STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225326	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reservoir Center for Health & Rehabilitation, The	400 Bolton Street Marlborough, MA 01752

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43963 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required hemodialysis (a life-saving treatment that filters waste products and excess fluid when the kidneys stop working) three times a week, the Facility failed to ensure Resident #1's physician had been notified of a missed dialysis session, when on 09/13/24, due to a transport issue, Resident #1 missed his/her scheduled appointment, and required transfer to the Hospital Emergency Department for evaluation and dialysis treatment. Findings include: Review of the Facility Policy titled Change of Condition Notification, dated as lest revised 04/2023, indicated that the facility will inform the resident, resident 's healthcare provider, and the resident's family/legal representative when there is a change of condition. The Policy further indicated that the facility must consult with the resident's healthcare provider when there is an incident involving the resident which may result in injury or require medical treatment and must be documented in the electronic medical record. Resident #1 was admitted to the Facility in September 2024, diagnoses included End Stage Renal Disease (ESRD) and dependent on hemodialysis three days a week, history of a heart transplant [AGE] years ago, chronic anemia, and diabetes mellitus. Review of Resident #1's Physician Orders, dated 09/06/24, indicated to provide hemodialysis three times per week on Monday, Wednesday, and Fridays. Review of Resident #1's Nurse Progress Note, dated 09/13/24, indicated that his/her spouse was transporting him/her to dialysis secondary to transportation issues. During a telephone interview on 10/15/24 at 4:13 P.M., Family Member #1 said that she had called the transport company on 09/13/24 asking why they did not pick Resident #1 up for his/her dialysis session and said that they informed her that they had gone to the facility to pick him/her up, waited 15 minutes and even went into the Facility to see if he/she was in the lobby. (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family Member #1 said after driving Resident #1 to the appointment, the dialysis center staff were unable to assist with getting Resident #1 out of the care, so Resident #1 was not able to be dialyzed that day (09/13/24) and that she informed nursing staff that he/she missed that day's dialysis session, upon their return to the facility. Review of Resident #1's Medical Record for 09/13/24, indicated that there was no documentation to support that he/she had not received dialysis that day or that his/her Physician was made aware of the missed dialysis session. During a telephone interview on 10/18/24 at 1:24 P.M., the Evening Nurse Supervisor said that she was working on 09/13/24, the evening that Resident #1 spouse transported him/her to and from dialysis, and that she was aware that he/she had not received dialysis. The Evening Supervisor said that to the best of her knowledge, no one informed Resident #1's Physician that he/she missed his/her dialysis session, that missing a dialysis session was very significant and the Physician should have been notified. During a telephone interview on 10/23/24 at 10:02 A.M., the Nurse Practitioner said that she had not been informed of Resident #1 missing a dialysis session and said she would have expected the nursing staff to inform his/her provider. During a telephone interview on 10/23/24 at 2:49 P.M., the Physician said she was unaware that Resident #1 had missed a dialysis session and that missing a dialysis session is important information that should have been reported. During an interview on 10/15/24 at 1:22 P.M., the Assistant Director of Nurses said she was unaware that Resident #1 had missed his/her scheduled dialysis day on 09/13/24 and said that his/her physician/provider should have been notified so that another dialysis session could be arranged. During an interview on 10/15/24 at 2:03 P.M., the Director of Nurses said that she was not aware that Resident #1 missed a dialysis session, or that nursing had not informed his/her physician. The DON said that it is the Facility's expectation that nursing staff inform a resident's physician of a missed dialysis session.