STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225452	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Village	18 Dana Hill Road Sterling, MA 01564

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) Assessment was accurately coded to reflect the correct status for one Resident (#129) out of three applicable residents. Specifically, the facility staff failed to ensure that the MDS Assessment accurately reflected that Resident #129 was discharged home. Findings include: Resident #129 was admitted to the facility in July 2024, with diagnoses including urinary tract infection (UTI: bacterial infection of the urinary tract) and Sepsis (a life-threatening medical emergency that occurs when an infection triggers the body's immune system to damage its own organs and tissues). Review of Resident #129's Nurses Progress Note dated 7/18/24, indicated that the Resident had chosen to be discharged home on the same day (7/18/24) against medical advice (AMA). Review of Resident #129's July 2024 Physician's orders indicated an order to discharge the Resident with medications and services on 7/18/24. Review of Resident #129's clinical record indicated that the Resident had signed a document releasing the facility of responsibility for his/her discharge on 7/18/24, and that the Resident would be discharged home with medications and Visiting Nursing Association (VNA) services. Review of Resident #129's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated that the Resident was discharged to a short-term hospital. During an interview on 9/4/24 at 12:15 P.M., the MDS Nurse said that the MDS Assessment had been inaccurately coded and should have marked the Resident as discharged home.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on observation, interview, record and policy review, the facility failed to provide three Residents (#113, #20, and #92), out of a total sample of 25 residents, with an environment as free of accidental hazards as possible. Specifically, the facility staff failed to: 1. provide adequate supervision and food of the required texture to ensure Resident #113's safety while eating when the Resident had a diagnosis of Oropharyngeal Phase Dysphagia (disorder or impairment in the ability to swallow), required his/her food to be pureed (soft, smooth foods that require no chewing), and required supervision and verbal cues while eating, increasing the Resident's risk for aspiration (inhaling food/drink into one's airways or lungs, and can result in Pneumonia). 2a. appropriately review Resident #20's food allergy list, when the Resident with a documented allergy for green beans, was served green beans at mealtime, increasing the Resident's risk for adverse reactions to food consumption. 2b. provide adequate supervision for Resident #20 to ensure the Resident's safety while eating for a documented diagnosis of Oropharyngeal Phase Dysphagia, and required supervision and verbal cues for safety while eating, increasing the Resident's risk for aspiration. 3. provide supervision and adaptive equipment for Resident #92 when the Resident had a history of sustaining a burn from hot liquids, required hot liquids to be covered with a specialized lid, and required supervision for safety while eating/drinking, increasing the Resident's risk for sustaining further burn injuries. Findings include: Review of the facility policy titled Assisting the Resident to Eat, dated 9/1/04, indicated the following: -The purpose of the policy was to assist residents to eat and to provide nutrition for residents needing assistance to eat. -Examples of items that would be provided for residents included the ordered diet tray and self-help eating aids. -Staff were required to obtain the resident's tray, identify the resident, and verify that the correct diet was served. -Staff were to prepare food as necessary for the resident. -Staff were required to ensure that the consistency of foods were appropriate. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff were required to assist the resident as necessary. 1. Resident #113 was admitted to the facility in August 2023, with diagnoses including Dementia (the impaired ability to remember, think, or make decisions that interferes with doing everyday activities), Malignant Neoplasm (abnormal growth of tissue that can be non-cancerous or cancerous) of the tongue, and Oropharyngeal Phase Dysphagia. Review of Resident #113's Cognitive Function Care Plan, initiated 8/4/23 and revised 12/18/24, indicated staff were to cue . and supervise the Resident as needed. Review of Resident #113's Nutrition Care Plan, initiated 8/7/23 and revised 12/18/24, indicated the following: -The Resident was at increased nutritional risk related to Dementia, Dysphagia, and Tongue Neoplasm. -Staff were required to serve the ordered diet to the Resident. Review of Resident #113's Swallowing Risk Care Plan, initiated 9/28/23 and revised 12/18/24, indicated the following: -Instruct Resident to .eat slowly and to chew each bite thoroughly. -Staff were required to