STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225747	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Ridge Center	455 Brayton Avenue Somerset, MA 02726

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 42742 Based on record review and interview, the facility failed to complete a discharge assessment to ensure timely coding and transmitting of a Minimum Data Set (MDS) assessment for one Resident (#80), out of one resident assessment reviewed, resulting in a 137-day delay in the encoding and transmission of a MDS post-discharge from the facility. Findings include: Review of the facility's policy titled Electronic Transmission of the MDS, revised November 2019, indicated but was not limited to the following: -All MDS assessments (e.g. admission, annual, significant change, quarterly review, etc.) and discharge and reentry records are completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data. Review of Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, Version 3.0, indicated assessments must be completed no later than 14 calendar days after the assessment reference date (ARD) and transmitted and encoded within 7 days of assessment completion. Resident #80 was admitted to the facility in January 2024 and had diagnoses including mild cognitive impairment, Alzheimer's disease, cerebral infarction, syncope (loss of consciousness) and collapse, left femur fracture, muscle wasting and atrophy, and generalized anxiety. The Resident was discharged to the community in May 2024. Review of the medical record on 10/1/24 at 8:57 A.M. indicated a discharge MDS had not been encoded and transmitted to CMS and was 137 days overdue. During an interview on 10/1/24 at 12:43 P.M., the MDS Coordinator said the discharge assessment was not completed and electronically coded into the facility's MDS information system and transmitted to CMS in accordance with current OBRA regulations but should have been.

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 42742 Based on interview and record review, the facility failed to ensure residents were provided care in accordance with professional standards of practice for one Resident (#61), out of a total sample of 23 residents. Specifically, the facility failed to ensure a schedule II-controlled substance (hydrocodone-acetaminophen, high potential for abuse) medication to treat pain was administered to the Resident within parameters as ordered by the physician. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised 4/11/18, indicated but was not limited to: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Review of the facility's policy titled Administering Medications, revised April 2019, indicated but was not limited to the following: - Medications are administered in accordance with prescriber orders, including any required timeframe. -The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Resident #61 was admitted to the facility in December 2023 and had diagnoses including type 2 diabetes mellitus with diabetic neuropathy, osteomyelitis, and post procedural pain. Review of the Minimum Data Set (MDS) assessment, dated 6/26/24, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and was on a scheduled and as needed pain medication regimen. Review of current Physician's Orders indicated the following: -hydrocodone-acetaminophen (Norco) oral tablet 5-325 milligrams (mg), give 1 tablet by mouth every 8 hours as needed for pain 7-10, 7/1/24 Review of the September 2024 Medication Administration Record (MAR) indicated the Norco was administered outside of physician prescribed parameters (pain scale documented as less than 7-10) (the pain scale is a tool that helps people measure their pain so that doctors can plan how to treat it with 0 indicating no pain and 10 the worst) on the following days: -9/2/24, 5:05 A.M., pain level 6 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-9/3/24, 12:05 P.M., pain level 6 -9/3/24, 8:07 P.M., pain level 6 -9/4/24, 11:20 P.M., pain level 6 -9/6/24, 5:16 A.M., pain level 6 -9/11/24, 4:41 A.M., pain level 5 -9/13/24, 5:02 A.M., pain level 6 -9/13/24, 10:38 P.M., pain level 6 -9/15/24, 10:26 P.M., pain level 6 -9/16/24, 5:24 A.M., pain level 6 -9/17/24, 9:01 P.M., pain level 5 -9/24/24, 8:30 A.M., pain level 2 -9/25/24, 5:04 A.M., pain level 6 -9/27/24, 5:20 A.M., pain level 5 -9/29/24, 8:45 A.M., pain level 6 Review of the October 2024 MAR indicated the Norco was administered outside of physician prescribed parameters on the following days: -10/1/24, 8:25 A.M., pain level 5 During an interview on 10/1/24 at 11:30 A.M., Resident #61 said he/she had frequent pain in his/her mouth, upper back, neck, and right middle finger status post a partial amputation about a month ago and took Tylenol and Norco for it. During an interview on 10/1/24 at 11:52 A.M., the surveyor reviewed the medical record with Nurse #5 who said the physician's order indicated to give the Norco as needed for a pain scale rating of 7-10. She said she gave it this morning for a pain scale rating of 5; it was not given per physician's orders as it was below the parameter. During an interview on 10/1/24 at 3:44 P.M., the surveyor reviewed the medical record with the Director of Nursing (DON). The DON said the Norco should be given per physician's orders due to the risk of dependence, respiratory depression, lethargy, and constipation if not given as indicated.

