STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225690	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baypointe Rehab Center	50 Christy Place Brockton, MA 02301

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 43963 Based on records reviewed and interviews for one of three sampled resident (Resident #1), the Facility failed to ensure that the resident and/or his/her family member or legal representative participated in the development and implementation of their person-center care plans, which included conducting and inviting the resident and/or their legal representative to an interdisciplinary care plan meeting following the completion of any Comprehensive Minimum Data Set (MDS) Assessment, including the Admission, Quarterly, and Annual MDS. Findings include: Review of the Facility Policy titled, Care Plans, dated as last revised 02/2022, indicated that each resident in the facility shall be involved in the development and review of his/her plan of care along with his/her family member. The Policy further indicated that the Interdisciplinary Team (IDT) conferences shall be held for each resident at 90-day intervals and the IDT shall; -Evaluate the resident's progress toward meeting the goals outlined in the care plan; -Revise the plan of care, and services; -Collaborate with the resident and family in revising the plan of care; -Resident, family members, or other responsible persons shall be invited to attend the IDT conference; and -Dates of each IDT care conference and the participants in each conference shall be documented in the resident's medical record. Resident #1 was admitted to the facility in April 2024, diagnoses included both lower extremity necrotizing cellulitis (infection causing skin tissue to die), diabetes mellitus, peripheral vascular disease, and fibromyalgia (long-term condition causing body pain and tiredness). Review of Resident #1's Face Sheet, dated 03/01/24, indicated his/her Responsible Party (Family Member #1) was listed as his/her first contact. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/07/24 at 2:48 P.M., Family Member #1 said that the facility had been aware that Resident #1's Health Care Proxy had been activated while he/she was in the Hospital, but that the Facility had not activated his/her HCP upon his/her admission there. Family Member #1 said that she had been quite involved in Resident #1's care and had asked the nursing staff to keep her informed of his/her progress, health status, and any changes. Family Member #1 said the Facility had not had a meeting with her or Resident #1 to review his/her progress and plan of care since admission. Review of Resident #1's Quarterly MDS Assessment, dated 07/04/24, indicated that he/she was alert and had a Brief Interview Mental Status (BIMS) score of 13 (score of 13-15 indicated cognitively intact). Review of Resident #1's Medical Record indicated that there was no documentation to support he/she had a comprehensive care plan meeting after the completion of his/her latest MDS. During an interview on 08/08/24 at 2:23 P.M., the Unit Manager said that she was unaware that Resident #1 had not had a care plan meeting in July as per the Care Plan schedule generated from the social service department. The Unit Manager said that care plan meetings are run by the Social Service Department, and they are responsible for inviting the resident and their family members to attend the meetings. During an interview on 08/08/24 at 3:08 P.M., Social Worker (SW) #1 said that the Former Director of Social Services had been doing the Care Plan meeting schedule, but said the Director had resigned earlier that month. SW #1 said she does not know why the care plan meeting for Resident #1 had been missed. During an interview on 08/08/24 at 2:44 P.M., Social Worker #2 said that Care Plan meetings are set according to the resident's MDS schedule and said that even if the resident is responsible for themselves, the facility still invites their family members to attend the meetings. SW #2 said between 07/11/24 and 07/17/24, care plan meetings on her unit (Baywood) had been missed. During an interview on 08/08/24 at 4:13 P.M., the Assistant Director of Nurses (ADON) said that she was not aware that Care Plan meetings (for Resident #1's unit) were not being completed in a timely manner. The ADON said that it is the Facility's expectation that care plan meeting be completed in a timely manner and in accordance with the completion of a residents' MDS.

