STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225727	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Rehab & Skilled Nursing Ctr - Natick	3 Vision Drive Natick, MA 01760

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 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 two of three sampled residents (Resident #1 and Resident #3), the Facility failed to ensure they maintained a complete and accurate medical record including but not limited to hospice services documentation and an integrated plan of care. Findings include: Review of the Facility Services Agreement for Hospice Care, signed however, undated, indicated that Hospice Services means those services provided to a Hospice Patient that are reasonable and necessary for palliation and management of such Hospice Patient's terminal illness and are specialized in a Hospice Patient's Plan of Care. The Agreement also indicated that the Plan of Care means a written care plan established, maintained, reviewed, and modified, if necessary, at intervals identified by the Interdisciplinary Team (IDT). Hospice and Facility will jointly develop and agree upon a coordinated Plan of Care. 1). Resident #1 was admitted to the Facility in December 2023, diagnoses included myelodysplastic syndrome (conditions that occur when the blood-forming cells in the bone marrow become abnormal), hyponatremia (low sodium), dysphagia (difficulty swallowing), and toxic metabolic encephalopathy (acute cerebral dysfunction due to metabolic disturbances). Review of Resident #1's Physician Order, dated 01/24/24, indicated he/she had been admitted to Hospice services. Review of Resident #1's Significant Change Minimum Data Set (MDS) Assessment, dated 02/02/24, indicated he/she had been on Hospice Services. Review of Resident #1's medical record indicated that there was no documentation to support a Hospice Care Plan had been integrated or made accessible to Facility Staff to follow so they could effectively collaborate with Hospice to meet his/her care needs. 2). Resident #3 was admitted to the Facility in March 2024, diagnoses include breast cancer, chronic obstructive pulmonary disease, and pulmonary fibrosis. (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
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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	Review of Resident #3's Physician Order, dated 03/12/24, indicated he/she had been admitted to Hospice services. Review of Resident #3's Significant Change MDS Assessment, dated 03/19/24, indicated he/she had been on Hospice Services. Review of Resident #3's medical record indicated that there was no documentation to support a Hospice Care Plan had been integrated or made accessible to Facility Staff to follow so they could effectively collaborate with Hospice to meet his/her care needs. During a telephone interview on 06/06/24 at 10:28 A.M., the Assistant Director of Hospice Services said that all Hospice patient information is uploaded and stored within Home Care Home Base (their electronic medical record)and the Facility is unable access that information. The Director said that the Facility's Social Worker (SW) is their primary contact, that Hospice had been instructed to e-mail Hospice documents to the SW and that the facility SW would then be responsible for printing and scanning that information into the medical record for each Hospice Resident making the Hospice information accessible for nursing. During an interview on 06/04/24 at 1:26 P.M., the Unit Manager said that she was not certain where Resident #1's and/or Resident #3's integrated Hospice Care Plans were and could not locate them in their medical record. The Unit Manager said the documentation should had been scanned into their medical records under the Hospice tab in Matrix (Facility's electronic medical record) so all of the staff could view and follow the care plans. During a telephone interview on 06/10/24, the Former Assistant Director of Nurses (ADON), said that she had not been aware of the Facility's protocol for Hospice residents related to receipt and integration of their Hospice documentation. The ADON said that the Facility care plan is different from an integrated Hospice care plan and that nurses need to be aware and have access to the information on the Hospice care plan. During a interview on 06/04/24 at 2:27 P.M., the Social Worker (SW) said that she thought the required Hospice documentation automatically got uploaded to each resident's medical record. The SW said she had not known that it was her responsibility to print the documents received by Hospice and upload the information into each of the Hospice resident's facility medical records. During an interview on 06/10/24 at 1:00 P.M., the Director of Nurses said that she had been under the impression that all Hospice documents were being scanned into each of the resident's medical record. The DON said it is the expectation of the Facility to ensure all required Hospice documentation, including but not limited to the integrated plan of care be accessible to Nursing staff caring for any Resident on Hospice.