monitor the Resident for any signs of dysphagia, including: pocketing, choking, coughing, drooling, holding food in the mouth, several attempts at swallowing, refusing to eat, and appearing concerned at meals. -The Resident was to eat only with supervision. Review of Resident #113's Speech/Language Pathology Evaluation, dated 4/11/24, indicated the following: -The Resident's family reported the Resident having had a history for having a tumor removed from the base of his/her tongue. -The Resident had experienced an approximate 15-pound weight loss over the previous four months. -The Resident's diet texture was for mechanical soft (type of texture-modified diet for people who have difficulty chewing and swallowing solid food items. -The Resident was referred for a Speech/Language Pathology Evaluation due to reports of the Resident coughing with PO (per os: Latin for by mouth) intake. -Due to the progressive nature of Dementia in the setting of a history for Neoplasm of the Tongue, weight loss, and reports of difficulty with PO intake, the Speech/Language Pathology Evaluation was warranted to support the Resident's safety . and to reduce the risks for aspiration and infection. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Speech/Language Pathologist (SLP) observed the Resident coughing while eating lunch during the Speech/Language Pathology Evaluation. Review of Resident #113's September 2024 Physician's orders indicated an active Dietary Order dated 4/15/24, for pureed texture. Review of Resident #113's Speech/Language Pathology Discharge Summary dated 6/18/24, indicated the following: -Functional outcome skills for mastication (ability to chew), bolus preparation (when food is chewed into a cohesive unit, ready to be swallowed), anterior-posterior transfer (immediately before the initiation of a swallow, the front of the tongue rises as the back of the tongue drops, propelling the bolus backward), and swallow reflex were impaired. -The Resident required pureed foods. -Caregiver instruction had been completed. Review of Resident #113's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of five out of a total 15 points. On 8/29/24 between 8:18 A.M. and 8:43 A.M., the surveyor observed a staff member tell Resident #113 that it was time for breakfast and that the Resident was to walk from his/her room to the dining room. The surveyor observed Resident #113 stand up from his/her bed and walk into the hallway with the staff member. The surveyor then observed the staff member move away from the Resident once the Resident walked to an area in the hallway close to the dining room entrance. At the same time, the surveyor observed another staff member remove a breakfast tray from the meal cart, turn toward Resident #113 and instructed the Resident to return to his/her room to eat breakfast. The surveyor then observed Resident #113 turn and walk with the staff member back to his/her room. The surveyor observed Resident #113 sit on the edge of his/her bed and the staff member set up the Resident's meal tray on the bedside table, and the meal tray included pureed eggs and hot cereal. The surveyor observed the staff member exit Resident #113's room once the meal tray was set up. The surveyor observed Resident #113 start to eat. The surveyor observed one staff member enter the Resident's room during this time to provide the Resident with some sugar for the meal, but no staff were observed remaining in the room to supervise the Resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/30/24 at 12:15 P.M., the surveyor observed Resident #113 seated in the hallway, eating lunch with two staff members present in the hallway assisting other residents to eat. The surveyor observed mashed potatoes, pureed green vegetables, and three chunks of solid white fish on Resident #113's plate. The surveyor observed Resident #113 use his/her spoon to press down on the fish, then mix it with the mashed potato, while the Resident cleared his/her throat. The surveyor then observed Resident #113's meal ticket on his/her meal tray that indicated the Resident required pureed food. At this time, Resident #113 said he/she had to be careful eating, and the surveyor immediately located Nurse #1 and notified her that the Resident had solid chunks of fish on his/her meal tray. Nurse #1 immediately went to Resident #113, observed the Resident's meal and said she did not know how the solid pieces of fish ended up on the Resident's tray. Nurse #1 said she would call the SLP to inquire about the Resident's ability to have fish that was not pureed. The surveyor observed Nurse #1 walk away from the Resident, down the hallway, and did not remove the fish from the Resident's plate. The surveyor then observed the Resident eat the pieces of fish that were left on his/her plate. During an interview on 8/30/24 at 12:25 P.M., with Nurse #1 and the Unit Manager (UM) #1, UM #1 said that Dietary Staff were required to send meals for residents to the units according to the residents' diet orders. At the time, Nurse #1 said