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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. 48362 Based on observation, interview and record review, the facility failed to provide the necessary respiratory care and services for two Residents (#86 and #11), out of a total sample of 23 residents. Specifically, the facility failed: 1. For Resident #86, to ensure nasal cannula (device that delivers extra oxygen (O2) through a tube into the nose) tubing and nebulizer mask/tubing (device that delivers aerosolized medication through tubing into the mouth and nose) was maintained to ensure sanitary conditions and decrease the risk of potential contamination by germs; and 2. For Resident #11, to maintain sanitary conditions of nasal cannula tubing and O2 equipment to help decrease the risk of potential contamination and exposure of infection to the Resident. Findings include: Review of the facility's policy titled Departmental (Respiratory Therapy) - Prevention of Infection, revised 11/2011, indicated but was not limited to the following: - The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. - Infection Control Considerations Related to Oxygen Administration: 7. Change the oxygen cannula and tubing every seven (7) days, or as needed, 8. Keep the oxygen cannula and tubing used as needed (PRN) in a plastic bag when not in use. - Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: 7. Store the circuit in plastic bag, marked with date and resident's name, between uses, 9. Discard the administration set-up every seven (7) days. Review of the facility's policy titled Nebulizer/Care and Use Of, dated 3/1/24, indicated but was not limited to the following: - Nursing will replace tubing, mask/mouthpiece weekly. - Tubing will be dated and replacement documented in resident record. - Equipment will be stored in a loosely covered plastic bag. 1. Resident #86 was admitted to the facility in October 2023 with diagnoses including Post-Polio Syndrome, disorders of diaphragm, and asthma. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 7/16/24, indicated Resident #86 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. The MDS assessment also indicated Resident #86 did not use continuous oxygen and required substantial or maximal assistance with activities of daily living. Furthermore, the MDS assessment indicated Resident #86 had shortness of breath (SOB) with exertion, SOB sitting at rest, and SOB lying flat. Review of Resident #86's current Physician's Orders indicated but was not limited to: - 11/15/23: Oxygen at two liters per minute (LPM) via nasal cannula (NC) PRN. - 11/23/23: Albuterol Sulfate Inhalation Nebulization Solution (25 milligrams (MG)/3 milliliters (mL)) 0.083%, one vial inhale orally via nebulizer every four hours as needed for SOB/wheeze. - 6/18/24: Change and date nebulizer tubing and storage bag once weekly, every night shift every Sunday. On 9/26/24 at 9:35 A.M., the surveyor observed the following: - Nebulizer mask/tubing was attached to the concentrator on a nightstand next to the Resident's bed. - The nebulizer mask/tubing was dated 9/30/24 and not covered or contained within a bag. During an observation with interview on 9/26/24 at 2:50 P.M., the surveyor observed Resident #86 resting in bed. The nebulizer mask/tubing was attached to the concentrator on a nightstand next to his/her bed and not covered or contained in a bag. Resident #86 said he/she uses the nebulizer as needed when he/she is SOB. Resident #86 said the nursing staff administers the treatment to him/her and when the treatment has ended takes the nebulizer mask/tubing back to store it. On 9/30/24 at 9:58 A.M., the surveyor observed the following: - An oxygen concentrator (a piece of equipment used to deliver oxygen to a resident through tubing or mask) was noted next to the Resident's bed by the window. - The NC tubing, dated 9/30/24, was wrapped around the top of the oxygen concentrator not stored in a bag. On 9/30/24 at 2:53 P.M., the surveyor observed the following: - Resident #86 sleeping in bed with the NC tubing donned (on). - The NC tubing was dated 9/30/24. - The oxygen concentrator was set to 2-LPM of Oxygen. On 10/1/24 at 7:56 A.M., the surveyor observed Resident #86 eating breakfast while positioned upright. Resident #86 had oxygen donned via his/her NC tubing dated 9/30/24. Resident #86 said he/she was feeling SOB and nursing staff helped him/her put the oxygen tubing on yesterday. