

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225747	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Somerset Ridge Center		STREET ADDRESS, CITY, STATE, ZIP CODE 455 Brayton Avenue Somerset, MA 02726	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>43935</p> <p>Based on observation, interview, record review, and policy review, the facility failed to develop and implement comprehensive person-centered care plans for three Residents (#84, #107, and #77), out of a sample of 24 residents. Specifically, the facility failed to:</p> <ol style="list-style-type: none"> 1. For Resident #84, to develop and implement a care plan for resident safety with smoking; 2. For Resident #107, to develop and implement a person-centered care plan to address the use of antidepressant medication and behaviors; and 3. For Resident #77, to implement the plan of care for supervision while eating. <p>Findings include:</p> <p>Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, dated as revised March 2022, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - a comprehensive person-centered care plan is developed and implemented to meet the resident's physical, psychosocial and functional needs - care plan interventions are derived from a thorough analysis of the information gathered as part of the assessment - the comprehensive person-centered care plan includes measurable objectives, describes services to be furnished and reflects current standards of practice - assessments of residents are ongoing and care plans are revised as information about the residents and their condition changes <p>1. Review of the facility's policy titled Smoking Policy - Residents, dated as revised July 2022, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - a resident will be evaluated upon admission to determine if they are a smoker and their ability to safely smoke <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - a resident's ability to smoke safely will be re-evaluated quarterly, upon significant change and as determined by staff - any smoking related privileges, restrictions, and concerns shall be noted on the care plan and all personnel caring for the resident will be alerted <p>Resident #84 was admitted to the facility in December 2023 with diagnoses including: cerebral palsy and muscle weakness. The most recent Brief Interview for Mental Status (BIMS), dated 3/20/24, indicated the Resident was cognitively intact with a score of 15 out of 15.</p> <p>Review of the medical record indicated Resident #84 had a smoking assessment completed upon admission and again on 3/21/24. The 3/21/24 smoking assessment indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - Yes, the Resident is a smoker and smokes cigarettes - There are no cognitive loss, visual deficit, or dexterity problems - Smoking occurs 1-2 times a day and the Resident can light their own cigarette and use an ashtray properly - the Resident does not express a desire to quit smoking - Resident is independent and does not require assistance to smoke - The care plan has been updated to assure the Resident is safe with smoking <p>Review of the current active care plans for Resident #84 as of 5/31/24 failed to indicate a care plan had been developed for smoking.</p> <p>Review of the Resident's care Kardex (nursing reference with resident-specific care information), dated 5/31/24, failed to indicate Resident #84 was a smoker.</p> <p>During an interview on 5/31/24 at 9:11 A.M., Activity Assistant #1 said Resident #84 is an active smoker and joins the smoking group daily at approximately 9:00 A.M. and 3:30 P.M. She said the Resident does not require any safety devices and is handed his/her cigarette and lighter and can independently light their cigarette, manage the ashes and extinguish the cigarette. She said cigarettes and lighting materials are kept locked up in the staff's possession and all smoking residents come to the smoking area at the designated times and a staff member is present.</p> <p>During an interview on 5/31/24 at 9:24 A.M., Nurse #1 said Resident #84 is an active smoker and is assessed quarterly. She said the process is to assess residents who smoke upon admission and quarterly and then an individualized care plan is developed for the Resident. She reviewed the medical record and care plans for Resident #84 and said there was not a care plan in place for smoking.</p> <p>During an interview on 5/31/24 at 9:34 A.M., Unit Manager #1 said Resident #84 was a smoker and should have a care plan for smoking safety. She reviewed the medical record and care plans for Resident #84 and said there was no care plan in place and it must have been missed in error.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/31/24 at 10:54 A.M., the Director of Nurses (DON) said all residents who smoke are required to have a care plan for smoking as part of the smoking assessment and care planning process. She reviewed the care plans for Resident #84 and said a care plan was not in place for smoking.</p> <p>2. Resident #107 was admitted to the facility in April 2024 with diagnoses including dislocation of left hip prosthesis and metabolic encephalopathy. Review of the BIMS for Resident #107, dated 5/22/24, indicated the Resident was cognitively intact with a score of 14 out of 15.</p> <p>Review of the active orders for Resident #107, as of 5/31/24, indicated but were not limited to the following:</p> <ul style="list-style-type: none"> - Trazodone (an antidepressant) 0.5 milligrams every eight hours as needed for agitation to be re-evaluated in 14 days (5/22/24) <p>Review of the current care plans for Resident #107 failed to indicate a care plan had been developed for management of the perceived agitation or use of the antidepressant medication.