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	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Ridge Center	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records reviewed, the facility failed to provide services that met professional standards of practice for one Resident (#124,) out of 24 sampled residents and one of two closed records. Specifically, the facility failed to ensure medication recommendations, after a hospitalization and an office visit, were implemented as recommended. Findings include:Review of the facility's policy titled Reconciliation of Medication on Admission, dated as revised 7/2017, indicated but was not limited to:-Medication reconciliation is the process of comparing pre-discharge medication to post-discharge medication by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route and indication for use for the purpose of preventing unintended changes or omissions at transition points in care.-If there is a discrepancy or conflict in medications, dose, route or frequency, determine the most appropriate action to resolve the discrepancy-Document findings and actions-Document the medication discrepancy on the medication reconciliation form.-Document what actions were taken by the nurse to resolve the discrepancy-If the discrepancy was resolved, document how the discrepancy was resolved. Resident #124 was admitted to the facility in July 2021 with diagnoses which included esophageal obstruction and gastroesophageal reflux disease (GERD). Further review of the medical record indicated he/she was hospitalized and returned to the facility on 9/28/25. Review of Resident #124's Hospital Discharge summary, dated [DATE], indicated but was not limited to:-Change how you take these medications: pantoprazole (used to decrease the amount of acid produced in the stomach) 40 milligrams (mg), take one tablet (40mg) by mouth two times a day. What changed: medication strength, how much to take, when to take this-Expected medication list at discharge: pantoprazole 40mg by mouth two times per day (before breakfast and dinner) Review of Resident #124's Medication Reconciliation Form, dated 9/28/25, indicated but was not limited to:-Home medication list: pantoprazole 40mg by mouth twice daily, marked as continued on discharge Review of Resident #124's Physician's Progress Note, dated 10/3/25, indicated but was not limited to:-Medications: pantoprazole 40mg Review of Resident #124's Progress Note, dated 9/28/25, indicated he/she was readmitted to the facility and new orders for medications were sent to and reviewed by the physician. Further review of his/her progress notes failed to indicate the pantoprazole dose had been clarified or changed. Review of Resident #124's Consultation Report, dated 10/14/25, indicated he/she should continue present meds. Review of Resident #124's Consulting Physician's documentation titled After Visit Summary, dated 10/14/25, indicated but was not limited to:-Continue taking these medications: pantoprazole 40 mg by mouth two times per day before breakfast and dinner Review of Resident #124's Progress Notes, dated 10/14/25, indicated he/she saw a consulting physician and was to continue his/her present meds. Further review of his/her progress notes failed to indicate the pantoprazole dose had been clarified. Review of Resident #124's Physician's Orders indicated but was not limited to:-pantoprazole 20mg by mouth two times per day Review of Resident #124's September, October, November, and December 2025 Medication Administration Record (MAR) indicated he/she received pantoprazole 20mg by mouth twice per day as ordered. During an interview on 12/3/25 at 9:40 A.M., Nurse #2 said Resident #124 had GERD and was receiving pantoprazole 20mg twice per (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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day. Nurse #2 said when a resident returned from the hospital or an appointment, recommendations were reviewed and reported to the provider for approval or declination. Nurse #2 said if the provider declined a recommendation the nurse should document the refusal in the medical record. During an interview on 12/3/25 at 9:49 A.M., Unit Manager #2 said when a resident returned from a hospital or a consultation/appointment a nurse would review the orders and recommendations. Unit Manager #2 said medication reconciliations are completed on admission and/or readmission. Unit Manager #2 reviewed Resident #124's Discharge Summary Medication Reconciliation Form, dated 9/28/25, and the Consultant Physician's documentation, dated 10/14/25, and said the Resident should have been receiving pantoprazole 40mg twice per day as ordered. Unit Manager #2 reviewed the medical record and said there was no documented evidence that the recommendations for pantoprazole dose of 40mg had been declined. During an interview on 12/3/25 at 11:02 A.M., the Director of Nurses (DON) said she was not sure how the inaccurate dose was missed. The DON said Resident #124 should have been receiving pantoprazole 40mg twice daily.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and records reviewed, the facility failed to ensure it was free from a medication error rate of greater than 5% when one of three nurses observed during the medication pass made two errors out of 35 opportunities, resulting in a medication error rate of 5.71%. Those errors impacted two Residents (#134 and #136). Findings Include:Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice dated and revised April 11, 2018, indicated but was not limited to the following: Nurses Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers.Review of the facility's policy titled Administering Medications, dated as last revised April 2019, indicated but was not limited to the following:-The medications are administered in a safe and timely manner, and as prescribed.