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43963 Based on records reviewed and interviews, for two of three sampled residents, (Resident #1 and #2), the facility failed to ensure that upon admission, nursing developed and implemented baseline care plans with interventions, treatments, goals, and outcomes that addressed the residents overall immediate care needs within 48 hours of admission, or in the absence of a baseline care plans that comprehensive care plans had been developed with in 48 hours. Findings include: Review of the Facility Policy titled, Baseline/Comprehensive Person-Centered Care Plan, dated as last revised 3/2023, indicated that a baseline care plan must be developed within 48 hours of admission. The baseline care plan includes at least a minimum of healthcare information necessary to provide proper care for the residents. 1) Resident #1 was admitted to the Facility in September 2024, diagnoses included End Stage Renal Disease (ESRD) and dependent on hemodialysis three days a week, history of a heart transplant [AGE] years ago, chronic anemia, and diabetes mellitus. Review of Resident #1's Original Admission Nursing Evaluation, dated 09/06/24, indicated his/her immediate care needs were identified as follows; -ESRD with hemodialysis three times per week; -Alteration in skin integrity with multiple pressure injuries; -Alteration in comfort; -Alteration in respiratory status requiring oxygen via a nasal cannula; -Alteration in mood related to anxiety and depression with psychotropic medication use; and -Need for physical and occupational therapy. Review of Resident #1's Medical Record indicated there was no documentation to support that either Baseline Care Plans and/or Comprehensive Care Plans were developed and implemented that addressed these areas of concern within 48 hours of his/her admission. 2) Resident #2 was admitted in October 2024, diagnoses included urinary tract infection, acute on chronic respiratory distress, chronic obstructive pulmonary disease (COPD), malnutrition, and urinary retention with an indwelling catheter in place. Review of Resident #2's Discharge Summary, dated 10/02/24, indicated his/her immediate care needs were identified as followed; (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Urinary tract infection, urinary retention with an indwelling catheter in place; -Acute on chronic respiratory distress with use of multiple inhalers; -Diabetes Mellitus with risk for skin breakdown; and -Risk for abnormal bleeding related to anticoagulant use. Review of Resident #2's Medical Record indicated there was no documentation to support that either Baseline Care Plans and/or Comprehensive Care Plans that addressed these areas of concern, were developed and implemented within 48 hours of his/her admission. During a telephone interview on 10/18/24 at 1:24 P.M., the Evening Supervisor said that she was not very good at care plans and only puts in the fall risk and activities of daily living care plans upon admission. The Evening Supervisor said that the Nurse responsible for completing the Nursing Admission Packet are responsible for completing the Baseline Care Plans for the resident. During an interview on 10/15/24 at 1:22 P.M., the Assistant Director of Nurses (ADON) said that the Unit Manager is usually responsible for developing a resident's baseline care plan and said that management staff does a chart check within 48 hours of admission. The ADON said that it is the Facility's expectation for nursing to initiate a resident's baseline care plan upon admission and must be completed within 48 hours of admission. During an interview on 10/15/24 at 2:03 P.M., the Director of Nurses (DON) said that it is the responsibility of the nurses to initiate and complete baseline care plans for the residents and said that the management team is responsible for doing chart audits to ensure completion. The DON said that it is the Facility's expectation to complete each resident's baseline care plans within 48 hours of admission per the facility policy.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43963 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required hemodialysis (a life-saving treatment that filters waste products and excess fluid when the kidneys stop working) three times a week for end stage renal disease, the facility failed to ensure Resident #1 received the care and services consistent with his/her care plan, when Resident #1 missed a dialysis session because of a transportation issue, and days later required transfer to the Hospital Emergency Department (ED) for evaluation of changes in his/her mental status, and required dialysis treatment. Findings include: Review of the Facility Policy titled Hemodialysis, dated as last revised 6/2023, indicated that a resident who is admitted to the facility requiring hemodialysis, with their consent, will have their dialysis needs met. The Policy further indicated that the resident would leave the facility to obtain hemodialysis to a dialysis center agreed upon by the resident and the physician and the resident will be transported via wheelchair/stretcher to and from the facility by inside and outside Transportation Company on their assigned hemodialysis days. Review of the Facility's