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 at 10:21 A.M., the surveyor observed the following: - The oxygen concentrator was positioned by the window, not running. - The NC tubing, dated 9/30/24, was wrapped around the top of the oxygen concentrator not stored in a bag. During an interview on 10/1/24 at 1:08 P.M., Nurse #4 said nebulizer mask/tubing along with NC tubing is changed weekly and dated by the nursing staff. Nurse #4 said at that time a bag is supplied to store the mask and/or tubing when not in use. Nurse #4 and the surveyor made an observation of Resident #86's oxygen concentrator and NC tubing. Nurse #4 said the NC tubing should not be wrapped around the concentrator when not in use. Nurse #4 said it should be stored in the bag attached to the concentrator. Nurse #4 and the surveyor also reviewed the observations made regarding the nebulizer mask/tubing. Nurse #4 said the nebulizer mask/tubing is cleaned after use and then should be stored in a bag. During an interview on 10/2/24 at 8:34 A.M., Unit Manager (UM) #3 said tubing for nebulizers and oxygen is changed weekly on Sunday nights. UM #3 said NC tubing and nebulizer masks/tubing should be stored in bags when not in use. 42742 2. Resident #11 was admitted to the facility in May 2021 and had diagnoses including bronchiectasis (condition in which the lungs' airways become damaged, making it hard to clear mucous), asthma, and dementia. Review of the MDS assessment, dated 7/18/24, indicated Resident #11 was cognitively intact as evidenced by a BIMS score of 14 out of 15 and had a pulmonary condition. Review of current Physician's Orders indicated the following: -Oxygen via NC 1-3 Liters (L) as needed for shortness of breath/keep sats >92%, 6/20/23 -Oxygen equipment maintenance as needed for equipment maintenance. Change oxygen tubing (mask, nasal cannula) and storage bags as needed, 10/13/22 -Oxygen equipment maintenance as needed for equipment maintenance. Cleanse oxygen concentrator filter, 10/13/22 -Oxygen equipment maintenance every night shift, every 1 month starting on the 8th for 1 day for equipment maintenance. Wipe down oxygen concentrator with clean damp cloth once monthly, 11/8/22 -Oxygen equipment maintenance every night shift, every Monday for equipment maintenance. Change oxygen tubing mask, nasal cannula, humidifier bottle, and storage bags once weekly, 10/13/22 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 9/26/24 at 9:36 A.M., the surveyor observed Resident #11 sitting in a chair in their room. His/her NC tubing was observed attached to an O2 concentrator (takes air from your surroundings, extracts and filters it into purified oxygen for you to breathe) which was in the off position. The exterior of the concentrator was laden with a white powdery substance and dust. Resident #11 said, Yeah, it needs to be cleaned and that he/she used the oxygen at night for his/her breathing and for asthma. On 9/30/24 at 12:00 P.M., the surveyor observed Resident #11 sitting in a chair in their room eating lunch. His/her NC tubing was observed inserted into the Resident's nostrils with the other end attached to an O2 concentrator which was delivering 2 L of Oxygen. The exterior of the concentrator was laden with a white powdery substance and dust. On 10/1/24 at 8:17 A.M., the surveyor observed Resident #11 sitting in a chair in their room eating breakfast. His/her NC tubing was observed attached to an O2 concentrator which was delivering 2 L of Oxygen. The other end of the tubing was observed resting on top of the Resident's mattress, partially underneath a pillow, and potentially exposed to environmental contaminants. The tubing was not stored in the protective bag when not in use which was observed hanging from the concentrator. The tubing was dated 9/23/24 indicating it had not been changed. The exterior of the concentrator was laden with a white powdery substance and dust. On 10/1/24 at 8:21 A.M., Unit Manager (UM) #2 said she was the Resident's assigned nurse that morning and entered the room with the surveyor to observe the oxygen equipment. UM #2 said the oxygen tubing should have been changed and dated weekly on Sundays, but it was not, and should be stored in a plastic bag when not in use. UM #2 removed the concentrator's internal filter and said it needed to be changed and was not clean. She said the oxygen concentrator should be sanitized every week and as needed and the Resident needed a whole new concentrator. During an interview on 10/1/24 at 8:24 A.M., the surveyor reviewed the medical record with UM #2 who said, per physician's orders, the concentrator should be wiped down monthly and as needed, the tubing changed weekly on Mondays during the night shift, and the filter cleansed as needed but this was not done as ordered. During an interview on 10/1/24 at 3:37 P.M., the Director of Nursing (DON) said O2 concentrators should be wiped down as needed and the tubing should be changed weekly on the overnight shift on Monday. She said oxygen tubing should be labeled with the date when changed and initials of the nurse. She said this verifies how old the tubing is. The DON said maintenance oversees the external components, filters, and cleaning of the external parts and was frustrated this was missed. She said the oxygen tubing should be stored in a plastic bag when not in use and if it's a prn (as needed) thing, then it should be stored in a bag when not in use.