-Medications are administered in accordance with prescriber orders.-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.-Staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications as applicable.a. Resident #134 was admitted to the facility in October 2025 with diagnoses which include moderate protein-calorie malnutrition (moderate protein-calorie malnutrition is an insufficient intake of protein/calories, causing weight loss, fatigue, poor appetite, and muscle loss) and hypertensive heart disease (medical condition with high blood pressure that affects the heart).On 12/1/25 at 9:25 A.M., the surveyor observed Nurse #4 prepare and administer medication for Resident #134. Nurse #4 poured a magnesium oxide 400 milligram (mg) tablet (white, round pill) into the medication cup with Resident #134's other morning medications and administered the medications to Resident #134.Review of the Physician's Orders indicated but were not limited to following:-Magnesium Oral Tablet 250mg (Magnesium), give 250mg by mouth one time a day. (10/23/25)Review of the Medication Administration Record (MAR) indicated but was not limited to the following:-Magnesium Oral Tablet 250mg was signed off as administered on 12/1/25.During an interview on 12/2/25 at 8:30 A.M., Nurse #4 said he administered the wrong medication and dose to Resident #134.b. Resident #136 was admitted to the facility in October 2025 with diagnoses which include multiple fractures of ribs left side, wedge compression fractures of T5-T6 and T7-T8 vertebra (when the front part of the vertebra collapses resulting in a partial or complete break in the bone).On 12/1/25 at 9:00 A.M., the surveyor observed Nurse #4 prepare and administer Resident #136's medication. Nurse #4 prepared one Lidocaine patch 4% for topical application and applied one Lidocaine patch 4% to Resident #136's middle upper back.Review of Physician's Orders indicated but were not limited to the following:-Lidocaine External Patch 4% (Lidocaine)- Apply to bilateral rib cage topically one time a day for pain management. Apply one patch to each side of ribs for total of two patches in am and remove in pm. Removal after 12 hours and remove per schedule (10/29/25).Review of the MAR indicated but was not limited to the following:-Lidocaine External Patch 4% - Apply to bilateral rib cage topically one time a day for pain management. Apply one patch to each side of ribs for total of two patches in am and remove in pm was signed off as administered on 12/1/25.During an interview on 12/2/25 at 8:32 A.M., Nurse #4 said he administered the Lidocaine patch 4% to the wrong location on Resident #136 and failed to apply two (2) patches as ordered.During an interview on 12/2/25 at 9:28 A.M., Unit Manager #1 said Magnesium oxide 400mg and Magnesium 250mg are not the same medication and said the nurse should be administering the correct medication per physician's orders.During an interview on 12/3/25 at 3:55 P.M., the Director of Nurses said the nurse should administer the correct dose of medication and follow the medication orders as prescribed.

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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. Based on observation, interviews, and record review, the facility failed to establish and 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 for three Residents (#3, #134, #136), out of a total of seven residents. Specifically, the facility failed:1. For Resident #3, to implement personal protective equipment (PPE) for Transmission-Based Precautions when entering the Resident's room;2. For Resident #134, to follow hand hygiene procedures prior to handling medication(s) and after administering medication(s); and3. For Resident #136, to implement PPE, safe injection practices, and hand hygiene procedures prior to handling medication(s) and after administering medication(s).Findings include:Review of the facility's policy titled Standard Precautions, last revised 1/25, indicated but was not limited to:-Standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases.-Hand hygiene is performed with alcohol-based hand rub (ABHR) or soap and water: Before and after contact with the resident Before performing an aseptic task After contact with items in the resident's room; and after removing gloves.-Safe Injection practices, always use aseptic technique when handling injection equipment.-Transmission-Based Precautions, Contact precautions; potential exposure to microorganisms through direct contact with the resident, or indirect contact with belongings/environment to include: Use standard precautions (SP) with transmission-based isolation precautions.Review of the facility's policy titled Administering Medications, last revised 4/19, indicated but was not limited to: Medications are administered in a safe and timely manner, and as prescribed. Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.Review of the facility's Inservice education for all staff provided by the facility's Infection Control Nurse, dated 9/2/25, indicated but was not limited to: Contact precautions apply to entire room regardless of who is infected or not. Hand hygiene is to be performed prior to entering room and upon exiting. Personal protective equipment (PPE) must be worn in the room-no exceptions. Centers for Disease Control and Prevention (CDC) Contact precaution isolation sign. Contact precautions everyone must: clean their hands, including before entering and when leaving the room. Providers and Staff must also: put on gloves and gown before entering the room (DON), discard gown and gloves before room exit (DOFF), do not wear the same gown and gloves for the care of more than one person, use dedicated or disposable equipment, clean and disinfect reusable equipment before use on another person. Seventy-two (72) staff members signed the education, including Nurse #4 and Activities Director #1. 