she checked the meal trays prior to the meals being served on the unit and identified no discrepancies between diets ordered and diets served. UM #1 said having solid chunks of fish on Resident #113's meal tray must have been overlooked by both the Dietary Staff and Nurse #1 and would need to be investigated further. UM #1 also said she did not know why Resident #113 was instructed to eat in his/her room for the breakfast meal on 8/29/24. During a follow-up interview on 9/3/24 at 8:35 A.M., Nurse #1 said she was alerted by Certified Nurses Aide (CNA) #1 that Resident #113 had eaten most of his/her meal at lunch on 8/29/24, and had requested more potatoes. Nurse #1 said CNA #1 told her CNA #3 had scraped some potatoes from an unserved lunch tray onto Resident #113's plate and that the unserved lunch tray contained regular texture fish, not pureed fish. Nurse #1 further said CNA #3 should not have scraped food items from the unserved tray onto Resident #113's plate and that CNA #3 should have contacted Dietary staff to request additional food items specific to Resident #113's diet order when the Resident requested more food. CNA #3 was not available to be interviewed by the surveyor on 9/3/24. During an interview on 9/3/24 at 8:39 A.M., CNA #1 said she observed CNA #3 scrape mashed potatoes from an unserved lunch meal tray onto Resident #113's lunch plate on 8/30/24. CNA #1 said she observed that the unserved meal tray contained fish that had not been pureed, so she alerted CNA #3 to be careful because Resident #113 required pureed food items. CNA #1 said there must have been pieces of fish with the mashed potatoes that CNA #3 scraped onto Resident #113's plate. During an interview on 9/4/24 at 12:55 P.M., the SLP said he had provided services in the past relative to swallowing and cognition to Resident #113. The SLP said that Resident #113 was cognitively impaired, and also had Dysphagia. The SLP said that Resident #113 required a pureed diet and supervision while eating. The SLP said the Resident experienced food residue build up in his/her mouth with variable awareness that the food residue was present and required instruction from a staff member to perform a liquid rinse to clear the residue. The SLP further said the pureed food, supervision during meals, and cueing was required for the Resident's safety due to the risk for aspiration and Aspiration Pneumonia. The SLP also said that Resident #113's swallowing status had not changed since he/she was discharged from Speech/Language Pathology services on 6/18/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #20 was admitted to the facility in December 2023, with diagnoses including Age-Related Cognitive Decline (difficulty with thinking, memory, concentration and other brain functions beyond what is typically expected due to aging), Chronic (persisting for a long time or continually occurring) Migraines (headaches that can cause severe throbbing pain or a pulsing sensation, usually on one side of the head and is often accompanied by nausea, vomiting, and extreme sensitivity to light and sound), and Oropharyngeal Phase Dysphagia. Review of Resident #20's Cognitive Function Care Plan, initiated 12/12/23 and revised 8/21/24, indicated the following: -The Resident had impaired cognitive function related to impaired decision making. -Staff were required to cue . and supervise the Resident as needed. Review of Resident #20's Swallowing Risk Care Plan, initiated 12/12/23 and revised 8/21/24, indicated the following: -All staff to be informed of Resident's special dietary and safety needs. -Alternate small bites and sips. -Use a teaspoon for eating. -Encourage Resident to . eat slowly and to chew each bite thoroughly. -Monitor . for signs of Dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appearing concerned during meals. Review of Resident #20's Nutrition Care Plan, initiated 12/12/23 and revised 8/21/24, indicated the Resident was at increased nutritional risk related to . Dysphagia . Further review of the Resident's Nutrition Care Plan indicated staff were required to provide and serve the Resident's diet as ordered. Review of Resident #20's Speech/Language Pathology Discharge Summary, dated 1/29/24, indicated the following: -The Resident's attention, memory, and executive function (cognitive skills used to manage everyday tasks) skills were impaired. -The Resident reported globus (a persistent or intermittent non-painful sensation of a lump in the throat) when using a high rate of intake. -The Resident no longer reported globus when cues to slow his/her rate for intake and cues for alternating bites and sips were provided. -The Resident demonstrated impaired: mastication, bolus preparation, anterior-posterior transfer of bolus, and swallow reflex. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Caregiver training and instruction had been provided. Review of Resident #20's September 2024 Physician's orders indicated an active Dietary order dated 3/1/24, for mechanical soft food texture. 