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 42742 Based on record review and interview, the facility failed to monitor for signs and symptoms of adverse consequences (i.e., side effects) of medications for one Resident (#61), out of 23 sampled residents. Specifically, the facility failed to monitor for signs and symptoms of hypoglycemia and hyperglycemia (low and high blood sugars) with the administration of insulin (anti-diabetic injectable medication). Findings include: Review of the facility's policy titled Diabetes-Clinical Protocol, revised December 2020, indicated but was not limited to the following: - Risk of hypoglycemia should be considered in any treatment plan, as it is a significant and high-risk complication of treatment. - The physician will follow up on any acute episodes associated with a significant sustained change in blood sugars or significant deterioration of previous glucose control and document resident status at subsequent visits until the acute situation is resolved. - The physician will order desired parameters for monitoring and reporting information related to blood sugar management. - The staff will incorporate such parameters into the Medication Administration Record and care plan. - An example of appropriate treatment of hypoglycemia for a responsive individual would be 15 grams (g) to 20 g of carbohydrates in the form of glucose, sucrose tablets, or juice, combined with a sandwich, crackers, or other light snack containing protein. Resident #61 was admitted to the facility in December 2023 and had diagnoses including type 2 diabetes mellitus (DM) with diabetic neuropathy, end stage renal disease, and dependence on renal dialysis. Review of the Minimum Data Set (MDS) assessment, dated 6/26/24, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and received insulin injections. Review of current Physician's Orders indicated the following: - Insulin glargine subcutaneous solution 100 units/milliliter (ml), inject 10 units subcutaneously at bedtime for DM, 8/29/24 - Novalog FlexPen subcutaneous solution pen-injector 100 units/ml (insulin aspart), inject 5 units subcutaneously with meal for diabetes, hold for CBG (capillary blood glucose) less than 120, 5/11/24 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Novolog injection solution 100 units/ml (insulin aspart), inject per sliding scale: if 0-250=0 units; 251-300=2 units; 301-350=4 units; 351-400=6 units; 401-450=6 units, subcutaneously with meals for diabetes. If blood sugar is less than 70 or greater than 400 notify MD, 4/3/24 Review of Resident #61's Blood Sugar Vitals Record indicated the following values documented as being less than 70: 9/3/24 - 9:17 A.M., 60.0 mg/deciliter (dL) 9/4/24 - 10:21 A.M., 64.0 mg/dL 9/5/24 - 8:01 A.M., 69.0 mg/dL 9/11/24 - 11:36 A.M. and 11:39 A.M., 69.0 mg/dL 9/13/24 - 10:39 A.M., 68.0 mg/dL 9/14/24 - 9:09 A.M., 68.0 mg/dL 9/15/24 - 8:27 A.M., 68.0 mg/dL 9/18/24 - 10:25 A.M., 63.0 mg/dL Review of the September 2024 Medication Administration Record (MAR) indicated the insulin was held for the above below range blood sugar readings as ordered per sliding scale parameters. Further review of the September 2024 MAR and review of the September 2024 Treatment Administration Record (TAR) did not indicate documentation of monitoring of adverse consequences related to insulin medications. Further review of the medical record failed to indicate documentation that the above below range CBGs were reported to the physician to obtain potential treatment orders, if the Resident was experiencing signs and symptoms of hypoglycemia such as sweating, chills, confusion, anxiety, shakiness dizziness, or blurred vision, or follow up monitoring of the Resident's blood glucose level. During an interview on 10/1/24 at 11:30 A.M., Resident #61 said he/she was on insulin and his/her blood sugars could run low. The Resident said he/she was on dialysis so they could not have orange juice for it, but had food brought in by the family that he/she would eat. During an interview on 10/1/24 at 11:41 A.M., the surveyor reviewed the medical record with Nurse #5 who said there should be an order for hypo/hyperglycemia monitoring and treatment but there wasn't. She said there was no sign off on the MAR or TAR for it. Nurse #5 said the order is to call the physician if the blood sugar is less than 70 or greater than 400 and, if out of range, the nurse should document in a progress note. She said she could not locate documentation that this was done. She said the Resident should be monitored, but she has not had to personally treat him/her for low blood sugars. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/1/24 at 4:07 P.M., the Director of Nursing (DON) said the batch orders for diabetes management for Resident #61 were not entered which would have included: may obtain blood glucose as needed for symptoms of hypo/hyperglycemia, offer diabetic snack at bedtime, glucose gel (treats severe low blood sugar), Glucagon (treats severe low blood sugar) emergency medication, and diabetic hypo/hyperglycemia monitoring. She said the batch order is prepopulated and would have included everything. The DON said the orders should have been placed but weren't. She said if the blood sugar is less than 70 then the nurse should be notifying the physician even if the resident isn't symptomatic to let them know what the blood sugar was and to get a recommendation or order for treatment. She said the nurse would then document this in the medical record and go through the protocol. She said she couldn't determine if the Resident was symptomatic or not if it was not documented and would continue to look for the documentation and get back to the surveyor. During an interview on 10/2/24 at 7:16 A.M., the DON said she could not locate any documentation to support whether or not the Resident had signs and symptoms of hypoglycemia, if the physician was notified, or if recommendations or treatment orders were obtained for the below range blood sugar readings. During a telephone interview on 10/2/24 at 10:39 A.M., Physician #2 said he was covering for the attending physician but was familiar with the Resident. He said the Resident's blood sugars seemed to be stable with the highest recent daily reading being 155 and the lowest 74 with an order to notify the physician if the blood sugars were less than 70 or greater than 400. He said he would follow up with those readings and tell staff to hold the insulin if below range and said maybe the Resident just hadn't eaten. He said nurses would call and he would give a verbal telephone order for treatment. The surveyor reviewed the September 2024 blood sugar readings with Physician #2 that were below 70. Physician #2 said yes, he saw them in the electronic record and was somewhat familiar with them but said he couldn't locate any documentation about them or if the Resident had experienced any symptoms. He said typically he does not document in the record when on call but said the Resident usually did not have symptoms of hypoglycemia. He said typically there is an order for monitoring for hypo/hyperglycemia and treatment orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 49425 Based on observation, document review, and interview, the facility failed to store drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed to store drugs and biologicals in accordance with accepted professional standards of practice until time of disposal, on one of three units. Findings include: Review of the facility's policy titled Administering Medications, dated as last revised April 2019, indicated but was not limited to the following: - Medications are administered in a safe and timely manner, and as prescribed Review of the facility's policy titled Storage of Medications, dated as last revised January 2018, indicated but was not limited to the following: - The facility stores all drugs and biologicals in a safe, secure, and orderly manner - Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. On 10/1/24, the surveyor observed the following during the morning medication pass at 8:18 A.M.: - Nurse #3 poured the scheduled 8:00 A.M. medications for Resident #370 into one small, clear plastic medication cup which included: a. Loratadine (antihistamine) 10 milligrams (mg) one tablet for allergies b. Oxycodone (opioid for pain) 5 mg one tablet for pain management c. Zofran (antiemetic) 4 mg one tablet for nausea/vomiting - Resident #370 was sitting upright in his/her bed, with a pink basin on his/her lap. Resident #370 told the nurse he/she was nauseous and only wanted his/her medication for nausea and would take the rest of his/her medications, when he/she felt better. Nurse #1 administered only the Zofran 4 mg to Resident #370. - Nurse #3 returned to the medication cart in the hallway, opened the narcotic drawer, and put the clear, plastic medication cup including the Loratadine and Oxycodone (unlabeled) in the bottom of the narcotic drawer, surrounded by other resident medications, and locked the top of the narcotic drawer. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Nurse #3 then proceeded to medicate one other resident with their scheduled morning medications (the clear plastic medication cup unlabeled remained in the narcotic drawer of the medication cart). - At 8:40 A.M., Nurse #3 returned to the mediation cart with Unit Manager (UM) #1 and unlocked it and then unlocked the narcotic drawer, retrieved the clear plastic cup of pills, and handed the clear plastic cup of pills to the UM. The UM placed the two tablets into a clear pouch and placed the clear plastic pouch into the pill crushing machine crushed and disposed of the pills. During an interview on 10/1/24 at 8:43 A.M., Nurse #3 said she did not know what to do with the medications after she poured them for Resident #370, and was unable to administer them, so she locked them in the narcotic box. She said she went to ask her UM what to do with the medications. During an interview on 10/1/24 at 8:45 A.M., UM #1 said no medications should be stored in the medication cart, unlabeled, they should have been destroyed, and that is why she was destroying and disposing of the medications with Nurse #1. During an interview on 10/1/24 at 4:01 P.M., the Director of Nursing (DON) said the cup of pills should not have been put back in the medication cart without the proper packaging. She said they should have been disposed of when Resident #370 refused them.

