STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225463	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Health Care of Milford	Countryside Drive Milford, MA 01757

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31830 Based on interview and record review, the facility failed to timely report completed investigations to the Department of Public Health's (DPH) Health Care Facility Reporting System (HCFRS- a web-based system that health care facilities must use to report incidents and allegations of abuse, neglect and misappropriation) as required for two Residents (#16 and #2), out of a total sample of 20 residents. Specifically, the facility failed: 1. For Resident #16, to ensure a bruise of unknown origin was reported to DPH within 24 hours as required; and 2. For Resident #2, to ensure an allegation of abuse was reported to DPH within two hours as required. Findings include: Review of the facility's policy titled Abuse, Neglect, Exploitation, and Mistreatment, The Elder Justice Act of 2010, dated as revised 7/2024, indicated but was not limited to: - Residents will not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, volunteer staff, family members, friends or other individuals. - All reports of resident abuse, neglect, mental abuse, mistreatment and injuries of an unknown origin (bruises, skin tear) shall be investigated thoroughly and promptly by facility management. - When an alleged or suspected case of abuse, mistreatment, neglect, exploitation, misappropriation of resident property, or injuries of unknown origin is reported, the Administrator or designee, will immediately notify the State Agency but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the State Agency and all other persons or agencies in accordance by State law through established procedures. - Reports to the State agency will be submitted electronically through the HCFRS system. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #16 was admitted to the facility in April 2019 with diagnoses which included cerebrovascular disease. Review of the Minimum Data Set (MDS) assessment, dated 10/19/24, indicated Resident #16 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15, was unable to make needs known, and required extensive assistance/dependent of staff for bed mobility, transfers and all other activities of daily living. Review of the Grievance Log, dated 1/1/24 through 11/2024, included a grievance, dated 7/31/24, filed by Resident #16's family member which indicated a bruise was observed on Resident #16's upper lip area and family alleged negligence of staff. Review of the Event Report and completed Facility Investigation, dated 7/31/24, indicated Resident #16 was assessed with a bruise to the right-side upper lip, measuring 2 centimeters (CM) W X .6 CM L. The Resident was unable to give a description of the incident. Review of the HCFRS on 11/20/24 at 11:00 A.M., failed to indicate Resident #16's bruise of unknown origin was reported to DPH as required. During an interview on 11/20/24 at 1:00 P.M., the Director of Nurses (DON) said although she completed the investigation and was unable to substantiate the allegation, she did not feel she needed to report the incident as required. 41106 2. Resident #2 was admitted to the facility in June 2020 with diagnoses which included dementia with other behavioral disturbances, mood disorder, anxiety, and psychosis. Review of the MDS assessment, dated 9/10/24, indicated Resident #2's cognitive level could not be determined by a BIMS as evidenced by a score of 99, which indicated Resident #2 did not complete the interview. During an interview on 11/13/24 at 8:44 A.M., Resident #2 said four weeks ago he/she left the room and a man with silver hair pounded his fist together three times at him/her. Resident #2 said he/she did not report the incident to staff, but the man came back the following evening. Resident #2 said after seeing the man again, he/she spoke to the Administrator about the man who pounded his fists at him/her. Resident #2 said he/she was scared of the silver haired man and if he/she sees him again he/she will call the police. Review of the HCFRS on 11/13/24 at 9:05 A.M., failed to indicate Resident #2's alleged complaint of abuse was reported to DPH as required. During an interview with the Administrator and the DON on 11/13/24 at 9:11 A.M., the Administrator said Resident #2 did report the incident to her and they investigated it and found it was not substantiated. The DON said Resident #2 has a history of accusatory behaviors and delusions. The Administrator said she did not report the incident in HCFRS.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 49425 Based on interview and record review, the facility failed to ensure that Minimum Data Set (MDS) assessments were transmitted within 14 days after a resident assessment was completed for two Residents (#40 and #101), out of a total sample of 20 residents. Findings include: Review of Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, Version 3.0, indicated assessments must be completed no later than 14 calendar days after the assessment reference date (ARD) and transmitted and encoded within 7 days of assessment completion. Review of the medical record for Resident #40 indicated a discharge MDS (with return anticipated) was initiated with an ARD of 6/13/24. Further review of the medical record indicated the Resident returned to the facility and an entry MDS was initiated with an ARD of 6/14/24. The system indicated that both MDS assessments were not transmitted until 11/13/24. Review of the medical record for Resident #101 indicated a discharge MDS was initiated with an ARD of 7/9/24. The system indicated the MDS was not transmitted until 11/13/24. During an interview on 11/19/24 at 2:07 P.M., the MDS Coordinator said all three MDS assessments were completed but not transmitted timely as required.