2a. On 9/3/24 at 12:01 P.M., the surveyor observed the door to Resident #20's room was half-way closed. The surveyor observed the foot of the Resident's bed from the hallway but was unable to observe whether the Resident was in the room. When the surveyor knocked on Resident #20's door, the Resident responded to come in. Upon entering the Resident's room, the surveyor observed there was no staff in the room with the Resident. Resident #20 was sitting up in bed, eating his/her lunch meal. The surveyor observed mechanical soft texture meat with gravy, mashed potatoes and green beans on the Resident's plate and the Resident was eating with a fork. The surveyor observed Resident #20's meal tray ticket that indicated the Resident had an allergy to green beans. Resident #20 said he/she could not eat green beans because green bean consumption made his/her migraines worse. The surveyor immediately located Nurse #1 and alerted her that Resident #20 had green beans on his/her tray and that the Resident's meal ticket indicated an allergy to green beans. Nurse #1 immediately removed Resident #20's meal tray, then called Dietary Staff for a new meal tray without green beans for the Resident. During an interview at the time, Nurse #1 said that she was unsure whether the green bean allergy was an actual allergy for Resident #20 or if it indicated a dislike for green beans. Nurse #1 said that often resident dislikes for food were indicated under the allergy section of the meal ticket. During an interview on 9/3/24 at 12:20 P.M., the UM said she would have to investigate whether green beans were an actual allergy or dislike for Resident #20. The UM also said she was not aware of Resident #20 requiring the use of a teaspoon for eating or requiring cues to eat slowly and chew each bite thoroughly. The UM further said she was not aware of the Resident's need to alternate small bites and sips while eating. During an interview on 9/3/24 at 12:43 P.M., the Dietitian said if a resident told the facility they had a food allergy, the facility was required to indicate that food item as an allergy as there would be no way to confirm the allergy. The Dietitian said if a food allergy was indicated for a resident, then the Resident should not be served the food item. The Dietitian further said he would have to look into whether green beans were indicated as an allergy or if they were a disliked food item for Resident #20. During a follow-up interview on 9/3/24 at 1:15 P.M., the Dietitian said that he identified in Resident #20's record that green beans were indicated as a food allergy and that the Resident should not have received green beans with his/her lunch meal on 9/3/24. During an interview on 9/3/24 at 1:30 P.M., Dietary Staff #2 said she was responsible for calling off the resident diets for the lunch meal tray line on 9/3/24. Dietary Staff #2 said she missed calling off Resident #20's green bean allergy, so the Resident received green beans with his/her lunch meal but should not have. Dietary Staff #2 said Nurse #1 called the Dietary department to request a replacement meal tray for Resident #20, and the replacement tray was provided to the Resident with carrots instead of green beans. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/3/24 at 2:20 P.M., the SLP said Resident #20 had impaired cognitive function and Dysphagia and required a modified diet texture of mechanical soft foods. The SLP said that due to the Resident's level of cognitive function for problem solving, Resident #20 required staff intervention during meals for taking small bites and alternating solids and liquids. The SLP also said Resident #20 was supposed to be eating with a teaspoon. The SLP said he had communicated all these interventions to staff and had recorded the interventions in the Resident's care plan. The SLP said that the interventions were still required for the Resident's safety while eating. 2b. On 9/3/24 at 2:40 P.M., the surveyor observed Resident #20 positioned in his/her bed with the head of the bed in an upright position and no staff were present in the Resident's room. The Resident was observed leaning to the right side, his/her head positioned down with his/her chin resting on his/her chest, and his/her eyes closed. The surveyor also observed that the Resident's lunch meal tray was still in front of him/her and contained mechanical soft meat with gravy, mashed potato, and diced carrots. The surveyor observed that the Resident's fork was in his/her hand. At that time, the surveyor spoke to Resident #20, the Resident opened his/her eyes briefly, then began to verbalize something the surveyor could not understand. The surveyor observed several small pieces of diced carrot on the tip of the Resident's tongue and protruding from behind the Resident's inner upper and lower lips while he/she was attempting to speak. The Resident kept his/her eyes closed and placed his/her index finger and thumb in his/her mouth and removed some of the pieces of diced carrot. The surveyor did not observe any staff member enter the