STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225710	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain at Sudbury	136 Boston Post Road Sudbury, MA 01776

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. 48138 Based on interviews and records reviewed, for one of three sampled residents (Resident #1), who had a physicians order, dated 5/12/24, for discharge to his/her Assisted Living Facility (ALF) with Hospice services, when family members arrived at the facility on 5/12/24, the day they anticipated him/her to be discharged , facility staff told them them Resident #1 was not scheduled to be discharged until the following day (5/13/24). Family members said the discharge plan all along was for Resident #1 to be discharged home by Mother's Day and that the facility needed to make it happen, and although Resident #1 was discharged to his/her ALF that day, the Facility failed to ensure Resident #1's (unplanned) transfer/discharge was safe and orderly, when his/her necessary medical information including physicians orders with his/her list of medications, (either in the form of discharge paperwork or discharge instructions), were not sent to or communicated to nursing staff at the receiving facility (ALF) so that his/her medical and personal care needs could be met. Findings include: The Facility Discharge Planning Process Policy, dated as revised 12/06/21, indicated the following; -discharge planning is a process that begins on admission -the facility would provide the necessary assistance with discharge. - all relevant information would be provided in a discharge summary to avoid unnecessary delays in the resident's discharge or transfer, and to assist the resident in adjustment to his/her new living environment. Review of Resident #1's medical record indicated that he/she was admitted to the Facility during April 2024, diagnoses included left femur fracture, status post hemiarthroplasty (surgical fixation of the fracture), and urinary retention. During a telephone interview on 6/17/24 at 11:16 A.M., Family Member #1 said that the family had communicated to facility staff from the day of Resident #1's admission to facility, that the plan was to have Resident #1 discharged home in time for Mother's Day. Family Member #1 said the facility was not prepared to discharge Resident #1 on 5/12/24, and said they did not send any discharge paperwork to the Assisted Living Facility. Family Member #1 said the facility should have sent Resident #1's medication list or communicated Resident #1's care needs to the receiving facility. (continued on next page)

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
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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/25/24 at 11:37 A.M., the Hospice Social Worker said she had communicated with the on-call Nursing Supervisor at the facility on 5/11/24 about Resident #1's family's discharge plans for 5/12/24. The Hospice Social Worker said she notified the on-call Nursing Supervisor at the facility on Sunday 5/12/24 in the morning that an ambulance would be coming at 2:00 P.M. to transport Resident #1 to his/her Assisted Living Facility. During an interview on 6/18/24, at 1:23 P.M., Nurse #1 said the facility's protocol for unplanned discharges is to send a face sheet and medication list to the receiving facility. During a telephone interview on 6/18/24 at 2:35 P.M., the Unit Manager said Resident #1's discharge was unplanned, and the facility offered to send the discharge paperwork with Resident #1's HCA, who declined to wait. The Unit Manager said she did not fax the discharge paperwork to Resident #1's Assisted Living Facility on the date of his/her discharge. During a telephone interview on 6/18/24 at 9:40 A.M., and a follow-up telephone interview on 6/24/24 at 1:19 P.M., the Resident Care Director at the Assisted Living Facility said there was no discharge paperwork sent with Resident #1 or faxed to their facility on the day he/she arrived, and said there was no telephone call received from the discharging facility that day either. During an interview on 6/18/24 at 2:05 P.M., the Director of Nursing (DON) said the protocol for an unplanned discharge is to send at a minimum, a face sheet and medication list to the receiving facility. The DON said that was not done in this case.

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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. 48138 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had a physicians order for discharge home with Hospice Services to the Assisted Living Facility on 5/12/24, the Facility failed to ensure they maintained a complete and accurate medical record when nursing staff and the provider, failed to document his/her discharge in the medical record. Findings include: Review of the Facility's policy, titled Charting and Documentation, undated, indicated the following: -all services provided to the resident, progress toward the care plan goals, or changes in the resident's physical, functional or psychosocial condition, shall be documented in the resident's medical record; -objective observations, treatments and changes in the resident's condition shall be documented in the resident medical record. Review of the Facility's policy, titled Discharge Planning Process, dated as revised 12/06/21, indicated the following; -evaluation of the resident's discharge needs and discharge plan would be completely documented on a timely basis in the clinical record. Resident #1 was admitted to the Facility in April 2024, diagnoses include left femur fracture, status post hemiarthroplasty (surgical fixation of the fracture), and urinary retention. Review of Resident #1's Physician Orders, dated 5/12/24, indicated he/she had an order for discharge to an Assisted Living Facility with Hospice Services. Review of Resident #1's Nurse Progress Notes dated 5/12/24, indicated that there was no documentation to support that he/she had been discharged from the facility to an Assisted Living Facility. Further review of Resident #1's medical record indicated there was no documentation to support that a discharge summary had been completed by his/her provider, and when requested, facility staff were unable locate a discharge summary. During an interview on 06/18/24 at 2:05 P.M., the Director of Nurses (DON) said that it was her expectation that nursing document on a resident's discharge to another facility and that was not done in this case.