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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** 48084 Based on record review and interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) assessments were completed for one Resident (#10), out of a total sample of 20 residents. Specifically, the facility failed for Resident #10, to accurately code the diagnosis of depression on 6 out of 7 MDS assessments reviewed. Findings include: Review of the facility's policy titled Resident Assessment Instrument and Care Planning, dated as last reviewed 11/2023, indicated but was not limited to the following: -It is the policy of the facility to ensure that each resident is assessed using the Resident Assessment Instrument (RAI) specified by the State in accordance with the guideline of the RAI User's Manual. -The MDS Coordinator or designee will encode and transmit [NAME]. Resident #10 was admitted to the facility in October 2023 with diagnoses which included depression. Review of the MDS assessments indicated but were not limited to the following: -MDS dated [DATE], failed to code the diagnosis of depression. -MDS dated [DATE], failed to code the diagnosis of depression. -MDS dated [DATE], failed to code the diagnosis of depression. -MDS dated [DATE], failed to code the diagnosis of depression. -MDS dated [DATE], failed to code the diagnosis of depression. -MDS dated [DATE], failed to code the diagnosis of depression. During an interview on 11/19/24 at 2:31 P.M., MDS Nurse #1 said the diagnosis of depression should have been coded on each of the MDS assessments and they would need to be modified. During an interview on 11/20/24 at 12:17 P.M., the Director of Nurses (DON) said the diagnosis of depression should have been coded on each of the MDS assessments and they would need to be modified.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49425 Based on interview and record review, the facility failed to develop and implement an individualized, person-centered care plan to meet the physical, psychosocial, and functional needs for one Resident (#40), out of 20 sampled residents. Specifically, the facility failed to ensure a comprehensive care plan was developed and implemented for the care and maintenance of an indwelling urinary catheter device (a thin, flexible tube inserted into the bladder to drain urine). Findings include: Review of the facility's policy titled Comprehensive Care Planning, dated as revised 11/23, indicated but was not limited to the following: -Development of the care plan will begin at admission, utilizing information gathered from the resident, family, admission assessments and records from the transferring facility or referral source. -The care plan will be reviewed at the IDT meeting and the amended as needed in conjunction with the nurse and Certified Nursing Assistant (CNA) who routinely cares for the resident. -The care plan will be reviewed and updated as needed, but not less than quarterly or when there is a change in condition. -The care plan will include a statement of the problem, reasonable, measurable, and time-limited goals, and specific intervention, along with the discipline responsible. Resident #40 was admitted to the facility in June 2024 with diagnoses including metabolic encephalopathy (brain disorder that occurs when there is a chemical imbalance in the blood) and was receiving Hospice care. Review of the Minimum Data Set (MDS) assessment indicated Resident #40 had a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating he/she was cognitively intact. Further review of the MDS indicated Resident #40 had an indwelling urinary catheter in place. Review of Resident #40's medical record indicated he/she had an indwelling urinary catheter for neuromuscular dysfunction of the bladder (a condition that occurs when the nerves and muscles that control the bladder do not work properly). Review of Resident #40's care plan failed to indicate a care plan for his/her indwelling urinary catheter had been developed. During an interview on 11/18/24 at 3:08 P.M., Nurse #2 said Resident #40 has a catheter in place due to urinary retention. She said she provides catheter care daily, and it should be documented on the care plan. Nurse #2 reviewed Resident #40's care plan and said there is no care plan in place for the catheter as there should be. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 9:34 A.M., Unit Manager (UM) #1 said she noted there was no care plan developed for Resident #40's indwelling urinary catheter. She said the care plan should have been put into place months ago and was overlooked. During an interview on 11/20/24 at 9:28 A.M., the Director of Nursing (DON) said care plans should be developed and updated to reflect a resident's current medical status. She said there should have been a care plan for Resident #40's indwelling urinary catheter to ensure proper care and maintenance of the device.