Resident's room to monitor the Resident during the observation. On 9/3/24 at 2:45 P.M., CNA #4 said she was familiar with Resident #20 and provided care for the Resident often. CNA #4 said the Resident required no intervention from staff for eating other than setting up and cleaning up his/her meal tray. On 9/3/24 at 3:45 P.M., the Director of Nursing (DON) said she was unsure which residents in the facility required supervision throughout meals versus check-ins from staff, and that she would need to work with the SLP to figure this out. 45429 3. Review of the facility's policy titled Nutrition Policy, last revised 4/28/11, indicated: -A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition -the facility provides special eating equipment and utensils for residents who need them. Resident #92 was admitted to the facility in April 2024, with diagnoses including non-traumatic intracerebral hemorrhage (bleeding in the brain), dysphagia (swallowing difficulty) and hemiplegia (partial or total paralysis of one side of the body). Review of Resident #92's care plan for increased nutritional risk dated 4/26/24, indicated an intervention to provide and serve diet as ordered. Review of Resident #92's care plan for swallowing dated 4/29/24, indicated: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the Resident will have clear lungs, no signs and symptoms of aspiration (swallowing something that enters the airway or lungs). -monitor, document, report as needed any signs or symptoms of dysphagia (choking, coughing, drooling, holding food in mouth). -Resident to eat only with supervision. Review of the Speech and Language Pathology (assessment of communication disorders) Daily Note dated 5/24/24, indicated that the Speech Therapist (ST) recommended that Resident #92 have supervision for meals. Review of Resident #92's Nurses Progress Notes dated 7/4/24, indicated that the Resident had suffered a burn on the right thigh due to drinking hot tea that his/her spouse had given him/her. Further review of the Nurses Progress Notes indicated that the intervention for the burn incident was to provide a sip cup lid to prevent further burns from hot liquids. Review of Resident #92's Unusual Event Report dated 7/4/24, indicated: -that the Resident's spouse gave him/her tea, it had spilled on the Resident and burned him/her. -that it appeared the spouse had popped the blister of said burn. -that the intervention to prevent recurrence or injury was to provide a sip cup lid with hot liquids. Review of Resident #92's care plan for potential impairment to skin integrity last revised 7/4/24, indicated an intervention to provide a sip cup lid with hot drinks. Review of Resident #92's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #92: -was unable to complete the Brief Interview for Mental Status (BIMS) exam because they are rarely or never understood. -required set up assistance with eating (the ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on the table). Further review of the MDS Assessment revealed that Resident #92 had exhibited the following signs and symptoms of a swallowing disorder: -loss of liquids or solids from mouth when eating or drinking -coughing or choking during meals or when swallowing medications -complaints of difficulty or pain when swallowing (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #92's September 2024 Physician's orders indicated a sip lid with hot liquids, start date of 7/12/24. On 8/29/24 at 8:22 A.M., the surveyor observed Resident #92 sitting alone in his/her room eating breakfast. The surveyor observed there was a mug of thickened coffee with no sip cup lid on the Resident's breakfast tray. Review of Resident #92's meal ticket slip dated 9/3/24, generated by the facility's kitchen indicated a coffee mug with sip lid for all hot liquids. On 9/3/24 at 8:21 A.M., the surveyor observed Resident #92 sitting in his/her room eating breakfast and coughing. The surveyor requested CNA #2's assistance with the Resident as he/she had trouble communicating. During an interview at the time, CNA #2 said that the Resident wanted the assistance of the facility's ST because he/she was coughing because he/she had drank too much (breakfast beverage). On 9/3/24 at 8:26 A.M., the surveyor and CNA #2 observed Resident #92's breakfast tray and there was no sip cup lid observed on the Resident's coffee mug. During an interview at the time, CNA #2 said that she was familiar with Resident #92 and did not usually see a sip cup lid on the Resident's food tray. During an interview on 9/3/24 at 8:36 A.M., Nurse #2 said that Resident #92 was not supervised with meals. Nurse #2 also said that the Resident had required supervision with meals when he/she was first admitted to the facility, but they had improved and no longer required the supervision. On 9/3/24 at 12:09 P.M., the surveyor observed Resident #92 being supervised while eating in the dining room. During an interview at the same time, Nurse #2 said that there had been an err (error) and the Resident was now supervised