1. Resident #3 was admitted to the facility in August 2025 and had diagnoses including Methicillin Resistant Staphylococcus Aureus (MRSA- a type of bacteria that is resistant to several antibiotics) infection, atherosclerosis with gangrene (plaque buildup of ones arteries which blocks blood flow causing tissue death), osteomyelitis (serious infection of the bone), lower leg, other specified bacterial agents as the cause of diseases.Review of Resident #3's December 2025 Medication Administration Record (MAR) indicated but was not limited to:-Infection precautions, contact r/t MRSA and cellulitis of wound, current active order with a start date of 10/06/25.On 12/2/25 at 11:58 A.M., the surveyor observed Activities Director #1 enter Resident #3's room without performing hand hygiene or donning gloves and gown. Activities Director #1 exited Resident #3's room with a food tray, the food tray was placed in the food delivery truck. She did not perform hand hygiene. Resident #3 had a sign posted outside the entrance of the room which identified Transmission-Based Precautions, specifically Contact Precautions, were required.During an interview on 12/2/25 at 3:56 P.M., Activities Director #1 said Resident #3 was on precautions for something with his/her wound. Activities Director #1 said she did not perform hand hygiene when entering or exiting the room or wear PPE. During an interview on 12/2/25 at 12:28 P.M., Nurse #6 said Resident #3 was on contact precautions for MRSA of the wound (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and she observed Activities Director #1 enter Resident #3's room without performing hand hygiene or donning/doffing PPE and remove Resident's meal tray. Nurse #6 said there is a sign posted, and her expectation is all staff follow the sign posted by performing hand hygiene and wearing PPE.2. Resident #136 was admitted to the facility in October 2025 with diagnoses which included multiple fractures of ribs left side, wedge compression fractures (when the front part of the vertebra collapses resulting in a partial or complete break in the bone) of T5-T6 and T7-T8 vertebra.Review of Resident #136's December 2025 MAR indicated but was not limited to:-Lidocaine External Patch 4% - Apply to bilateral rib cage topically one time a day for pain management. Apply one patch to each side of ribs for total of two patches in am and remove in pm [10/29/25] (Lidocaine patch is an adhesive, medicated patch which contains the local anesthetic lidocaine, which is used for targeted pain relief by numbing the nerves in specific areas of the skin were applied).-Heparin Sodium (Porcine) injection solution 5000 unit/ML. Inject 1mL subcutaneously (under the skin) every 12 hours for blood clot [10/21/25] (Heparin is a medication that acts as a blood thinner).On 12/1/25 at 9:00 A.M., the surveyor observed Nurse #4 prepare Resident #136's medications without performing hand hygiene prior to or after administration of medications to include a topical application of one Lidocaine patch 4% and Heparin Sodium injection solution. Nurse #4 was observed applying one Lidocaine patch 4% to Resident #136's middle upper back with his ungloved left hand. Nurse #4 administered Heparin Sodium injection solution with glove donned to right hand only with ungloved left hand having contact with Resident #136's abdomen during injection administration. Nurse #4 then disposed of the used injection into the sharps container that was located on his medication cart. Nurse #4 did not perform hand hygiene. Nurse #4 then went to his keypad on the computer that was located on top of the medication cart and began typing.During an interview on 12/2/25 at 8:32 A.M., Nurse #4 said he administered the Lidocaine 4% patch and Heparin injection to Resident #136 without wearing a glove to his left hand or performing hand hygiene prior to or after medication administration. 3. Resident #134 was admitted to the facility in October 2025 with diagnoses which include moderate protein-calorie malnutrition (Moderate protein-calorie malnutrition is an insufficient intake of protein/calories, causing weight loss, fatigue, poor appetite, and muscle loss) and hypertensive heart disease (medical condition with high blood pressure that affects the heart).On 12/1/25 at 9:25 A.M., the surveyor observed Nurse #4 prepare medications for Resident #134 without performing hand hygiene prior to administration. Nurse #4 did not perform hand hygiene post medication administration. Nurse #4 was observed going to his computer that was located on top of the medication cart and began typing.During an interview on 12/2/25 at 8:30 A.M., Nurse #4 said he did not perform hand hygiene before and after each medication administration for Resident #134.During an interview on 12/3/25 at 2:53 P.M., Unit Manager #1 said her expectation was all staff must follow the precautions signs to hand sanitize before entering and when exiting the resident's room and follow appropriate PPE steps required. Unit Manager #1 said nurses should follow proper hand hygiene steps with medication administration.During an interview on 12/3/25 at 3:55 P.M., the Director of Nurses said nurses should follow hand hygiene procedures for medication administration. She said all staff should follow standard precautions and follow appropriate signs indicated for precautions to include hand hygiene and PPE as required by the signs posted.