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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. 43935 Based on document review and interview, the facility failed to maintain complete medical records to accurately reflect the care of one Resident (#111), out of a total sample of 23 residents. Specifically, the facility failed to: 1. Document an administered dose of intravenous antibiotics (IV ANTBX) on the medication administration record (MAR) to reflect the date and time it was received; and 2. Ensure the medical record reflected physician notification of an acute change in potential medication side effects and the physicians follow up assessment to the presence of the condition. Findings include: Review of the facility's policy titled Charting and Documentation, dated as revised July 2017, indicated but was not limited to the following: - all services provided to the resident, progress towards goals or any changes in the resident's condition shall be documented in the medical record - the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care - the following information must be documented in the medical record: objective observations, treatments and services, medications administered - documentation of procedures and treatments will include: date and time the treatment/procedure was provided, notification of physician or other staff, and assessment data Review of the facility's policy titled Acute Condition Changes, revised March 2018, indicated but was not limited to the following: - the attending physician or nurse practitioner will respond in a timely manner to notification of problems or changes in condition and status Resident #111 was admitted to the facility in June 2024 with diagnoses including: malignant neoplasm of the bone (cancer), obsessive compulsive disorder and agoraphobia (intense fear of being in places or situations in which it may be difficult to escape or help is not available) with panic disorder. Review of the Brief Interview for Mental Status, dated 9/8/24, indicated Resident #111 was cognitively intact with a score of 15 out of 15. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During an observation with interviews on 9/26/24 at 9:40 A.M., the surveyor observed Resident #111 with a Contact precautions sign posted outside of his/her bedroom door and a dual lumen peripherally inserted central line (PICC) in their right arm. There was an intravenous (IV) pump and pole in the room, but no tubing or bag of medication was observed. Resident #111 said he/she is receiving medicine through he PICC for an infection on their leg. Nurse #2 said the Resident had methicillin resistant staph aureus (MRSA) as their infection germ and reason for IV antibiotics. Review of the current Physician's Orders as of 9/26/24 indicated but were not limited to the following: - Vancomycin IV solution 750 milligrams (mgs) in 150 milliliters of solution two times a day for infection until 10/3/24 at 8:00 A.M., and 8:00 P.M. Review of the progress notes for Resident #111 indicated but was not limited to the following: 9/25/24 at 10:46 P.M., PICC line blocked, MD notified and gave orders to contact IV support to have line unblocked or changed; Vancomycin on hold Review of the September MAR on 9/26/24 for Resident #111 indicated the IV Vancomycin was on hold for the 8:00 P.M. dose on 9/25/24 and 9/26/24 and the 8:00 A.M. dose on 9/26/24. During an observation with interview on 9/27/24 at 8:41 A.M., Resident #111 was lying in bed, beside the bed on the IV pole the surveyor observed a bag of IV Vancomycin not infusing. The Resident said he/she believes he/she received the IV medication the night prior at around 10:00 P.M. but was unsure of the exact time. During an interview on 9/27/24 at 9:25 A.M., Nurse #6 said she was the nurse for Resident #111 this morning and had just hung the IV ANTBX a few moments ago and took down the previous bag and replaced all the tubing. She said the bag that was hanging on the IV pole this morning was from the evening shift the night prior and was in place when she arrived at 11:00 P.M. the previous night and the medication must have been administered on 9/26/24 on the evening shift. During an interview on 9/27/24 at 9:31 A.M., Nurse #1 reviewed the MAR for 9/26/24 and said the MAR was documented as having the IV ANTBX on hold, as indicated by the H, for the evening shift on 9/26/24 and she could not explain how or why the IV medication was in the room this morning and not signed off as administered last evening if it was. During an interview on 9/27/24 at 9:32 A.M., Unit Manager #1 said she was having the Director of Nurses (DON) look into what may have occurred with the IV ANTBX last evening since the medication was documented on the MAR as being on hold and not signed off as administered on the 9/26/24 evening shift. Unit Manager #1 said she was in the room numerous times yesterday and never saw an IV bag or tubing in the room so the medication must have been administered in the evening after she had left for the day. Review of the progress notes for Resident #111 from 9/26/24 and 9/27/24 indicated but were not limited to the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/26/24 at 10:29 A.M., Infectious disease called and said rash is not related to IV ANTBX and medication may continue 9/27/24 at 1:30 A.M., IV team fixed occluded line, MD aware of missed doses and gave order to resume Vancomycin at current dose; IV patent and flushing; Vanco running at scheduled time During an interview on 9/27/24 at 9:53 A.M., the DON said she reviewed the medical record and spoke to the Nurse who worked on 9/26/24 in the evening and the Nurse informed her she did administer the IV ANTBX but did not sign the administration off on the MAR and therefore the medical record is inaccurate and it appears the Resident had missed three doses of the IV ANTBX when they would have only missed two doses. During an interview on 9/27/24 at 10:43 A.M., Nurse #2 said she worked on the evening