Outpatient Dialysis Services Agreement, dated 03/2022, indicated that the Nursing Facility shall have the responsibility for arranging suitable transportation of the resident to and from the dialysis unit, including the selection of the mode of transportation, qualified personnel to accompany the resident and transportation equipment usually associated with this type of transport or referral including the use of appropriate life support measures in accordance with the applicable federal and state laws and regulations. Resident #1 was admitted to the Facility in September 2024, diagnoses included End Stage Renal Disease (ESRD) and dependent on hemodialysis three days a week, history of a heart transplant [AGE] years ago, chronic anemia, and diabetes mellitus. Review of Resident #1's Hospital Discharge Summary, dated 09/12/24, indicated he/she had dialysis last on 09/11/24 and was due to have his/her next session via outpatient on 09/13/24. Review of Resident #1's Physician Orders, dated 09/12/24, indicated to provide Hemodialysis three times per week, Monday, Wednesday, and Fridays. Review of Resident #1's Nurse Progress Note, dated 09/13/24, indicated that his/her spouse was transporting him/her to dialysis secondary to transportation issues. (continued on next page)

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 10/15/24 at 4:13 P.M., Family Member #1 said after driving Resident #1 to his/her dialysis appointment, because of an issue with the transportation company, the dialysis center staff told her that they were unable to help assist with getting Resident #1 out of the car, so he/she was not able to get dialysis (09/13/24). Family Member #1 said she brought Resident #1 back to the facility and informed nursing staff that Resident #1 had not gotten his/her dialysis treatment that day. Review of Resident #1's Medical Record Nursing Progress Notes for 09/13/24, indicated that there was no documentation to support that he/she had not received his/her dialysis treatment that day or that his/her Physician was made aware of the missed dialysis session. Review of Resident #1's Nurse Practitioner (NP) Progress Note, dated 09/16/24, indicated she was called to assess Resident #1 that morning secondary to him/her being unresponsive. The Note indicated that he/she had received an increased dose of Oxycodone (narcotic), he/she was later checked and found to be unresponsive, Narcan was administered without effect and Resident #1 was transported to the Hospital Emergency Department for evaluation. Review of Resident #1's Hospital Emergency Department report, dated 09/16/24, indicated that he/she was found to have an altered mental status and was hypoxic. The ED report indicated he/she was unable to engage in conversation, his/her eyes were closed and having clonus (neurological condition that causes involuntary, rhythmic contractions and relaxations) and jerky movement. Resident #1's Potassium was 6.1 milliequivalents per liter (mEq/L, normal range is 3.5 to 5.2), and Resident #1 required emergent dialysis treatment. During a telephone interview on 10/23/24 at 10:02 A.M., the Nurse Practitioner said that she had not been informed of Resident #1 missing a dialysis session on 09/13/24 and said she would have expected the nursing staff to inform his/her provider. During a telephone interview on 10/23/24 at 2:49 P.M., the Physician said she was unaware that Resident #1 had missed a dialysis session on 09/13/24 and said missing a dialysis session is very significant. During an interview on 10/15/24 at 1:22 P.M., the Assistant Director of Nurses said she was unaware that Resident #1 had missed his/her scheduled dialysis day and that his/her physician should have been notified so that another dialysis session could be arranged. During an interview on 10/15/24 at 2:03 P.M., the Director of Nurses said that she was not aware that Resident #1 missed a dialysis session, and that nursing had not informed his/her physician. The DON said that it is the Facility's expectation that nursing staff inform a resident's physician of a missed dialysis session and ensure appropriate transportation is set-up for each resident requiring dialysis.