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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. 49425 Based on observation, interview, and document review, the facility failed to ensure professional standards of care were met for one Resident (#96), out of a total sample of 20 residents. Specifically, the facility failed to obtain a physician's order for the self-administration of medications. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling 9324 titled Accepting, Transcribing, and Implementing Prescriber Orders, dated as last revised April 11, 2018, indicated but was not limited to the following: -It is the responsibility of the licensed nurse to ensure that there is a proper patient care order from a duly authorized prescriber prior to the administration of any prescription or non-prescription medication. -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers. -In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. Review of the facility's policy titled Self-Administration of Medications, dated as revised 11/21, indicated but was not limited to the following: -A resident may self-administer drugs if ordered by the attending physician and if the interdisciplinary team has determined that this practice is safe. -If a resident requests to self-administer their medications, an assessment for self-administration of medications is conducted by the interdisciplinary team. -If the resident is deemed safe to self-administer, a physician's order is obtained. -At least once during each shift, the nursing staff should check for usage of the medications by the resident. Resident #96 was admitted to the facility in February 2023 with diagnoses including chronic kidney disease and type II diabetes. Review of the Minimum Data Set (MDS) assessment, dated 10/1/24, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating he/she was cognitively intact. During an observation with interview on 11/18/24 at 8:31 A.M., the surveyor observed Nurse #1 prepare Resident #96's 9:00 A.M. medications which included the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Atorvastatin (high cholesterol) 10 milligrams (mg) one tablet -Vitamin D3 (supplement) 25 micrograms (mcg) one tablet -Colace (stool softener) 100 mg one tablet -Vitamin B-12 (supplement) 500 mcg one tablet -Folic Acid (supplement) 1 mg one tablet -Lasix (diuretic) 20 mg one tablet -Lisinopril (high blood pressure) 40 mg one tablet -Metformin extended release (diabetes) 500 mg one tablet -Omeprazole (gastric reflux) 20 mg two tablets -Tolterodine extended release (overactive bladder) 4 mg capsule Nurse #1 then brought the medications in a clear, plastic medication cup, with a cup of water into Resident #96's room. The Resident was sitting in his/her bedside chair. Nurse #1 placed the medications on top of the bedside table and told Resident #96, I have your medications and exited the room. Nurse #1 told the surveyor that Resident #96 is a very private person and likes to administer his/her own medications. Review of the Medication Administration Record (MAR) for the month of November 2024 indicated Resident #96 was receiving these medications daily at 9:00A.M. Review of Resident #96's active Physician's Orders failed to include orders for self-administration of medications. Review of Resident #96's medical record indicated a Self-Administration of Medications assessment was completed on 10/16/24, indicating he/she wished to self-administer some medications, and was appropriate to do so. Further review of the assessment indicated meds left at bedside after the nurse preps them, however failed to indicate which medications were appropriate for the Resident to self-administer. Review of Resident #96's active care plan failed to indicate that a care plan had been developed for self-administation of medications. During an interview on 11/18/24 at 10:46 A.M., Resident #96 said he/she has been administering his/her own medications for a few months now. He/she said at first the nurse would bring the medications to him/her and watch him/her take them. Resident #96 said he/she did not need to be watched and requested to administer own medications. Resident #96 said the nurse does not always return to ensure all medications have been taken. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/18/24 at 10:49 A.M., Nurse #1 said she prepares Resident #96's medications, and leaves them at the bedside, and he/she will take them on their own. Nurse #1 and the surveyor reviewed Resident #96's medical record together, and she said there is no physician's order, for the Resident to self-administer medications, and she is not sure if one is needed. She said after she brings the medications to the Resident she follows up with them approximately 30 minutes later, to ensure the Resident has taken all of the medications. During an interview on 11/18/24 at 11:02 A.M., Unit Manager (UM) #2 said when a resident requests to self-administer medications, they complete an initial assessment to make sure they can do it safely and review it quarterly. She said they notify the physician, obtain a physician's order and update the care plan to include self-administration of medications. UM #2 said she reviewed Resident #96's medical record and noted there was no physician's order or care plan in place. During an interview on 11/18/24 at 11:53 A.M., the Director of Nursing (DON) said when a resident chooses to self-administer medications an assessment is completed and reviewed with the physician. She said residents must have a physician's order in place. The DON said once the order is obtained, it should be documented on the care plan. She said the nurse should always return to ensure all medications are taken as ordered and document their findings in the medical record.