</p> <p>Review of the current care Kardex, dated 5/31/24, failed to indicate the Resident had any agitation behaviors.</p> <p>During an interview on 6/4/24 at 9:51 A.M., Unit Manager #1 said the Resident does exhibit some minor agitated behaviors at times, but it is infrequent. She reviewed the care plans for Resident #107 and said the Resident does not have a care plan developed for the agitated behavior or the trialing of an antidepressant at this time. She said there should be care plans in place for the use of the antidepressant and the management of the Resident's agitation and there are not.</p> <p>During an interview on 6/4/24 at 10:02 A.M., the DON said the process is for residents on antidepressant medications or who demonstrate behaviors is to have specific care plans to address the need for those medications and to assist staff in managing any potential behaviors. She reviewed the medical record and care plans for Resident #107 and said there were no care plans in place to address the Resident's behavior of agitation or the antidepressant use as there should be in accordance with the care plan policy.</p> <p>36542</p> <p>3. Resident #77 was admitted to the facility in September 2020 with a diagnosis of dysphagia (difficulty swallowing).</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 4/11/24, indicated Resident #77 needed supervision (helper provides verbal cues or touching/steadying as resident completes activity) with eating.</p> <p>Review of the care plans indicated Resident #77 required assistance with activities of daily living including continual supervision while eating.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Physician's Orders indicated that effective 6/9/23 Resident #77 had a mechanical soft diet, nectar thick liquids, one to one (1:1) supervision and aspiration precautions for aspiration pneumonia.</p> <p>Review of the Speech Therapy Discharge Summary, dated 3/27/23, indicated Resident #77 needed 1:1 supervision and to be cued to cough to clear penetration and minimize aspiration.</p> <p>During an interview on 5/30/24 at 8:55 A.M., the family member of Resident #77 said he visits Resident #77 twice per day, for breakfast and dinner. He said Resident #77 does not get out of bed and eats all meals in bed.</p> <p>On 5/30/24 at 12:00 P.M., the surveyor observed Resident #77 in his/her room alone, self-feeding. At 12:02 P.M., the surveyor observed a nurse enter the room and leave at 12:04 P.M. No staff were observed to be with the Resident during lunch.</p> <p>On 5/31/24 at 11:43 A.M., the surveyor observed Certified Nurses Assistant (CNA) #2 bring the lunch tray to Resident #77, thicken the Resident's juice and attempt to wake the Resident up to eat, then leave the room.</p> <p>On 5/31/24 at 11:54 A.M. and 12:05 P.M., the surveyor observed Resident #77 in bed with his/her eyes closed and the lunch tray in front of them.</p> <p>During an interview on 5/31/24 at 12:19 P.M., CNA #2 said she occasionally works on this unit and was told when she was passing trays that Resident #77 needed to be set up for meals and that the Resident can feed him/herself and did not need any assistance after set-up.</p> <p>On 5/31/24 at 12:32 P.M., the surveyor observed Resident #77 to be awake and attempting to eat a piece of cauliflower (with two heads) from a spoon. The Resident was not able to open his/her mouth wide enough for the piece of cauliflower.</p> <p>During an interview with observation on 5/31/24 at 12:33 P.M., Nurse #2 said she was helping on the unit and could not speak to the Resident's supervision level. She said the cauliflower should have been cut up for the Resident when the meal tray was set-up.</p> <p>During an interview on 5/31/24 at 12:38 P.M., CNA #3 said she was familiar with Resident #77. She said the Resident did not like to get out of bed and that the Resident did not like to be fed and did well feeding his/herself once they woke up. She said the staff set up the meals and then leave the Resident to self-feed.</p> <p>During an interview on 5/31/24 at 12:45 P.M., the DON said she was not sure of the supervision status of Resident #77 and thought the Resident's family member was at the facility for every meal.</p> <p>During an interview on 5/31/24 at 1:25 P.M., the DON said Resident #77 should be supervised for all meals and staff should be assisting in cutting up food as needed.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49425</p> <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, interview, and policy review, the facility failed to follow professional standards of nursing practice for one Resident (#6), out of a total sample of 24 residents. Specifically, the facility failed to allow adequate time for absorption of eye medication, when administering two eye medications.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Instillation of Eye Drops, dated as revised January 2014, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -The purpose of this procedure is to provide guidelines for instillation of eye drops to treat medical conditions, eye infections and dry eyes. -When administering two or more different eye drops allow three to five minutes between each application. <p>Resident #6 was admitted to the facility in November 2021 with diagnoses including dry eyes and insomnia.