with meals. During an interview on 9/3/24 at 12:41 P.M., the Dietitian said that he was aware that Resident #92 had experienced a burn while drinking and should have a sip cup lid with hot liquids for all meals. During an interview on 9/3/24 at 1:18 P.M., the Food Service Director (FSD) said that the facility had an ample supply of sip cup lids. The FSD also said that Resident #92 should have had a sip cup lid on his/her coffee mugs for all meals and he/she did not. During an interview on 9/3/24 at 1:34 P.M., Rehabilitation Services Staff (Speech Therapist) #1 said that he had evaluated Resident #92 and recommended that the Resident be supervised for all meals. Rehabilitation Services Staff #1 also said that his recommendations were noted in the Resident's electronic plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225452	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Village	18 Dana Hill Road Sterling, MA 01564

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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** 50320 Based on record and policy review, and interview, the facility failed to ensure that one Resident (#52) out of a total sample of 25 residents was free from significant medications errors. Specifically, the facility staff failed to adhere to the Physician's orders to hold the dose of Losartan Potassium (a medication used to decrease blood pressure and decrease the incidence of Stroke in patients with Hypertension [HTN: high blood pressure. When the blood pressure measures consistently above 130/80 millimeters of mercury [mmHg]) for a Systolic Blood Pressure (SBP) of less that 110 mmHg. Findings include: Review of the facility policy titled Medication Pass Guideline, with a revision date of 2/12/15 indicated: >Physician's Orders: -Medications are administered in accordance with the written orders of the attending Physician. *If a dose seems excessive considering the resident's age and condition or a medication order seems to be unrelated to the resident's current diagnosis or condition, contact the Physician for clarification prior to administration of the medication. *Documentation of the interaction with the Physician in the progress notes and elsewhere in the medical record as appropriate. *The Nurse who receives the order is responsible for transcribing to the chart. Resident #52 was admitted to the facility in July of 2021, with diagnoses including Hypertension, Cerebral Vascular Accident (CVA: when blood flow to a part of the brain is stopped either by a blockage or a rupture of a blood vessel), Peripheral Vascular Disease (PVD: a slow progressive disorder of the blood vessels caused by narrowing, blockage or spasms in a blood vessel reducing blow flow to the limbs). Review of Resident #52's Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -The Resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating the Resident was cognitively intact. -The Resident had diagnoses including Hypertension, PVD and CVA. Review of Resident #52's Physician's orders dated 7/16/24, indicated: -Losartan Potassium oral tablet 50 milligrams (MG) (Losartan Potassium), Give 1 tablet by mouth every 12 hours related to Essential (Primary) Hypertension. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Hold for Systolic Blood Pressure (SBP) of less than 110 (mmHg). Review of Resident #52's August 2024 Medication Administration Record (MAR) indicated the Losartan Potassium medication had not been administered per the Physician's orders on the following dates: -8/9/24 with a SBP reading of 114 mmHg (higher than the ordered parameters to hold the medication) -8/11/24 with a SBP reading of 114 mmHg (higher than the ordered parameters to hold the medication) -8/19/24 with a SBP reading of 110 mmHg (higher than the ordered parameters to hold the medication) -8/25/24 with a SBP reading of 120 mmHg (higher than the ordered parameters to hold the medication) -8/27/24 with a SBP reading of 118 mmHg (higher than the ordered parameters to hold the medication) Review of Resident's #52 progress notes and clinical record did not indicate that the Physician was contacted for clarification of orders. During an interview on 9/3/24 at 2:16 P.M., Unit Manager (UM) #2 said the Losartan Potassium medication should have been administered to Resident #52 on the days documented in the August MAR when the SBP was greater than 110 mmHg. During an interview on 9/4/24 at 8:40 A.M., UM #2 said she could not locate any evidence in the clinical record of why the (Losartan Potassium medication) doses were not administered to the Resident when the SBP were within the parameters for (medication) administration. UM #2 said the medication should have been administered as ordered. During an interview on 9/4/24 at 9:20 A.M., the Director of Nursing (DON) said the Nurse administering the Resident's Losartan Potassium medication should have followed the parameters in the Physician's order and should have contacted the doctor (Physician) and documented why the doses were not administered.