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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. 48084 Based on interview, observation, and record review, the facility failed to ensure staff implemented dialysis care and services consistent with professional standards of practice for one Resident (#44), out of 20 sampled residents. Specifically, the facility failed for Resident #44, to notify the physician and obtain orders for removal of the pressure dressing applied by the dialysis center to the left arm Arteriovenous (AV) fistula (a surgically connected artery and vein used for long term dialysis), to provide monitoring of the AV site for complications or signs of infection, and to develop and implement a care plan for the care and maintenance of the AV site. Findings include: Review of the facility's policy titled Dialysis Patient - Care and Maintenance of the AV Fistula or AV graft, dated as last revised 1/2024, indicated but was not limited to the following: -Check the patient's circulation by palpating pulses distal to the vascular access; observing capillary refill in his/her fingers; and assessing him/her for numbness, tingling, altered sensation, coldness, and pallor in the affected extremity. -Assess the vascular access for signs and symptoms of infection such as redness, warmth, tenderness, purulent drainage, open sores, or swelling. Patients with end-stage kidney disease are at increased risk of infection. -After dialysis, assess the vascular access for any bleeding or hemorrhage. -Assess for blebs (ballooning or bulging) of the vascular access that may indicate an aneurysm that can rupture and burst. Review of the facility's policy titled Physician Orders, dated as last revised 3/2024, indicated but was not limited to the following: -At the time a resident is admitted , the facility must have physician orders for the resident's immediate care. The orders should include at minimum dietary, medications, and routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. Resident #44 was admitted to the facility in July 2024 with diagnoses which included dependence on renal dialysis and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment, dated 10/1/24, indicated Resident #44 was cognitively intact as evidenced by a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment and he/she was receiving dialysis. Review of the Physician's Orders for Resident #44 indicated but were not limited to the following: -Diet: Renal; 1000 milliliter fluid restriction. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Record dialysis weights upon return on dialysis days: Call physician for gain of 2 pounds or more in 24 hours or 5 pounds in one week. -Dialysis three times a week Tuesday, Thursday, and Saturday. -Assess for bruit and thrill (swishing sound heard and vibration felt-indicates proper function) to AV fistula left upper arm every shift. -Assess for bruising, bleeding, peripheral pulses and circulation, sensation, and motion (CSM) every shift, on Eliquis (blood thinner). -No blood pressure or blood draws to left arm due to fistula. The physician's orders failed to include orders to assess the site upon return from dialysis, to monitor the site for adverse effects/complications, or instructions/orders related to the pressure dressing that is placed on the AV fistula site after dialysis. Review of the comprehensive care plan indicated but was not limited to the following: PROBLEM: Nutritional Status: Resident #44 has chronic kidney disease requiring hemodialysis. GOAL: He/she will maintain a stable weight and labs will be within parameters. APPROACH: Diet Renal, 1 liter fluid restriction, meds as ordered, labs as ordered, weights as ordered. Dialysis communication book used. Ongoing review of fluid restriction and rationale with Resident #44 and his/her family. PROBLEM: Pressure Ulcer/Injury: Resident has actual skin alterations as evidenced by open trauma wound to anterior left lower extremity, left upper extremity dialysis fistula, and at risk for new worsening skin alterations. GOAL: His/her skin alteration will remain free from signs/symptoms of infection. APPROACH: Provide treatments as ordered. The comprehensive care plan failed to include interventions to assess the site upon return from dialysis, to monitor the site for adverse effects/complications, or instructions/orders related to the pressure dressing that is placed on the AV fistula site after dialysis. During an interview on 11/13/24 at 12:37 P.M., Resident #44 said he/she goes to dialysis on Tuesday, Thursday, and Saturday and have been going for a few years. The Resident said he/she has a bag that goes with him/her with the binder the staff writes vitals and weights in. Resident #44 said they usually leave around 10:00 A.M. and return around 3:00 P.M. The Resident said when he/she returns there is a pressure dressing on the fistula, and it needs to be removed the next morning. The Resident said he/she rarely has bleeding issues but has big band-aids in case. The Resident said he/she usually can't get the tape off the dressing alone, so the staff must help remove the pressure dressing the next day. (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	On 11/19/24, Resident #44 went out for dialysis and remained out of the building from approximately 10:00 A. M. until 3:15 P.M. Upon return, the surveyor observed that Resident #44 had a pressure dressing on their left upper extremity covering the AV fistula site. During an interview on 11/20/24 at 10:38 A.M., Unit Manager #2 said Resident #44 only had an order to check the bruit and thrill. She said she did not know anything about a dressing, when it is put on, or when it should be removed. She said she would have to call the