop mattress in order to prevent self-injury while in bed -the summary of the explanation for the use of the scoop mattress included the following: Resident tries to get out of bed, has a history of falls and the mattress is used to prevent him/her from falling out of bed. Review of the October 2024 Physician's orders included the following: -activate Health Care Proxy (HCP: designated person who makes medical decisions when a person was unable), initiated 5/3/24 -fall precautions, initiated 6/4/24 -may utilize bilateral half side rails for medical necessity ., initiated 6/14/24 -scoop mattress at all times while in bed. Check every shift for placement, initiated 9/9/24 On 10/29/24 at 8:21 A.M., the surveyor observed the Resident was awake and lying upright in bed. The surveyor observed the head of the bed was elevated, bilateral side rails were in place and wedge cushions (shaped like V-shaped wedges, assist with posture, alignment and comfort during long sitting) were positioned adjacent to the side rails on both sides of the bed, at the same height as the side rails and extended from the Resident's hips to knees/lower legs. The surveyor observed there was no space between the side rails and the wedge cushions and a facility staff member was seated next to the Resident and assisting him/her with the breakfast meal. On 10/29/24 at 10:35 A.M., the surveyor observed Resident #98 lying in a low positioned bed. The surveyor observed the Resident was dressed in a hospital gown, bilateral side rails were in place, and wedge cushions were positioned adjacent to the side rails on both sides of the bed. The surveyor observed the wedge cushions were the same height as the side rails and were positioned under the fitted bottom sheet of the bed. The surveyor observed there was no space between the side rails and the wedge cushions, the Resident's eyes were open, and he/she waved at the surveyor. On 10/29/24 at 12:57 P.M., the Resident was observed dressed and seated in a specialized wheelchair in the dining room after lunch. On 10/29/24 at 2:17 P.M., the surveyor observed Resident #98 was awake and lying in a low positioned (in a lower position closer to the floor) bed with the head of the bed slightly elevated. Bilateral side rails were observed in place and wedge cushions positioned adjacent to the side rails on both sides of the bed, and under the fitted bottom sheet. The surveyor observed there was no space between the side rails and the wedge cushions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 3:12 P.M., the surveyor and Certified Nurses Aide (CNA) #3 observed Resident #98 was awake and lying in a low positioned bed. the surveyor observed the bilateral side rails were in the up position, and wedge cushions were positioned on both sides of the Resident's lower extremities adjacent to the side rails and were under the fitted bottom sheet. During an interview at the time, CNA #3 said the wedge cushions were put under the bottom sheet of the bed and were in place to prevent the Resident from falling out of bed. CNA #3 said the Resident would try to get out of bed and would fall. On 10/29/24 at 3:23 P.M., the surveyor and Nurse #1 observed the Resident, and Nurse #1 said the Resident had previous falls and the wedge cushions were placed under the fitted bottom sheet on both sides to prevent him/her from getting out of bed and falling. Nurse #1 further said the mattress was not a scoop mattress and was not sure why a scoop mattress was not in place. Nurse #1 said the Resident would be unable to remove the wedge cushions that were placed under the bottom sheet. On 10/29/24 at 3:31 P.M., the surveyor and Unit Manager (UM) #1 observed Resident #98 and UM #1 said the Resident had previous falls out of the bed and the wedge cushions were put into place to prevent him/her from exiting the bed. UM #1 said the wedge cushions would be considered a restraint and an evaluation was completed. UM #1 said that she had considered the use of the wedge cushions the same as a scoop mattress. The surveyor relayed observation of the placement of the wedge cushions which were adjacent to the bilateral side rails and allowed no space between their use and the side rails, and that the wedge cushions were positioned under the fitted bottom sheet. UM #1 said the wedge cushions were placed that way to prevent the Resident from exiting the bed due his/her numerous falls. UM #1 said the Resident would be unable to remove the wedge cushions and because the wedge cushions were used, an assessment would need to be completed, and the Resident's Representative would be notified. UM #1 said she was not sure if consent was obtained for the use of the wedge cushions or if the risks/benefits of the intervention were reviewed with the Resident's Representative. During an interview on 10/29/24 at 3:59 P.M., the Director of Nursing (DON) said she looked at Resident #98's bed. The DON said what was currently in place was not a scoop mattress but were wedge cushions that were placed on both sides of the Resident. The DON said there was no space for the Resident to exit the bed because the wedge cushions were positioned under the fitted bottom sheet. The DON said the wedge cushions were the same height as the side rails that were also in place and that she would consider the wedge cushions use a restraint. The DON said if the wedge cushions were to be used, the Resident's Representative would need to be educated on their use, consent would have to be obtained, a Physician's order for their use would need to be in place, and the use as a restraint would need to be reviewed periodically.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 50320 Based on record review and interview the facility failed to ensure that Minimum Data Set (MDS) assessments were transmitted within 14 days after the completion date for 17 Residents (#4, #43, #57, #90, #95, #102, #103, #18, #51, #54, #65, #80, #81, #82, #100, #116, and #118) out of a total sample of 23 residents. Specifically, the facility failed to ensure that: 1) Comprehensive MDS assessments for Resident's #4, #43, #57, #90, #95, #102, #103 were not submitted late with submission dates more than 14 days after the completion date. 2) Non comprehensive MDS assessments for Residents #18, #51, #54, #65, #80, #81, #82, #100, #116, and #118 were not submitted late with submission dates more than 14 days after the completion date. Findings include: Review of The Centers for Medicare and Medicaid (CMS) MDS 3.0 Resident Assessment Instrument (RAI) Manual dated October 2024, indicated: -Comprehensive assessments (Omnibus Budget Reconciliation Act (OBRA)-required comprehensive assessments include the completion of both the MDS Assessment and the Care Area Assessment (CAA) process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required) must be transmitted (Assessment Transmission refers to the electronic transmission of submission files to the