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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. 42761 Based on interview and policy review, the facility failed to develop an infection prevention and control policy and procedure (IPCP) in accordance with current accepted national standards and guidelines relative to controlling COVID-19 infection. Specifically, the facility failed to indicate what measures would be implemented to identify and control the spread of COVID-19 infection for residents and staff in the facility in the event of a COVID-19 outbreak. Findings include: Review of the CDC guidance titled Infection Control Guidelines: SARS-CoV-2, dated 5/8/23, indicated: -Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. -Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at Day 1 (where day of exposure is Day 0), Day 3, and Day 5. -Employers should be aware that other local, . state, . requirements may apply. Review of the Commonwealth of Massachusetts (MA) Executive Office of Health and Human Services Department of Public Health (DPH) Bureau of Health Care Safety and Quality guidance titled Update to Infection Prevention and Control Considerations When Caring for Long-Term Care Residents, including Visitation Conditions, Communal Dining, and Congregate Activities, dated 5/10/23, indicated: - . long-term care facilities are required to perform outbreak testing of residents and staff as soon as possible when a case is identified. -If the long-term care facility identifies that the resident or staff member's first exposure occurred less than 24 hours ago, then they should wait to test until 24 hours after any exposure, if known. -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 a DPH Epidemiologist directs otherwise. Review of the Centers for Disease Control and Prevention (CDC) guidance titled Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, dated 3/18/24, indicated: -Exposures that might require testing and/or restriction from work can occur both while at work and in the community. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Higher-risk exposures generally involve exposure of HCP's (Health Care Professionals - staff who work in healthcare settings) eyes, nose, or mouth to material potentially containing SARS-CoV-2 . -For this guidance an exposure of 15 minutes or more is considered prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. -Following a higher-risk exposure, HCP should: -Have a series of three viral tests for SARS-CoV-2 infection. -Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at Day 1 (where day of exposure is Day 0), Day 3, and Day 5. -Employers should be aware that other local, . state, . requirements may apply. Review of the facility's policy presented during the survey period, titled COVID-19 Policy All Inclusive, dated 5/4/24, indicated the following: -The facility was expected to follow the infection prevention and control practices recommended by DPH. -The facility's procedure for testing residents who were newly admitted and a close contact of a case of COVID-19 was to test the resident as soon as possible, but not sooner than 24 hours following exposure, then again on Day three and Day five, but did not indicate continued testing every 48 hours until the facility goes seven days without a new case unless a DPH epidemiologist directs otherwise. -The facility's policy did not include any COVID-19 testing procedure for residents who were not newly admitted to the facility and had exposure to COVID-19. -The facility's policy did not include any COVID-19 testing procedure for facility staff with exposure to COVID-19. During an interview on 8/30/24 at 10:58 A.M., the Infection Preventionist (IP) said no outbreak or requisite outbreak testing was required if a positive case of COVID-19 was identified in the facility. The IP said that staff and residents only needed to be tested if they became symptomatic. During an interview on 9/3/24 at 11:25 A.M., the Risk Management Director said she was the responsible person to update the facility's COVID-19 policy and that she had updated the policy in May 2024. The Risk Management Director also said the facility was required to adhere to the MA DPH guidance relative to COVID-19 testing. The Risk Management Director said she thought that the COVID-19 testing guidance for staff had changed and that the facility would only test residents and staff who were symptomatic for COVID-19. The Risk Management Director further said she did not know that outbreak and requisite outbreak testing were still required when a positive COVID-19 case was identified in the facility.