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition Based on record reviews and interviews, the facility failed to identify a significant change in condition and complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) assessment for two Residents (#11 and #25), out of a total sample of 24 residents. Specifically, the facility failed:1. For Resident #11, to identify a significant change in his/her condition and complete a SCSA; and2. For Resident #35, to complete a SCSA when he/she was discharged from Hospice A and admitted to Hospice B. Findings include:Review of the facility's policy titled Change in a Resident's Condition or Status, last revised February 2021, indicated but was not limited to:-If a change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA (Omnibus Budget Reconciliation Act of 1987) regulations governing resident assessments and as outlined in the MDS RAI Instruction Manual. Review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual, dated October 2025, indicated but was not limited to the following:-An SCSA comprehensive assessment must be completed by the end of the 14th calendar day following determination that a significant change has occurred.-An SCSA is appropriate when: -There is a determination that a significant change (either improvement or decline) in a resident's condition from their baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and -The resident's condition is not expected to return to baseline within two weeks. -An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than)-Decline in two or more of the following: -Resident's decision-making ability has changed; -Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment; -Any decline in an ADL physical functioning area (e.g., self-care or mobility) (at least 1) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individual's functioning; -Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days) 1. Resident #11 was admitted to the facility in October 2024 with diagnoses including dementia.During an interview on 12/1/25 at 11:44 A.M., Certified Nursing Assistant (CNA) #1 said Resident #11 had a change in his/her transfer ability to transfer from one surface to another.Further review of the medical record indicated Resident #11 had a significant weight loss of 12.20% from 4/1/25 (weight 108.2 pounds (lbs.)) to 10/17/25 (95 lbs.).Review of Resident #11's MDS assessment, dated 10/23/25, indicated but was not limited to:-He/she had a severe cognitive deficit as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 3 out of 15.-He/she was dependent on staff for eating.- Walking 10 feet: Not attempted due to medical condition or safety concerns.-He/she was dependent on staff for toileting transfers-He/she had a Health Care Proxy (HCP- health care agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions) and it was activated.Review of Resident #11's MDS assessment, dated 7/24/25, indicated but was not limited to:-He/she had a moderate cognitive deficit as evidenced by a BIMS assessment score of 12 out of 15.-He/she was able to eat independently with assistance for set-up and clean-up.-He/she was able to walk 10 feet, 50 feet, and 150 feet with moderate assistance.-He/she required moderate assistance for toileting transfers.-He/she had an HCP, which was not activated.During an interview on 12/2/25 at 5:09 P.M., CNA #2 said Resident #11 was on a regular texture diet before and now was on a puree diet, and used to be able to stand and walk, but now required a wheelchair when out of bed. CNA #2 said Resident #11 had a decline over the last four or five months.During an interview on (continued on next page)

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	12/3/25 at 10:20 A.M., Activity Assistant #1 said Resident #11 used to actively participate in activities but now participates passively.During an interview on 12/2/25 at 5:02 P.M., MDS Nurse #2 said an SCSA is indicated when a resident had a significant change in weight, a decline in activities of daily living (ADLs), and change in behavior. MDS Nurse #2 reviewed Resident #11's medical record and said Resident #11 should have had a SCSA completed because he/she had a significant weight loss, change in ADL status, change in mental status, and he/she was no longer able to make his/her own medical decisions; a SCSA was not done. 2. Resident #35 was admitted to the facility in December 2022 with diagnoses including Alzheimer's disease.Review of the medical record indicated Resident #35 was discharged from Hospice A and admitted to Hospice B on 11/11/25.Further review of Resident #35's medical record indicated the facility failed to conduct a SCSA when his/her hospice status changed.During an interview on 12/2/25 at 10:52 A.M., the Director of Social Work said Resident #35 was admitted to Hospice A in April 2024, but per their Health Care Proxy's request he/she was discharged from Hospice A and admitted to Hospice B on 11/11/25.During an interview on 12/2/25 at 11:00 A.M., MDS Nurse #2 said when a resident switched from one hospice to another hospice a SCSA should be completed. MDS Nurse #2 said a SCSA should have been completed for Resident #35 when he/she switched hospice providers but one had not been completed.