Internet Quality Improvement and Evaluation System (iQIES)), not later than 14 calendar days after completion of the care plan. -Further review of the RAI manual indicated that non comprehensive MDS assessments (OBRA-required non-comprehensive MDS assessments include a select number of MDS items, but not completion of the CAA process and care planning.) must be transmitted to IQIES no later than 14 calendar days after the MDS completion date. Review of the Facility's MDS 3.0 Final Validation Report indicated: -Comprehensive MDS assessments for Resident's #4, #43, #57, #90, #95, #102, #103 were submitted late with submission dates more than 14 days after the completion date. -Non comprehensive MDS assessments for residents #18, #51, #54, #65, #80, #81, #82, #100, #116, and #118 were submitted late with submission dates more than 14 days after the completion date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 1:39 P.M., the Corporate MDS Coordinator said the facility uses the RAI manual to determine the dates for completion and submission of the facility's MDS assessments. The Corporate MDS Coordinator said the facility's regular MDS Coordinator is out on leave and the Corporate MDS Coordinator is responsible for the oversight of completion and submission of the facility's MDS assessments, while the regular facility MDS Coordinator is out on leave. The Corporate MDS Coordinator said the MDS assessments for the 17 Residents reviewed were submitted late per RAI manual standards. The Corporate MDS Coordinator said she was in the process of getting the MDS assessments up to date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 37400 Based on interview, and record review, the facility failed to ensure that a Preadmission and Resident Review Level I (initial PASRR - initial pre-screening completed prior to admission to a Nursing Facility that assess for Serious Mental Illness[SMI] or Developmental Disabilities[DD]) screen was completed prior to admission to the facility for one Resident (#85), out of a total sample of 23 residents. Findings include: Resident #85 was admitted to the facility in April 2023, with diagnoses including 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) and Psychotic Disorder (serious mental disorders characterized by a disconnection from reality which results in strange behaviors often accompanied by disturbances of thought [excessive suspiciousness, guilt] and perception [hearing voices, seeing things, feeling things] with hallucinations [an experience involving the apparent perception of something not present]). Review of the PASRR Level I Screening, dated 4/19/23, indicated the Level I (initial pre-screening completed prior to admission to a Nursing Facility) Screen was completed after the Resident was admitted to the facility. During an interview on 10/30/24 at 3:55 P.M., Social Worker (SW) #1 said the PASRR Level I Screen should be completed prior to the Resident's admission to the facility. During a follow-up interview on 10/30/24 at 4:08 P.M., the surveyor and SW #1 reviewed Resident #85's PASRR Level I Screening and SW #1 said it was completed after the Resident's admission and should have been completed prior to his/her admission to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. 37400 Based on interview, and record review, the facility failed to notify the State Mental Health Authority for a Resident Review (person-centered assessment taking into account all relevant information) after a significant change in mental condition occurred for one Resident (#98), out of a total sample of 23 residents. Specifically, the facility failed to request a Preadmission Screening and Resident Review Level II screen (PASRR- an evaluation done to determine if a resident has an intellectual or developmental disability and/or serious mental illness [SMI] and if a Resident is in need of additional specialized support services at the facility) after Resident #98 received emergency mental health interventions and was transferred to the hospital for a psychiatric evaluation. Findings include: Resident #98 was admitted to the facility in May 2024, with diagnoses including Severe Dementia (a group of symptoms that affects memory, thinking and interferes with daily life) with agitation, Adjustment Disorder (a disorder characterized by a group of symptoms such as stress, anxiety, feeling sad or hopeless, and physical symptoms that can occur after a stressful life event) with Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations), 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 #98's clinical record included the following: -Nursing Progress Note, dated 8/17/24, which indicated the Resident punched a Certified Nurses Aide (CNA) in the face during care and when the CNA attempted to get away, the Resident grabbed the CNA's hand so hard it left a reddened area with scratches. A subsequent Nursing Note indicated Section 12 (Section 12 (a): allows for an individual to be brought against his or her will to a hospital for evaluation. Section 12 (b): allows for an individual to be admitted to a psychiatric unit for up to three business days against the individual's will or without the individual's consent) paperwork was received and the Resident was sent to the hospital for a psychiatric evaluation. -Nursing Progress Note, dated 8/30/24, indicated the Resident was readmitted to the facility after being transferred to the hospital for a psychiatric evaluation. -no documented evidence that a PASRR Level II screen for Resident Review was completed after Resident #98 had a change/decline in his/her condition requiring psychiatric evaluation/treatment at the hospital. During an interview on 10/30/24 at 11:34 A.M., Social Worker (SW) #1 said she would have to review the Resident's paperwork after he/she was readmitted back to the facility after the Section 12 hospitalization to determine if a PASRR Level II screen would be required. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 10/30/24 at 2:31 P.M., SW #1 said the PASRR Level II review was not submitted after Resident #98's hospitalization for psychiatric evaluation. SW #1 said she was going to submit the request for the Resident's Level II review today.