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43963 Based on record reviews and interviews for one of three sampled residents (Resident #1), who upon admission and then re-admission, the Facility failed to ensure he/she was free from a significant medication errors, when medications from his/her Hospital Discharge Summary (s) were not accurately reconciled by Nursing and he/she was administered the incorrect dosage of medications for multiple days. Findings include: Review of the facility Policy titled, Medication Reconciliation, dated as last revised 04/2023, indicated that the medication reconciliation process is to be completed at admission, re-admission, and discharge by the nursing staff. The Policy further indicated that the purpose is to identify clarifications and discrepancies that needed to be resolved with the primary care physician to ensure the resident's safety and prevent negative outcomes as related to medication management. Review of the Facility Policy titled Medication Error, dated as last revised 5/2023, indicated that a medication error is a discrepancy between what the healthcare provider ordered and what the resident received. Resident #1 was admitted to the Facility in September 2024, diagnoses included End Stage Renal Disease (ESRD) and dependent on hemodialysis three days a week, history of a heart transplant [AGE] years ago, chronic anemia, and diabetes mellitus. Resident #1 was re-hospitalized from the Facility and readmitted again days later in relation to a fall with head strike and multiple fractured ribs. A) Review of Resident #1's Hospital Discharge (DC) Summary, dated 09/06/24, indicated that the following medications were being administered while hospitalized ; -Neurontin (Gabapentin, anticonvulsant) 300 milligram (mg) capsule (total of 300 mg a day, three times a week), take by mouth three (3) times a week on Monday, Wednesday, and Friday (Dialysis days, start taking on 09/09/24). -Nitroglycerin 2 percent (%) ointment, place 0.05 inch onto the skin two (2) times a day, once in the morning and once in the afternoon, as a scheduled dose. However, review of Resident #1's Physician's Orders, dated 09/06/24, indicated to administer the following; -Neurontin 300 mg capsule, take by mouth 3 times a day (total of 900 mg, every day). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nitroglycerin 2 % ointment, place 0.05 inch onto the skin every 15 minutes PRN (as needed) for chest pain, may give up to 2 times per day, therefore it was only administered as needed, and not scheduled per his/her Hospital DC Summary. Review of Resident #1's Medication Administration Record (MAR), dated 09/07/24 through 09/10/24, indicated he/she received nine (9) doses of Neurontin 300 mg (for a total of 2700 mg) but he/she should have only received one dose on 09/09/24 (for a total of 300 mg) per his/her physician's order. Review of Resident #1's Medication Reconciliation Form, dated 09/06/24, indicated that medications were reviewed with the on-call provider and no issues had been identified. During a telephone interview on 10/17/24 at 10:01 A.M., Nurse #1 said that she usually looks at the Hospital Discharge Summary medication list and then calls the on-call provider, unless there is a provider in-house at the time of admission. Nurse #1 said she does not recall any details of Resident #1's medication reconciliation and said she did not notice the discrepancy with his/her Neurontin. During an interview on 10/15/24 at 1:22 P.M., the Assistant Director of Nurses (ADON) said that medication reconciliation consisted of Nursing matching medications lists from all sources and clarifying any discrepancies with the provider. B) Review of Resident #1's Hospital Discharge Summary, dated 09/12/24, indicated that the following medications were being administered while hospitalized ; -Tacrolimus (helps to prevent organ rejection) one (1) mg capsule, take one capsule by mouth 2 times a day (for a total of 2 mg daily); However, review of Resident #1's Medication Administration Record (MAR), dated 09/13/24 through 09/16/24, indicated the following: - there were duplicate physician's orders for the Tacrolimus 1 mg capsule, take one capsule by mouth 2 times a day. -both orders on the MAR for the Tacrolimus had been signed off as being administered by nurses on 09/13/24 and 09/15/24, - therefore Resident #1 was being administered a total of 4 mg a day, not 2 mg a day, per the Hospital DC summary. During a telephone interview on 10/17/24 at 2:36 P.M., Nurse #2 said that the only medication she remembered being questioned upon his/her readmission was Resident #1's Plavix (used to prevent blood clots). Nurse #2 said she did not recall seeing a duplicate order for his/her Tacrolimus upon admission. During a telephone interview on 10/17/24 at 1:50 P.M., the DON said that she was not aware that there were any medication errors made with the admission or readmission with Resident #1's reconciliation and/or transcription of medications. During an interview on 10/15/24 at 2:03 P.M., the Director of Nurses (DON) said that she was not aware of any issues with Resident #1's medication reconciliation process for his/her admission or readmission. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said that it is the Facility's expectation to include having two licensed nurses complete and sign any resident's medication reconciliation upon admission and readmission and said the nurse management will do a chart audit within 48 hours to ensure accuracy.