STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37086 Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose Physician's Orders included the administration of an as needed (PRN) antidepressant medication (Trazodone), the Facility failed to ensure they maintained a complete and accurate medical record when nursing failed to accurately transcribe the medication order in to Resident #1's Medication Administration Record, by adding parameters not included in the the telephone order, which resulted in the medication being discontinued and unavailable for PRN use. Findings include: Review of the Facility's policy, titled Verbal Orders, with an effective date of 04/2022, indicated the following: -Verbal Orders are those given by the authorized practitioner directly to a person authorized to receive and transcribe orders on his or her behalf. -The individual receiving the verbal order will read the order back to the practitioner to ensure that the information is clearly understood and correctly transcribed. Resident #1 was admitted to the Facility in July 2023, diagnoses included anxiety disorder, major depressive disorder and Post Traumatic Stress Disorder (PTSD). Review of Resident #1's Behavioral Health Progress Note, dated 12/26/23, indicated that Resident #1 endorsed sleep disturbances, had difficulty falling asleep and at times staying asleep. The Note indicated that under the section of Clinical Assessment Nurse Practitioner (NP) #1 recommended increasing the dose of his/her PRN Trazodone as the current dose (50 milligrams) may not be efficacious (produce the desired outcome) for insomnia. Further review of the Progress Note indicated that NP #1 made the following recommendation: -Increase Trazodone 50 milligrams (mg) by mouth (po) daily at bedtime as needed (PRN) to Trazodone 75 mg po daily PRN for insomnia. Review of Resident #1's medical record indicated he/she had a physician's telephone order, dated 01/05/24, that included (but was not limited to) the following: (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Discontinue bedtime Trazodone -(New order) Trazodone 75 mg po at bedtime PRN. The telephone order for the PRN Trazodone order did not include a duration/stop date for its use. Review of Resident #1's Medication Administration Record (MAR) for the month of January 2024, indicated he/she had an order for Trazodone 75 mg by mouth every 24 hours as needed for insomnia for 14 days (start date 01/05/24, end date 01/19/24). During an interview on 03/07/24 at 1:31 P.M., Unit Manager #1 said that she transcribed Resident #1's physician telephone order on 01/05/24 on to Resident #1's Medication Administration Record and that she added to the order duration to include 14 days, because that was her practice. Unit Manager #1 said it was her understanding that for all new PRN psychotropic medication orders, the duration was supposed to be 14 days. During a telephone interview on 03/08/24 at 12:32 P.M., Nurse Practitioner (NP) #1 said that she saw Resident #1 at the Facility on 12/26/23 and recommended to increase his/her Trazodone 50 mg PRN daily for insomnia, to 75 mg PRN daily for insomnia. NP #1 said that the order did not require (and she did not include) a 14 day stop date because Resident #1 had a PRN Trazodone order in place since July 2023. During a telephone interview on 03/08/24 at 2:22 P.M., Physician #1 said that if the original PRN Trazodone order had a stop date of July 2024, then the most recent order for PRN Trazodone would not require an assessment after 14 days. Physician #1 said that the telephone order was given without a stop date, however, nursing transcribed the order onto Resident #1's MAR with a 14 day stop date and that's why the PRN Trazodone fell off of the orders. During a telephone interview on 03/06/24 at 3:05 P.M., Witness #1 said that there had been on-going confusion related to Resident #1's PRN Trazodone order. During an interview on 03/07/24 at 2:53 P.M., the Director of Nurses (DON) said that Resident #1's telephone order that was received by nursing on 01/05/24 for Trazodone 75 mg by mouth at bedtime PRN for insomnia, did not include a 14 day stop date, however, nursing added it to the order.