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on observation, interview, record review and policy review, the facility failed to provide treatments in accordance with professional standards of practice for one Resident (#78) out of a total sample of 23 residents. Specifically, the facility failed to implement and perform care and treatment consistent with the Physician orders and professional standards of practice for a Resident with Diabetes Type II (DM II- a chronic medical condition where the body cannot effectively use insulin [hormone that regulates blood glucose/sugar] or produce enough insulin and has trouble controlling blood sugar levels), placing the Resident at risk for side effects of hyperglycemia (high blood sugar). Findings include: Review of the National Library of Medicine document titled, Management of Diabetes and Hyperglycemia in hospitalized Patients, dated October 2024, https://www.ncbi.nlm.nih.gov/books/NBK279093/ indicated: -hyperglycemia . is defined as blood glucose greater than 140 mg/dL (milligrams per deciliter) -for non-critically ill individuals, a glycemic goal of 100-180 mg/dL is recommended -there is a strong association between those with hyperglycemia and poor clinical outcomes such as mortality, infections and hospital complications. Review of the American Diabetes Association Treatment and Care target ranges for blood sugar testing, undated, https://diabetes.org/living-with-diabetes/treatment-care/checking-your-blood-sugar indicated: -before a meal: 80-130 mg/dL -1-2 hours after beginning of the meal: less than 180 mg/dL Review of the facility policy for Blood Glucose (sugar) Monitoring System, last revised January 2024 indicated: -to determine the capillary (small blood vessel) blood glucose levels for regulation of subcutaneous (under the skin) Insulin administration in accordance with Physician's orders. -for screening of asymptomatic or suspected hypoglycemia (low blood sugar) or hyperglycemia. -the Physician's order will include: >the frequency of testing >interventions (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>parameters (numerical or another measurable factor) Resident #78 was admitted to the facility in June 2022, with diagnoses including Diabetes Type II and hypoglycemia. Review of Resident #78's Nutrition Care Plan, last revised 8/7/24, indicated: -the goal is to maintain blood sugars between 80-180 mg/dL -an intervention to provide Insulin (hormone medication used to regulate blood sugar levels) and Finger Stick Blood Sugar (FSBS) as ordered -monitor for signs and symptoms of hypoglycemia and hyperglycemia Review of Resident #78's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of total 15. -was diagnosed with Diabetes Mellitus and received Insulin injections. Review of Resident #78's October 2024 Physician's orders indicated: -Finger Stick Blood Sugar (FSBS) 4 times a day (before meals and at hour of sleep) -Special Instruction: **Follow facility protocol for fasting blood sugar less than 60 mg/dL. -Report HI (high) reading to MD (Medical Doctor)/NP (Nurse Practitioner)** start date of 4/28/23. -Novolog FlexPen (fast acting Insulin injection) U-100 Insulin Pen; 100 unit/mL (Units/Milliliters) (3 mL); amount 10 Units subcutaneous with meals: 8 A.M., 12 P.M., 5 P.M., start date of 12/29/23 Review of Resident #78's Vitals Report indicated high blood sugar levels on the following dates: -9/10/24: 500 mg/dL -9/23/24: 504 mg/dL -10/1/24: 532 mg/dL -10/2/24: 411 mg/dL -10/4/24: 492 mg/dL -10/5/24: 541 mg/dL -10/7/24: 452 mg/dL (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/9/24: 439 mg/dL -10/29/24: 422 mg/dL Review of Resident #78's Nursing Progress Notes indicated that nursing staff did not notify the Physician or Nurse Practitioner (NP) regarding the Resident's high blood glucose levels on any of the dates listed when the Resident's FSBS results were high. During an interview on 10/30/24 at 3:01 P.M., the Director of Nursing (DON) said that Resident #78 did not have any parameters for what high blood sugar levels were since his/her admission to the facility. The DON also said that although the Physician's orders indicated to follow facility policy for blood sugar, the facility did not have a policy for hyperglycemia and there was no evidence that the Physician and/or Nurse Practitioner (NP) were notified of the elevated blood sugars in the Nursing Progress Notes. During a follow-up interview on 10/30/24 at 3:29 P.M., the DON said that she expects the nursing staff to notify the Physician or NP if the Resident's blood sugar levels are over 450 mg/dL and the nursing staff did not. During an interview on 10/30/24 at 3:45 P.M., Resident #78's Physician said that he did not put in the current order for high blood sugar levels and that the order should have documented the numerical value for contacting the Physician. The Physician also said that he was not contacted for Resident #78's elevated blood sugar levels but that his NP may have been contacted. Further review of the medical record did not indicate that the NP was contacted regarding the high blood sugar levels resulted for Resident #78 on: 9/10/24, 9/23/24, 10/1/24, 10/2/24, 10/4/24, 10/5/24, 10/7/24, 10/9/24, and 10/29/24. During an interview on 10/30/24 at 4:29 P.M., Resident #78 said that he/she had been experiencing high blood sugars which makes him/her feel uncomfortable. Resident #78 also said that when the high blood sugars occurs, his/her mouth becomes dry, breath smells sweet, and he/she urinate a lot. Resident #78 said that a year ago he/she had been sent out to the hospital when his/her blood sugar went up to 500 mg/dL.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on observation, interview, policy and record review, the facility failed to ensure that respiratory care and services consistent with professional standards of practice, were provided for two Residents (#87 and #24), out of a total sample of 23 residents. Specifically, the facility failed to: 1. For Resident #87, routinely maintain the oxygen concentrator (a device used to deliver supplemental oxygen) air intake gross particle filter in accordance with Physician orders and manufacturers guidelines, placing Resident #87 at risk for equipment malfunction, impaired oxygen delivery and contamination. 2. For Resident #24, ensure that the Resident had an active Physician's order for nebulizer (delivery device used to administer medication in the form of an aerosol that is inhaled into the lungs) equipment care, handling, and storage, to prevent contamination and the spread of infections. Findings include: Review of the facility policy titled Oxygen and Respiratory Equipment Management, dated September 2009, revised February 2019, indicated the following: -It is the policy of this facility to provide consistent care of all oxygen and respiratory equipment in accordance with recognized infection control practices. -After obtaining a Physician order to initiate oxygen therapy, the Nurse will initiate oxygen therapy on a treatment sheet (documentation location where Nurses record delivery of oxygen and care of oxygen equipment for residents) including all required elements (monitoring and equipment care). -after a Physician order is received for hand held nebulizer treatment, the Nurse will: <obtain tubing, face mask and plastic bag. Write date on sticker. <add handheld nebulizer to treatment sheet. <tubing and mask are changed weekly on 11-7 shift. <the handheld nebulizer is to be rinsed, air dried and replaced in the appropriate (storage) bag after each use. Review of the New Life Elite Oxygen Concentrator Service Manual, undated, retrieved at