dialysis center to see when the dressing is supposed to come off. Additionally, she said there are no other orders to monitor the site and the care plan is all about nutrition. She said they are trying to combine care plans so everything related to a concern is in one place and there should be additional information about the care of the fistula in the care plan but there is not. During an interview on 11/20/24 at 10:40 A.M., Nurse #7 said she was not sure if Resident #44 always came back with a dressing on the fistula and if there was one covering the site, she was not sure when it should come off. During an interview on 11/20/24 at 10:48 A.M., Resident #44 said the dressing comes off the next day. He/she said staff helped take it off when he/she got dressed earlier. During an interview on 11/20/24 at 12:17 P.M., the Director of Nurses (DON) said the vitals and weights go in the communication book and if dialysis has any recommendations to change medication orders etc., they will write them in there. She said her expectation is that the evening shift review the book on return and notify the physician for new orders if needed. She said they only have an order to monitor the bruit and thrill and if he/she is coming back with a dressing on the fistula then there should be an order when to remove the dressing. She said they will have to call dialysis to clarify. Additionally, she said they are combining care plans, but his/hers is mostly all nutrition related and should have a little more in it about the AV fistula.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225463	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Health Care of Milford	Countryside Drive Milford, MA 01757

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on observation, interview, and document review, the facility failed to ensure all medications used in the facility were stored and labeled in accordance with currently accepted professional standards. Specifically, the facility failed to ensure staff properly labeled and stored all medications in three of four medication carts reviewed. Findings include: Review of the facility's policy titled Medication Storage, dated as revised ,d+[DATE], indicated but was not limited to the following: -Medications are stored safely, securely and properly -Medications are kept in the packaging in which they were dispensed by the pharmacy Review of the facility's policy titled Medication Storage in the Facility, dated as revised [DATE], indicated but was not limited to the following: -When the original seal of a manufacturer's container or vial is initially broken the container or vial will be dated. -The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. -The nurse will check the expiration date of each medication before administering it. Review of the facility's policy titled Administration Procedures for all Medications, dated as revised [DATE], indicated but was not limited to the following: -Check expiration date on package/container before administering any medication. When opening a multidose container, place the date on the container. -Once removed from the package or container, unused or partial doses should be disposed of. During an observation with interview on [DATE] at 4:09 P.M., the surveyor completed a review of the medication cart on the Memory Care Unit, rear side, with Nurse #3, and made the following observations: -In the top drawer: three small clear plastic medication cups, all uncovered and not labeled, which included the following: -One contained four loose pills, one contained applesauce with a white powdery substance on top of it, and one contained nine loose pills (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225463	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Health Care of Milford	Countryside Drive Milford, MA 01757

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse #3 said the two cups containing loose pills were loose pills she was picking up in the drawers of the medication cart. She said she was placing them in the medication cups for disposal, and did not know what they were. She said the white powdery substance was Pepcid (for heartburn) crushed on top of applesauce. Nurse #3 said she prepared the crushed medication for a resident, but they were in the shower, and she could not administer it. During an observation with interview on [DATE] at 1:10 P.M., the surveyor completed a review of the medication cart on the [NAME] Unit, low side, with Nurse #4, and made the following observations: -One bottle of Latanoprost 0.005% (reduces pressure in the eye) eye drops, seal broken indicating it had been opened, not labeled with an open date. -One bottle of Artificial tears eye drops (lubricant), seal broken indicating it had been opened, not labeled with an open date. Nurse #4 said the night shift (11:00 P.M.-7:00 A.M.) is responsible for maintaining the medication cart and ensuring all medications are labeled correctly. On [DATE] at 2:05 P.M., the surveyor completed a review of the medication cart on the Pichetti Unit, with Nurse #5, and made the following observations: -One bottle of Dorzolamide 0.5% (reduces pressure in the eye) eye drops, seal broken indicating it had been opened, not labeled with an open date. During an interview on [DATE] at 9:41 A.M., the Director of Nursing (DON) said medications should not be stored in the medication cart once they are prepared for administration. She said if a resident is unavailable, the nurse should destroy the medications and prepare new ones when the resident can take them. The DON said eye drops have a shortened expiration date and must be labeled with the date opened when the seal is broken, to ensure they are not used after they have expired.