shift on 9/26/24 and the IV team attended to Resident #111 and unblocked the IV line. She said once the line was clear, she contacted the MD and received orders to resume the IV ANTBX administration. She said she thought she clicked the electronic medical record correctly to unhold the medication and administer the dose but she did not. She said she administered the IV ANTBX at approximately 10:00 P.M. but could not recall the exact time on 9/26/24. She said she did not document the administration of the medication on the MAR as she should have and she did not document the date and time of the IV ANTBX being administered in her progress note as she should have and that was an error on her part. During an interview on 9/27/24 at 11:55 A.M., the DON said the MAR does not accurately reflect the administration of the IV ANTBX on 9/26/24 as it should and the expectation is that medications are administered and documented at the time they are administered on the MAR to ensure the medical record is accurate and complete. She said the inaccurate record, if unnoticed, could result in inaccurate information being communicated to providers who make medical decisions on the Resident's care and accuracy of the MAR was important for these situations. 2. During an interview on 9/26/24 at 9:40 A.M., Resident #111 said he/she is on medications to manage his/her psychiatric conditions and has his/her own psychiatric provider in the community that they continue to have virtual therapy sessions with. He/She said it is important that they stay on their medications. Review of the current Physician's Orders for Resident #111 indicated but were not limited to the following: - Aripiprazole (antipsychotic) 5 mg oral tablet give one tablet by mouth at bedtime for mood stability - obsessive compulsive disorder (6/20/24) - Monitor for side effects of antipsychotic use: dry mouth, constipation, blurred vision, changes in urination, jerky movements in face tongue and jaw, swelling in hands ankles or feet, drooling, disturbed gait, or restlessness; every shift for surveillance. If side effect observed, document in progress note and notify practitioner. (6/18/24) Review of the MAR for Resident #111 for September 2024 indicated but was not limited to the following: - Aripiprazole was administered as ordered throughout the month daily at bedtime (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Yes, side effects of the antipsychotic medication were identified on: 9/13, 9/14, 9/15, 9/17, and 9/18 Review of the progress notes for Resident #111 for 9/12/24 through 10/2/24 indicated but were not limited to the following: 9/13/24 at 7:15 P.M., Resident noted with increased movement of tongue, medicated as ordered, will continue to monitor 9/14/24 at 9:22 P.M., Resident noted with increased movement of tongue, medicated as ordered, will continue to monitor Further review of the notes failed to indicate what side effects of the antipsychotic were identified on 9/15, 9/17 and 9/18/24 or that the MD or Nurse Practitioner (NP) were ever notified of the new onset of symptoms. During an interview on 10/2/24 at 8:45 A.M., Nurse #1 reviewed the medical record of Resident #111 and said she could not find any evidence that the MD was aware of the new onset of symptoms from the antipsychotic or that the MD or NP evaluated the Resident's new symptoms once they were identified. She did however say the Nurse who documented the symptoms was currently in the facility. During an interview on 10/2/24 at 8:59 A.M., Nurse #3 said residents are monitored for signs and symptoms (s/s) of side effects for antipsychotic medications and the information is then documented on the medication administration record (MAR). She said she would also write a progress note indicating what s/s were observed and notify the Unit Manager (UM). She said she may or may not notify the physician, but if she did, she would document it in the progress notes. She said she does not know why she did not document that the physician was notified for Resident #111 or why there were no documented symptoms in the progress notes on 9/15, 9/17, and 9/18 as there should be. During an interview on 10/2/24 at 9:03 A.M., UM #1 said she was aware of the situation with Resident #111 intermittently being observed to have new symptoms of side effects from his/her antipsychotic and said she believes she notified the physician and he came and evaluated the Resident himself. She said she cannot be sure what exact date she notified the physician, since there is no documentation of that, and she is also unsure of the exact date the physician saw the Resident or what the outcome was since there was no progress note available from the MD that addresses the situation. She said the physician would typically write a note after seeing the Resident and then fax it to the facility so it could be placed in the medical record but there is no documentation available from the physician at this time. During an interview on 10/2/24 at 9:14 A.M., Physician #1 said he was made aware that Resident #111 was having an increase in mouth and tongue movements but couldn't recall the exact date of that indicating it was a few weeks ago. He said he examined the Resident himself and did not observe any of the reported s/s and since the Resident is on the lowest dose, he felt the medication remained appropriate. He said he had not provided a note of that visit to the facility as of this time and that is his error. He said he had not yet sent his notes for the visit to the facility and that is why the medical record is incomplete and does not reflect his evaluation of the Resident and follow up to the new identified change. (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 10/2/24 at 9:27 A.M., the DON said the expectation is that the medical record is complete and accurate and the nurses document the s/s they observe in the progress notes along with notification to the MD as the order directs to ensure the record is complete and tells a story. She said the MD should have documented his follow-up visit to the Resident and that note should be available to the facility within a day or so to ensure the medical record reflects the follow up and resolution of a situation and is accurate and complete. She said at this time the medical record lacks the information that the MD was notified or visited the Resident to assess him/her and what was done.