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. 43963 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was alert, oriented and his/her own decision maker, the facility failed to ensure Resident #1 and/or his/her Representative were provided with a written explanation of the need to change his/her room, when on 06/26/24 Resident #1's was moved to a new room despite his/her wishes to remain in his/her original room. Findings include: Review of the Facility Policy tilted, Room Change, dated as last revised 10/2022, indicated that a room change or change in roommate shall be made when the resident or their representative requests the change or the facility deems it necessary. The Policy further indicated the following; -When a resident room change is occurring, the resident being moved or their representative, will be informed of the room change; and -The notice of change in a room or roommate assignment will be both verbal and in writing and will include the reason(s) for the change. Resident #1 was admitted to the facility in April 2024, diagnoses included both lower extremity necrotizing cellulitis (infection causing skin tissue to die), diabetes mellitus, peripheral vascular disease, and fibromyalgia (long-term condition causing body pain and tiredness). Review of Resident #1's Face Sheet, dated 03/01/24, indicated his/her Responsible Party (Family Member #1) was listed as his/her first contact. During an interview on 08/07/24 at 2:48 P.M., Family Member #1 said that the facility had been aware that Resident #1's Health Care Proxy had been activated while at the Hospital, but said the Facility had not activated his/her HCP upon his/her admission there. Family Member #1 said that she had been quite involved in Resident #1's care and had asked nursing staff to keep her informed of his/her condition and any change to his/her plan of care. Family Member #1 said that Resident #1 had not wanted his/her room changed and said that the facility had not given him/her a choice, they just moved him/her to different room. During an interview on 08/08/24 at 10:57 A.M., Resident #1 said that he/she had not been asked to change his/her room, that staff just told him/her that he/she was changing rooms and did not give him/her an explanation as to why his/her room needed to be changed. Resident #1 said that someone just came into his/her room and said have all your things packed by tomorrow because you are changing rooms. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 said he/she never saw the new room prior to the move, had not met with the roommate, did not know the reason for the room change, never signed anything saying he/she agreed to the move and was never informed that he/she could appeal the room change. Review of Resident #1's Medical Record, indicated that there was no documentation to support he/she had agreed to a room change, met with the new roommate prior to the move, or was aware of the reason for the room change. During an interview on 08/08/24 at 3:08 P.M., Social Worker (SW) #1 said that she was aware that Resident #1's Family Member was very involved and had requested that the facility inform her of his/her changes. SW #1 said that prior to moving Resident #1 to a new room, the facility must notify the resident and responsible party, explain the reason for the move, show the resident the room in advance, introduce the resident to the potential new roommate, and must issue them a Notice of Room Change 48 hours prior to the move. Social Worker #1 said that no one informed Family Member #1 of Resident #1's room change and said she did not think anyone showed Resident #1 the new room or introduced him/her to his/her new roommate prior to the room change. During an interview on 08/08/24 at 2:44 P.M., Social Worker #2 said that the Room Change Form does not have a spot for the resident to sign indicating they agree to the change and that the form only states the resident will be moved. Social Worker #2 said that documentation of receiving permission from a resident of a room change and the reason why a room change occurred should be documented in a progress note. During an interview on 08/08/24 at 4:37 P.M., the Director of Nurses said the Social Worker that had been involved with Resident #1's room change no longer works at the facility. The DON said that she does not think that Resident #1 saw the room or had been introduced to the new room mate prior to his/her room change. The DON said that it is the Facility's expectation that staff follow the Room Change Policy with all room changes, including that the Resident and/or their responsible party be informed of the reason for a room change, resident views the room and is able to meet the possible new roommate prior to the move.