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 5/7/24, indicated Resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact.</p> <p>Review of the current Physician's Orders indicated the following:</p> <ul style="list-style-type: none"> -Restasis Ophthalmic Emulsion 0.05% (eye drop to increase tear production) instill one drop in both eyes two times a day for prevention -Artificial Tear Solution Instill one drop in both eyes two times a day for dry eyes <p>During an observation on 6/3/24 at 8:41 A.M., Nurse #3 instilled one drop of Restasis into Resident #6's left eye, and one drop into his/her right eye. Nurse #3 then immediately picked up the container of Artificial tears and instilled one drop into Resident #6's left eye, and one drop into his/her right eye.</p> <p>During an interview on 6/3/24 at 2:45 P.M., Nurse #3 said she is not sure of the time frame needed to wait in between eye drops. She said she just administers them together.</p> <p>During an interview on 6/3/24 at 4:44 P.M., the Director of Nursing (DON) said when administering more than one eye drop, the nurse must wait a minimum of three to five minutes before administering another eye drop. She said if eye drops are given to close together, they do not have time to absorb, and are ineffective.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>36542</p> <p>Based on interviews and record reviews, the facility failed to ensure a monthly medication regimen review was completed once per month for one Resident (#52), out of a total of five residents selected for unnecessary medication review.</p> <p>Findings include:</p> <p>Resident #52 was admitted to the facility in December 2023.</p> <p>Review of the medical record for Resident #52 included monthly medication regimen reviews for February 2024, April 2024 and May 2024. The record failed to indicate a medication regimen review was completed in March 2024.</p> <p>During an interview on 5/31/24 at 10:30 A.M., the Director of Nurses said she reviewed the March 2024 pharmacy reports and Resident #52 did not have a recommendation and was also not on the list of residents reviewed who did not have recommendations.</p> <p>During an interview on 5/31/24 at 10:57 A.M., the consultant Pharmacist said he had reviewed the information and found that Resident #52 had switched units on the day the Pharmacist was at the facility doing monthly reviews and the Resident had not been reviewed in March 2024.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49425</p> <p>Based on observation, interview, and policy review, the facility failed to ensure staff stored drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed to ensure medications were administered under direct supervision and not left at the bedside for one Resident (#6), out of a total sample of 24 residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Administering Oral Medications, dated as revised October 2010, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -The purpose of this procedure is to provide guidelines for the safe administration of oral medications. -Remain with the resident until all medications have been taken. <p>Review of the facility's policy titled Storage of Medications dated as revised November 2020, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. -The nursing staff is responsible for maintaining medication storage. <p>Resident #6 was admitted to the facility in November 2021 with diagnoses including hyperlipidemia (high cholesterol).</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 5/7/24, indicated the Resident scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact.</p> <p>Review of the June 2024 Medication Administration Record (MAR) indicated the following medication was scheduled for 8:00 A.M. and signed off as administered by the nurse:</p> <ul style="list-style-type: none"> -Cholestyramine Light Oral Powder (used to treat high cholesterol) 4 grams (gm) <p>On 6/3/24 at 8:41 A.M., the surveyor observed Nurse #3 prepare Resident #6's 8:00 A.M. medications. The following was observed:</p> <ul style="list-style-type: none"> -Nurse #3 took one scoop of Cholestyramine Light Powder and mixed it with 4 ounces of water and placed it on top of the medication cart. -Nurse #3 placed the Cholestyramine mixed with water on Resident #6 bedside table <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Nurse #3 instructed Resident #6 to drink the medication and exited the room</p> <p>-Nurse #3 left the Cholestyramine on the bedside table, unattended, and unlocked</p> <p>Review of the Care Plan failed to indicate Resident #6 self-administered medications.</p> <p>Review of the Physician's Orders failed to indicate an order to self-administer medications.</p> <p>During an interview on 6/3/24 at 8:52 A.M., Nurse #3 said Resident #6 does not have an order to self-administer medications.</p> <p>During an observation with interview on 6/3/24 at 9:02 A.M., Resident #6 said the nursing staff leaves the medication with him/her alone every day. The Resident said he/she usually doesn't drink it all because he/she does not like the taste. The surveyor observed the Cholestyramine mixed with water on Resident #6's bedside table.</p> <p>During an interview on 6/3/24 at 4:44 P.M., the Director of Nursing (DON) said medications should not be left at the bedside unattended, and the nurse should remain with the resident until all medications have been administered. She said Resident #6 does not have an order to self-administer medications and the medication should not have been left unattended and unsecured at the bedside.</p>		