https://files.caireinc.com/MN105-1-E.pdf indicated: -To ensure accurate output and efficient operation of the oxygen concentrator, the user must clean the gross particle filter weekly, as described below: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>Remove the dirty air intake particle filter from the back of the unit, and install the clean filter stored in the pocket on the back of the unit. >Wash the dirty filter in warm soapy water and rinse. >Use a soft absorbent towel to remove excess water. >Place the clean air intake gross particle filter in the pocket on the back of the unit. 1. Resident #87 was admitted to the Facility in January 2022, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD- a chronic lung disease that causes obstructed airflow from the lungs that leads to respiratory problems including difficulty breathing, shortness of breath and wheezing) and Chronic Respiratory Failure (a condition that occurs when the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body, identified with symptoms of trouble breathing and fatigue). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #87: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of a total score of 15. -was receiving Oxygen therapy. Review of Resident #87's October 2024 Physician's orders included: -Oxygen at 2 Liters Per Minute (LPM - the flow rate of oxygen) via Nasal Cannula (NC - a thin flexible tube that provides supplemental oxygen through the nose via nasal prongs) continuous (non-stop), effective 1/8/23. -Rinse (oxygen concentrator) filter on Sunday night shift (11:00 P.M.-7:00 A.M.), effective 10/1/24 Review of Resident #87's current Comprehensive Care Plan, indicated: -Oxygen in use to promote comfort and optimize lung expansion, start date 11/22/22. >Administer Oxygen as ordered by Physician, effective 11/22/22. >Rinse oxygen concentrator filter weekly, effective 11/22/22. -Pneumonia (an infection of the lungs that may be caused by bacteria, viruses, fungi or aspiration [when food or liquid is accidentally inhaled into airways and lungs] and characterized by severe cough with phlegm, fever, chills and difficulty breathing), effective 9/29/24 >Keep room cool and free from irritants such as dust, effective 9/29/24. Review of Resident #87's October 2024 Treatment Administration Record (TAR) indicated that the oxygen concentrator filter had been cleaned on 10/27/24 as evidenced by the Nurse's signature of completion on the TAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 at 10:38 A.M., the surveyor observed Resident #87 lying in bed with Oxygen set at 2 LPM via NC from a New Life Elite oxygen concentrator located at the bedside. The surveyor observed the air intake gross particle filter on the back of the concentrator unit was covered in a thick layer of gray dust. During an observation and interview on 10/29/24 at 7:22 A.M., the surveyor and Unit Manager (UM) #2 observed Resident #87 lying in bed with Oxygen set at 2 LPM via NC from a New Life Elite oxygen concentrator and the air intake gross particle filter was covered in a thick layer of gray dust. UM #2 said the air intake gross particle filter should be cleaned weekly by the night shift Nurse on Sundays. UM #2 said that the oxygen concentrator filter was covered in thick gray dust and was not cleaned on Sunday as indicated had been done on the Resident's TAR. UM #2 said that air intake gross particle filters should be cleaned so that dirty air does not get inhaled by the Resident and to ensure accurate output of clean (filtered) air to the Resident. During a follow-up interview on 10/29/24 at 7:46 A.M., UM #2 said the New Life Elite oxygen concentrator user manual indicated that the air intake gross particle filters should be cleaned weekly because when the air intake gross particle filter is not cleaned weekly, the dirty filter could impact the oxygen concentrator function and impair oxygen flow to the Resident. UM #2 further said that impaired Oxygen flow could be dangerous for Resident #87 because the Resident might not get the correct Oxygen flow. 51571 2. Resident #24 was admitted to the facility in August 2024, with diagnoses including Pneumonia, Acute Respiratory Failure with hypoxia (a life-threatening condition where the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body, with difficulty attaining normal blood oxygen levels), and Orthopnea (discomfort with breathing while lying flat/supine). Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], indicated that the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of the Resident #24's October 2024 Physician's orders included the following: -Acetylcysteine (mucolytic - breaks down or dissolves mucus) solution; 100 milligrams (mg)/milliliters (ml) (10%); amount to administer (amt): 1 dose = 4 mls; inhalation. Special instructions: Shortness Of Breath (SOB)/wheeze, three times a day PRN (as needed), initiated 8/16/24, order active. -Albuterol Sulfate (bronchodilator - relaxes the airway muscles and open the airways) solution for nebulization. 2.5 mg/3 ml (0.083%); amt: 1 vial inhalation. Special instructions: for Bronchospasm, four times a day PRN, initiated 10/10/24, order active. -The Physician's orders did not include any orders for the care and maintenance of the nebulizer equipment or any special instructions for cleaning the nebulizer equipment after Acetylcysteine medication administration. Review of Resident #24's October 2024 Medication Administration Record (MAR) indicated the following medications were administered PRN as ordered: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Albuterol Sulfate solution for nebulization was administered once daily on: 10/12/24, 10/18/24, 10/22/24, and 10/24/24. -Acetylcysteine Solution for nebulization was administered once daily on: 10/5/24, 10/14/24, 10/16/24, 10/21/24, and 10/25/24. Review of the article, Acetylcysteine (inhalation route), reviewed at: https://www.mayoclinic.org/drugs-supplements/acetylcysteine-inhalation-route/description/drg - 20061456 indicated the following: -side effects: >patients using a face mask for inhalation of Acetylcysteine: the mask may leave a stickiness on your face This (stickiness) can be removed with water. >when you use Acetylcysteine, you may notice that the medicine has an unpleasant odor at first. However, this smell will go away soon after you use the medicine On 10/28/24 at 11:31 A.M. and 4:39 P.M., the surveyor observed Resident #24 lying in bed watching television, and the nebulizer equipment and tubing were laying on the Resident's nightstand table. The surveyor observed the nebulizer tubing and face mask were laying directly on the nightstand and touching the wood surface. The surveyor did not observe an equipment storage bag or date label on the nebulizer equipment. On 10/29/24 at 8:39 A.M., the surveyor observed Resident #24 lying in bed and the nebulizer equipment and tubing were laying on the nightstand table. The surveyor observed there