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43963 Based on records reviewed and interviews for one of three sampled residents (Resident #1) who had been admitted with three pressure injuries, the Facility failed to ensure they maintained complete and accurate medical/clinical records including but not limited to documentation related to the completion and accuracy of skin assessments. Findings include: Review of the Facility Policy titled, Charting and Documentation, dated as last revised 01/2023, indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's condition medical, physical, functional or psychosocial condition, shall be documented in the resident's medical records. The Policy indicated that the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Review of the Facility Policy titled, Admission Assessment, dated 10/2022, indicated the purpose of the admission procedure is to gather information about the resident's physical, emotional, cognitive and psychosocial conditions upon admission. The Policy indicated that the Nurse shall perform a complete skin assessment and document the findings accordingly . Resident #1 was admitted to the facility in April 2024, diagnoses included both lower extremity necrotizing cellulitis (infection causing skin tissue to die), diabetes mellitus, peripheral vascular disease, and fibromyalgia (long-term condition causing body pain and tiredness). Review of Resident #1's Hospital Discharge Summary, dated 04/01/24, indicated he/she had multiple pressure injuries present on admission and upon discharge to the Facility. The Discharge Summary indicated Resident #1 had a Stage 3 (full thickness tissue loss) pressure injury to his/her coccyx, an unstageable (stage is not clear because the wound base is covered by a layer of dead tissue) pressure injury to his/her right ischium (lower and back region of the hip bone), and a stage two (partial thickness loss of tissue) to his/her left ischium. Review of Resident #1's Admission Skin Assessments, dated 04/01/24, indicated he/she had no pressure injuries present upon admission. Review of Resident #1's Weekly Skin Assessment, dated 04/05/24, 04/12/24, 04/19/24, and 05/03/24 indicated there were no pressure injuries present. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Care Plan titled, Actual Pressure Injury, dated 04/05/24, indicated he/she had been admitted with three pressure injuries located on his/her coccyx, left ischium, and right ischium. Review of Resident #1's Physician's Orders, dated 04/01/24, indicated he/she required a skin check every evening shift on Fridays. Review of Resident #1's Physician's Orders, dated 04/01/24 through 05/06/24 indicated the following; -Left ischium wash with normal saline, apply Aquacel (antimicrobial dressing, reduces bacteria in the dressing) foam adhesive dressing to area and change every 2 days and as needed (PRN); -Right ischium wash with normal saline, apply Santyl (removes damaged tissue to wounds) to edge, cover with Aquacel AG, change every 2 days and PRN; and -Coccyx wash with normal saline, apply Santyl ointment, cover with aqualcel ag moistened cover with Aquacel foam adhesive dressing, change every other day and PRN. Review of Resident #1's Wound Clinic Progress Note (written by the Wound Physician), dated 04/10/24, indicated he/she had an unstageable pressure injury to his/her right ischium/coccyx and the wound measured 2.9 centimeters (cm) by 1.0 cm by 0.1 cm with partial granulation/slough and a scant amount of serosanguinous drainage and his/her coccyx pressure injury measured 3.0 cm by 0.3 cm x 0.2 cm with partial granulation/slough and no drainage noted. Review of Resident #1's follow-up Wound Clinic Progress Note (written by the Wound Physician), dated 05/08/24, indicated that the Facility staff reported he/she was refusing dressing changes to his/her right ischium and coccyx, and that the previous dressing orders for both areas were discontinued. Review of Resident #1's Treatment Administration Record (TAR), dated 04/01/24 through 04/30/24, indicated the skin checks on 04/05/24, 04/12/24, 04/19/24, and 04/26/24 were initialed by nursing as being completed, however, there was no documentation to support that the existing pressure injuries had been present on Resident #1. Review of Resident #1's Treatment Administration Record (TAR), dated 05/01/24 through 05/06/24, indicated the skin check on 05/03/24 had been initialed by nursing as being completed, however, there was no documentation to support that the existing pressure injuries had been present on Resident #1. During a telephone interview on 08/21/24 at 10:58 P.M., Nurse #1 said he could not recall completing Resident #1's skin assessment upon his/her admission. Nurse #1 said Resident #1 had multiple ulcers to both lower extremities but could not recall any pressure injuries. During a telephone interview on 08/12/24 at 2:05 P.M., the Registered Dietician said she recalled an area to Resident #1's coccyx upon admission and said she reviews the Wound Physician's Notes for changes and recommendations. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/08/24 at 3:45 P.M., Nurse #2 said she could not recall Resident #1's skin conditions upon admission however, but said he/she did have an area on his/her bottom. Nurse #2 (who had completed all weekly skin assessment from 04/05/24 through 05/03/24 for Resident #1), said she had no idea why his/her skin assessments had not included any of Resident #1's pressure injuries. During an interview on 08/08/24 at 2:03 P.M., the Staff Development Coordinator (SDC) said that it is the responsibility of the admitting nurse for any resident to complete a full head to toe skin assessment upon admission and accurately document the findings on the skin assessment form. During an interview on 08/08/24 at 4:37 P.M., the Director of Nurses said that she was unaware that Resident #1 had been admitted with pressure injuries. The DON said it is the Facility's expectation for all nurses to perform a thorough head to toe assessment upon admission, weekly and PRN, documenting all abnormal skin findings on the Skin Assessment found in Point Click Care (PCC, the Facility's electronic medical record).