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on observation, interview, and document review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections when the facility was currently experiencing an outbreak of COVID-19 infection. Specifically, the facility failed to ensure staff rapid antigen COVID-19 testing (CorDx) was conducted in a manner that is consistent with current standards of practice and manufacturer's instructions for use for two of three staff members observed. Findings include: During an interview upon entrance to the facility on [DATE] at 7:57 A.M., the Director of Nursing (DON) said the facility was experiencing a COVID-19 outbreak with 13 current positive residents residing on the Pottersville Unit (long-term care). During an interview on 9/30/24 at 3:42 P.M., the Infection Preventionist (IP) said staff were currently testing daily prior to their shift in the main lobby and that the facility followed Centers for Disease Control and Prevention (CDC), Massachusetts Department of Public Health (DPH), and Centers for Medicare and Medicaid Services (CMS) guidance for testing, whichever was the more stringent. Review of the 2024 staff and resident COVID-19 Positive Logs provided by the IP indicated there were currently 13 residents residing on the Pottersville Unit and three staff members who were positive for COVID-19. The [NAME] Unit (short-term rehab) became an affected unit on 9/4/24 and cleared on 9/28/24. The Pottersville Unit was affected on 9/12/24 to current. Review of the Massachusetts Department of Public Health (DPH) Memorandum titled Update to Infection Prevention and Control Considerations When Caring for Long-Term Care Residents, Including Visitation Conditions, Communal Dining, and Congregate Activities, dated May 10, 2023, indicated but was not limited to the following: - Long-term care facilities are required to perform outbreak testing of residents and staff as soon as possible when a case is identified. - Once a new case is identified in a facility, following outbreak testing, long-term care facilities should test exposed residents and staff at least every 48 hours on the affected unit until the facility goes seven days without a new case unless the DPH epidemiologist directs otherwise. - Residents and staff who are recovered from COVID-19 in the last 30 days can be excluded from this testing. Review of the CorDX rapid COVID-19 Ag Test manufacturer's product insert, revised September 2023, indicated but was not limited to the following: - A false result may occur if all the test steps are not followed as indicated below. If you skipped or incorrectly performed one or more steps, repeat the test with a new sample and cassette. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Step 1: Collect Sample - Carefully insert the swab tip into one nostril about 1/2 to 3/4 inch. Firmly and slowly rotate the swab 5 times, brushing against the inside walls of the nostril to ensure both mucous and cells are collected. - Using the same swab, repeat this process for the other nostril to ensure an adequate sample is collected from both nostrils. Failure to swab properly may cause incorrect results. Step 2: Process Sample - Insert the swab in tube to the bottom. - Rotate the swab at least 10 times while pressing the swab head against the bottom and side of the tube. Step 4: Read Result - Wait 10 minutes. Read the result at 10 minutes. - The result is valid when read at 10-30 minutes. If a positive result is obtained within 10 minutes, it should also be considered valid. On 10/1/24 at 6:35 A.M., the surveyor observed Rehabilitation Services Staff (RSS) #1 perform COVID-19 outbreak testing prior to his shift at the testing station in the main lobby of the facility. RSS #1 inserted the swab into each nostril rotating the swab only three times, not five. RSS #1 then inserted the swab into the tube to the bottom rotating the swab only four times, not 10, per manufacturer's instructions for use. During an interview on 10/1/24 at 1:05 P.M., RSS #1 said he should have swabbed each nostril five times and swirled the swab in the solution 10 times. On 10/1/24 at 6:38 A.M., the surveyor observed Nurse #4 perform COVID-19 outbreak testing prior to her shift at the testing station in the main lobby of the facility. Nurse #4 inserted the swab into each nostril rotating the swab only three times, not five. Nurse #4 inserted the swab into the tube to the bottom rotating the swab only four times, not 10. At 6:39 A.M., Nurse #4 applied three drops of the solution into the sample well. At 6:47 A.M., eight minutes later, Nurse #4 returned to the testing station to interpret her results then disposed of the testing cassette. Nurse #4 did not wait 10 minutes to read the result. During an interview on 10/1/24 at 10:34 A.M., Nurse #4 said the expectation was to swab each nostril five times, swirl the swab in the testing solution only four times, then wait 10 minutes for the result. Nurse #4 said she did not know she was supposed to swirl the swab in the solution 10 times. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/1/24 at 2:58 P.M., the surveyor reviewed the staff testing observations with the IP who said staff should have swabbed each nostril five times then put the swab in the vial of solution twisting it 10 times while pinching it to try and get the most sample out of there. She said staff are to wait 10 minutes for their test results and are expected to follow manufacturer's recommendations. The IP said if the sample is not collected properly it could lead to false results and staff are to retest.