was no equipment storage bag or date label on the nebulizer equipment. During an interview at the time, Resident #24 said that he/she have used the nebulizer equipment when he/she needed it, but the nebulizer equipment had never been changed. The Resident said he/she last used the nebulizer equipment a few days ago. Resident #24 further said that he/she had a nebulizer device at home and changed the home nebulizer equipment and tubing every few days. During an interview and observation on 10/30/24 at 12:46 P.M., Nurse #3 said the nebulizer equipment and tubing was changed once a week on Sunday by the night shift Nurse. Nurse #3 examined Resident #24's nebulizer equipment and tubing and said that there was a date written in marker which indicated 10/5. Nurse #3 said that the Resident's nebulizer equipment should have been changed on 10/28/24 and stored in a plastic bag but this had not been done. Nurse #3 said all nebulizer equipment and tubing are changed weekly, labeled and dated, and stored in a clean plastic bag when not in use. During an interview on 10/30/24 at 1:37 P.M., the Director of Nursing (DON) said nebulizer equipment should be changed once a week on Sunday by the night shift Nurse. The DON also said the nebulizer equipment changes should be recorded on the Treatment Administration Record (TAR). The DON said that there should have been an order from the Physician for nebulizer equipment maintenance but there was none.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 51466 Based on interview, record and policy review, the facility failed to ensure that professional standards of practice relative to dialysis (the process of cleansing the blood by passing it through a special machine, necessary when the kidneys are unable to filter the blood) care and services for one Resident (#32), of two applicable residents reviewed for dialysis, out of a total sample of 23 Residents. Specifically, for Resident #32, the facility failed to: 1. Monitor and assess the Physician's ordered fluid restriction to ensure adequate fluid intake. 2. Provide food items prior to dialysis as indicated in the plan of care and per the Resident's preferences. Findings include: Review of facility policy titled Guidelines for Initiating, Maintaining, and Removing Residents from Intake & Output Recording, dated 1/2016, indicated the following: -It is the policy of this facility to monitor the intake and output of residents as needed based on the resident's clinical condition and physician orders. -Conditions for which a resident must be put on I & O (intake and output) include the following: Dialysis and Fluid Restriction. -I & O monitoring will be communicated to all levels of staff. Review of the facility policy titled Fluid Restrictions, dated 2/12/24, indicated the following: -11:00 P.M. to 7:00 A.M. Nurse will transcribe the 24-hour totals to the Monthly I & O Record. -Any discrepancies or incomplete recordings will be reported to the Charge Nurse at this time. Review of the facility policy titled Nursing Management of Residents Requiring Dialysis, dated 1/8/19, indicated the following: -Notify Culinary Services of any need for meals to be sent with the Resident, day and time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #32 was admitted to the facility in June 2022, with diagnoses including End Stage Renal Disease (ESRD - a medical condition where the kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis [a procedure to remove waste products and fluid from the body when the kidneys stop working] or a kidney transplant to maintain life) on Hemodialysis (a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately), Hypotension (low blood pressure) of Hemodialysis, and Type 2 Diabetes (DM II - condition in which the body does not produce enough insulin hormone and has trouble controlling blood sugar levels). Review of the Minimum Data Set (MDS) Assessment, dated 9/6/24, indicated that Resident #32: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out 15 -utilized a wheelchair -required set-up assistance from staff for eating and oral hygiene -received Hemodialysis during the assessment period Review of the October 2024 Physician's orders indicated the following: -the Resident has dialysis at the [dialysis clinic] at 7:00 A.M. Leaves the facility at 6:00 A.M., returns after 10:30 A.M. on Monday, Wednesday, Friday, initiated 6/7/23 -Fluid Restriction 1500 milliliters (ml) per day, initiated 7/27/23 Review of the Registered Dietician (RD) Progress Note, dated 9/6/24, indicated Resident #32 was on a 1500 ml Fluid Restriction. Review of the Nutritional Status Care Plan, dated 9/6/24, included the following interventions: -Resident was to be sent to dialysis center with half sandwich or peanut butter crackers and 4 ounces (oz) of juice. -Maintain Fluid Restriction of 1500 ml. During an interview on 10/29/24 at 12:47 P.M., Resident #32 said he/she did not eat anything at dialysis and would like to have something to eat. Resident #32 said he/she would accept food from the facility staff if they offered and was hungry while at dialysis. Resident #32 said the facility staff did not offer any food/snacks prior to him/her leaving for dialysis and his/her family had provided crackers for him/her to eat. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/24 at 1:04 P.M., Certified Nurses Aide (CNA) #1 said Resident #32 had been on a fluid restriction in the past but was unsure if the fluid restriction was still in place. The surveyor and CNA #1 reviewed the Care Assist Tool (electronic documentation that included specific information about the Resident) which indicated the Resident's diet, and CNA #1 said the Care Assist Tool did not indicate that the Resident was on a fluid restriction. CNA #1 said that since the fluid restriction was not indicated on the Care Assist Tool, Resident #32 must no longer be on fluid restriction. During an interview on 10/30/24 at 6:50 A.M., Nurse #5 (who worked the 11:00 A.M. to 7:00 P.M. shift), said Resident #32 was sometimes provided with crackers and coffee prior to leaving for dialysis. Nurse #5 further said Resident #32 was on a fluid restriction and the dietary department sent a portion of the amount of fluids (750 ml) with the Resident's meal trays and that Nursing staff provided the remainder of the fluids (750 ml). Nurse #5 said the CNAs should be documenting the fluid intake provided with meals and the Nurses would document the total amount of fluids provided from the nursing staff and from meals on each shift. Nurse #5 said the 11:00 P.M. to 7:00 A.M. Nurse was responsible for totaling the 24-hour fluid amount totals and documenting the fluid amounts on the Medication Administration Record (MAR). The surveyor requested to review the 24-hour fluid intake amounts with Nurse #5 at this time, and Nurse #5 said she was unable to find the 24-hour fluid intake totals in the MAR and requested assistance from Unit Manager (UM) #1. The surveyor, Nurse #5 and UM #1 tried to review Resident #32's fluid intake amounts as documented by the CNAs and were unable to find amounts of fluids provided daily for Resident #32. Both Nurse #5 and UM #1 said it would be important to find this information in the MAR so that abnormalities could be reported to the Physician or Nurse Practitioner (NP) in order to maintain proper fluid balance for any Resident on fluid restriction. During an interview on 10/30/24 at 7:09 A.M., the Food Service Director (FSD) said the dietary staff save Resident #32's breakfast tray in the kitchen until he/she returns from dialysis. The FSD further said the nursing staff were responsible for making sure Resident #32 received something to eat at 5:00 A.M. because the kitchen was not open at that time. The FSD said dietary staff stock the kitchenettes on the nursing units with foods like juice, yogurt, jelly, cereal, and bread that could be provided to the Resident before he/she went to dialysis. The FSD further said Resident #32's diet slip indicated he/she was on a 1500 ml Fluid Restriction. The FSD said the dietary department provided one-half of the 1500 ml (750 ml) of the fluid restriction, and the nursing department provided the other half, and were responsible for totaling the Resident's 24-hour fluid intake amounts. During an interview on 10/30/24 at 9:15 A.M., Nurse #1 and UM #1 said they were unsure why the CNA Care Assist Tool documentation was not indicating fluids amounts for Resident #32. Nurse #1 and UM #1 both said the 1500 ml Fluid Restriction was not on the Resident's Care Card (specific information about the Resident's care) for Resident #32 or under Diet in the Care Assist Tool, and that this was how the CNA's find the information on how to take care of the Resident. During an interview on 10/30/24 at 9:19 A.M., CNA #4 said that he/she referred to the Residents Care Card and Care Assist Tool for how to appropriately care for a Resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 9:43 A.M., UM #1 provided the surveyor with the October 2024 MAR for Resident #32, which indicated the total 24-hour Intake and Output documentation for fluids for the past 30 days. UM #1 said that the fluid amounts totals on the MAR for Resident #32 did not fall within the normal range, and staff had not maintained accurate monitoring of his/her fluid intake. UM #1 said inaccurate monitoring of the Resident's fluid intake could put the Resident at risk for fluid overload or dehydration. Review of the October 2024 Medication Administration Record (MAR) indicated Total 24-hour Intake and Output for Resident #32 from 10/01/24 through 10/30/24 indicted the following: -15 days that the Resident's fluid intake was below 1000 ml. -8 days that the 24-hour fluid intake totals were not documented. -2 days that the 24-hour fluid totals were over 1500 ml. During an interview on 10/30/24 at 10:15 A.M., Resident #32 said he/she did not have any food or drink from staff this morning prior to dialysis and ate a few crackers which were provided from his/her family before leaving. Resident #32 said he/she was uncomfortable, was very hungry and wanted to eat his/her breakfast. UM #1 was observed to ask the Resident if he/she would like to be changed or repositioned and Resident #32 said he/she needed to eat breakfast because he/she was diabetic. During an interview on 10/30/24 at 3:06 P.M., the RD said the facility staff save Resident #32's breakfast tray and it was provided to him/her when he/she returned from dialysis. The RD said snacks were available in the unit kitchenette that the nursing staff could provide to Resident #32. The RD said she was unsure if the Resident was provided with any food/fluids prior to leaving for dialysis. The RD further said Resident #32 has had hypoglycemic (low blood sugar) episodes in the past and that the dialysis center had suggested the facility send the Resident to dialysis with peanut butter crackers. The RD said she was not sure if staff have asked Resident #32 what his/her preferences were in regards to receiving breakfast or snacks prior to his/her dialysis treatments. The RD said that the Resident was on a fluid restriction and that the nursing staff were responsible for tracking the 24-hour fluid totals for accurate fluid restriction/fluid intake monitoring. The RD further said best practice would be for the Nurses to report abnormal fluid intakes which included fluid intake less than 1000 ml and greater than 2000 ml to the Medical Doctor to avoid any complications related to potential dehydration or fluid overload.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 51571 Based on record review, interview, and policy review, the facility failed to ensure that one Resident (#84), out of a total sample of 23 residents, was free from the risks of side effects resulting from the unnecessary use of psychotropic medications. Specifically, the facility failed to ensure that appropriate monitoring for adverse consequences and side effects of antipsychotic medications using the Abnormal Involuntary Movement Scale (AIMS) assessment (a rating scale used to measure involuntary movements of the face, mouth, trunk, or limbs known as Tardive Dyskinesia (TD) in a resident taking antipsychotic medications) was completed timely in accordance with standards of practice. Findings include: Review of the facility policy titled Guidelines for Completing AIMS Testing, revised 10/2019, indicated: -All residents receiving antipsychotics (neuroleptics) will have an AIMS test completed prior to initiation of the medication and at least every six (6) months thereafter to monitor for movement disorder. -The AIMS aids in early detection of tardive dyskinesia as well as provides a method for ongoing surveillance. -In the absence of psychiatric services, the AIMS test will be completed by an authorized member of the nursing staff or the Nurse Practitioner. Review of the National Library of Medicine (NLM), dated 5/25/23, reviewed at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10292174/ indicated but was not limited to: -The Abnormal Involuntary Movement Scale (AIMS) is administered every three to six months to monitor the patient for the development of TD (tardive dyskinesia - a syndrome characterized by abnormal involuntary movements of the patient's face, mouth, trunk, or limbs). In elderly patients, however, TD can develop after as little as one month. Resident #84 was admitted to the facility in November 2021, with diagnoses including Alzheimer's disease (a progressive disease that destroy memory, thinking, and behavior), 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), Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/intense, excessive, and persistent worry and fear about everyday situations), Restlessness (a feeling of discomfort that arises when a person is unable to relax or make progress), Agitation (a state of extreme arousal that can cause a person to feel tense, irritable, and unable to relax) and Insomnia (sleep disorder with trouble falling and/or staying asleep). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) Assessment, dated 9/27/24, indicated Resident #84: -was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 8 out of a total of 15. -received an antipsychotic (psychotropic medication primarily used to manage psychosis [including delusions, hallucinations, paranoia or disordered thought]) and the antipsychotic was administered on a routine basis. Review of Resident #84's Care Plan last reviewed/revised on 10/23/24 included care planning to complete an AIMS test every six months and as needed (PRN). Review of Resident #84's October 2024 Physician's orders included: -Seroquel (Quetiapine - an antipsychotic medication used to treat agitation and anxiety) tablet (tab) 50 milligrams (mg), amount (amt) to be administered 1 tab = 50 mg, oral (by mouth). Special Instructions: For agitation, Give med (medication) during dinner time. At bedtime: 7:00 P.M., initiated 1/17/24, discontinued 10/11/24. -Seroquel (Quetiapine) tablet 25 mg, amt: 25 mg, oral. Special Instructions: For agitation, give med during dinner time. At bedtime: 8:00 P.M., initiated 10/11/24, discontinued 10/28/24. -Seroquel (quetiapine) tablet 50 mg, amt: 50 mg, oral. Special instructions: For agitation, give med during dinner time. At bedtime, 8:00 P.M., initiated 10/28/24, order active. Review of the October 2024 Medication Administration Record (MAR) for Resident #84 indicated that the Resident received the Seroquel medication as ordered. Review of Resident #84's clinical record did not indicate that an AIMS assessment was completed within the last six months. During an interview on 10/30/24 at 1:23 P.M., Unit Manager (UM) #2 said that the last time an AIMS assessment was completed for Resident #84 was on 1/31/24. UM #2 said that nursing should be checking on due dates for AIMS assessments. During an interview on 10/30/24 at 2:18 P.M., the Director of Nursing (DON) said AIMS assessments should be completed every six months for all residents receiving antipsychotic medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50138 Based on observation, interview, and record review, the facility failed to adhere to infection control standards to prevent contamination and stop the spread of infections for one Resident (#54), out of a total sample of 23 residents. Specifically, the facility failed to: 1. For Resident #54, perform appropriate hand washing/hygiene for five opportunities, during a wound care procedure which increased the Resident's risk for wound contamination and infection. 2. For Resident #54, Adhere to Enhanced Barrier Precautions (EBP: infection control guidelines that use Personal Protective Equipment [PPE] to reduce the spread of multidrug-resistant organisms [MDROs]) during medication and fluid administration through a gastrostomy tube (G-tube: a tube surgically inserted through the abdominal wall and into the stomach to provide nutrition, fluids and medications by bypassing the mouth and esophagus). Findings include: Review of the facility policy titled Handwashing, dated June 2012 with revision date of January 2016, indicated the following: -It is the policy of this facility to follow the Centers for Disease Control and Prevention (CDC) guidelines for hand hygiene .and reduce the risk of healthcare associated infections. Review of the Centers for Disease Control and Prevention Guidelines for Core Infection Prevention and Control Practices in All Settings indicated the following: >Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: -Immediately before touching a patient. -Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices. -Before moving from work on a soiled body site to a clean body site on the same patient. -After touching a patient or the patient's immediate environment. -After contact with blood, body fluids or contaminated surfaces. -Immediately after glove removal. Review of the Centers for Disease Control Hand Hygiene in Healthcare Settings Glove Use indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Gloves are not a substitute for hand hygiene. -If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. -Perform hand hygiene immediately after removing gloves. -Change gloves and perform hand hygiene during patient care, if gloves become damaged, or visibly soiled with blood or body fluids following a task. -Change gloves and perform Hand hygiene when moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. -Never wear the same pair of gloves in the care of more than one patient. -Carefully remove gloves to prevent hand contamination. Review of the facility policy titled Personal Protective Equipment (PPE- protective gear which includes gloves, masks, gowns and eyewear to prevent the spread of infection), dated June 2021 revised September 2021 indicated: -Gloves >Perform hand hygiene after removing gloves. >Gloves do not replace hand hygiene. Resident #54 was admitted to the facility in October 2019, with diagnoses including Stage Four Pressure ulcer (full thickness loss of skin with extensive destruction/damage to muscle, bone or supporting structures such as tendon or joint capsule) of the sacral (bony structure located at the base of the spine) area and Neuromuscular Dysfunction of the Bladder (a condition where the nerves and muscles of the bladder do not work together well and can cause problems with the emptying of the bladder), dysphagia (difficulty swallowing), Cerebrovascular Accident (CVA: when blood flow to a part of the brain is stopped either by a blockage or a rupture of a blood vessel) and presence of gastrostomy tube (feeding tube). Review of the Minimum Data Set (MDS) Assessment, dated 9/13/24, indicated Resident #54: >was severely cognitively impaired as evidenced by staff interview. >had an indwelling urinary catheter (soft flexible tube that drains urine from the bladder). >was dependent for Activities of Daily Living (ADLs-the basic self-care needs including washing, dressing, and getting in and out of bed or chair). >had a feeding tube which provided greater than 51 percent (%) calorie needs and greater than 501 milliliters (mls) of fluids daily. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #54's Comprehensive Person-Centered Care Plan indicated: >Pressure ulcer on the sacrum (large flat bone in the lower part of the spine), effective October 2020 >Feeding tube, effective March 2021 >Indwelling catheter, effective July 2022 1. Review of Resident #54's October 2024 Physician's orders indicated: >Stage 4 Pressure wound of the sacrum- wash with Normal Saline (NS- nine grams of salt per one liter of water solution) and pat dry. -Apply Santyl (a prescription ointment used remove dead tissue from wound beds) followed by Alginate Calcium (a fibrous dressing that absorbs wound drainage) followed by super absorbent gelling fiber with silicone border (an absorbent cover dressing that gels when exposed to liquids and has soft flexible edges made from silicone). -change three times a week. >Foley Catheter (a soft, flexible tube inserted to the bladder to drain urine) 16 French (5.3 millimeter tube) with 10 milliliter (ml) 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) to continuous drainage. On 10/30/24 at 11:50 A.M., the surveyor observed Nurse #4 and the Infection Preventionist (IP) Nurse provide the following wound care for Resident #54's sacral wound: -Nurse #4 and the IP performed hand hygiene and donned (put on) disposable gowns and gloves. -Nurse #4 and the IP then positioned the Resident into a side lying position in the bed. -Nurse #4 dragged Resident #54's urinary drainage bag (a collection bag attached to the indwelling Foley Catheter to collect urine), that was lying directly on the floor, across the floor and placed the urinary drainage bag on top of the Residents fitted sheet. -Nurse #4 removed the old sacral dressing from Resident #54 with the same gloves on that were used to pick up the urinary drainage bag from the floor and placed the old dressing into a trash bag. -Nurse #4 then removed her gloves and placed them in the trash bag. -Nurse #4 put on new gloves without performing hand hygiene first. -Nurse #4 cleansed the Resident's wound using NS with gauze and patted the area dry. -Nurse #4 removed her gloves and placed them in the trash bag. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse #4 put on new gloves without performing hand hygiene first. -Nurse #4 then measured the Resident's wound which was 2 cm (centimeters) x 2 cm x 0.3 cm. -Nurse #4 removed her gloves and placed them in the trash bag. -Nurse #4 put on new gloves without performing hand hygiene first and applied Santyl to the wound bed, followed by Alginate Calcium. -Nurse # 4 removed her gloves and washed her hands in the bathroom sink. -Nurse #4 put on new gloves and covered the Alginate Calcium with super absorbent gelling fiber with silicone border. -Nurse #4 removed her gloves and put them in the trash bag. -Nurse #4 then reached into her pocket without performing hand hygiene first, retrieved a marker pen and initialed the outer dressing which was on the Resident's sacrum. During an interview on 10/30/24 at 12:18 P.M., Nurse #4 said that she had dragged the urinary drainage bag across the floor and put it on top of the Resident's fitted sheet prior to the dressing change so the urinary drainage bag would not pull on the Resident. Nurse #4 said she knew that the urinary drainage bag should not have been placed on the bed because it was dirty from being on the floor and could spread germs. Nurse #4 said that she sometimes brings a bottle of hand sanitizer into the room when she performs wound care. Nurse #4 said should have used hand sanitizer each time she removed her gloves while providing wound care for Resident #54, but she did not. Nurse #4 said that hand cleansing was important for the prevention of infection when providing wound care. During an interview on 10/30/24 at 12:18 P.M., the IP said she was aware that Nurse #4 had not performed hand hygiene after removing soiled gloves and before putting on new gloves several times during the dressing change but did not say anything to correct Nurse #4, but she should have. The IP said hands should be cleaned every time gloves are removed to prevent the spread of infection. 37400 2. Review of the facility policy titled Enhanced Barrier Precautions, dated 4/1/24, indicated that it was the policy that all staff providing high-contact resident care activities will implement EBP for residents with any of the following: >infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply. >wound and/or indwelling medical device even if the resident is not known to be infected or colonized with a MDRO >high contact resident care activities are defined as to be .device care or use such as .feeding tubes . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>indwelling medical devices include .feeding tubes . >a sign indicating the need for EBP will be placed conspicuously to alert staff before approaching the resident for care >a receptacle with necessary PPE will be placed in or near the room for easy accessibility Review of the October 2024 Physician's orders indicated the following: -NPO (nil per os or nothing by mouth), initiated 7/24/21 -flush G-tube with minimum of 15 ml water pre/post medication administration four times daily, initiated 3/4/22 -check G-tube placement before feeding and prior to medication administration every shift ., initiated 12/29/21 -water flushes 400 ml every 4 hours per Medical Doctor (MD) via G-tube, initiated 4/13/24 -may combine all liquid/medications via G-tube, initiated 3/16/23 -may crush medications per guidelines, initiated 4/6/21 -maintain EBP every shift ., initiated 12/5/22 On 10/30/24 at 9:54 A.M., the surveyor observed Nurse #2 administer medications via Resident #54's G-tube and the following was observed: -EBP signage was posted outside of the Resident's room and indicated for everyone to cleanse hands before entering and when leaving the room, wear gloves and a gown for high contact resident care activities including device care . feeding tubes -a compartment containing different sizes of gloves and gowns was hanging on the outside of the Resident's door -Nurse #2, who was outside of the Resident's room at the medication cart, crushed the medication, put it in a disposable cup and mixed it with warm water. -Nurse #2 donned (put on) gloves and entered the Resident's room with the cup of medication and water. Nurse #2 did not don a gown as required. -Nurse #2 used her gloved hands to move the Resident's blanket and hospital gown to expose the G-tube. -Nurse #2 opened a piston syringe packet, uncapped the G-tube and checked the residual (the volume of fluid or food remaining in the stomach during enteral nutritional feedings) using the piston syringe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Healthcare Center	9 Arbetter Drive Framingham, MA 01701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse #2 then utilized the syringe connected to the G-tube, flushed the tube with 15 mls of water via gravity, then poured the cup containing the crushed medication and water into the syringe. -After administering the medication, Nurse #4 flushed the G-tube with 400 mls of water, replaced the cap on the end of the G-tube, disposed of the empty medication cup, doffed her gloves and exited the Resident's room. During an interview immediately following the observation, Nurse #2 said the Resident was on EBP precautions. Nurse #2 said a gown and gloves should be worn when providing direct care to the Resident. Nurse #2 said accessing his/her G-tube to administer medications was considered direct care. Nurse #2 said in addition to wearing the gloves, she should have worn a gown, but she did not.