STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225208	A. Building B. Wing	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on record review and staff interview, the facility failed to ensure that the resident representative had information in advance to exercise the resident's rights for four Residents (#13, #102, #301, and #44), out of sample of 22 residents and three closed records. Specifically, the facility failed to ensure that for: 1. Resident #13, the legal guardian (a person who has been appointed by a court or otherwise has the legal authority to care for the personal and property interests of another person who is deemed incapacitated) signed consents for equipment, services, and treatment upon admission to the facility; 2. Resident #102, a valid, court approved [NAME] treatment plan was in place for the administration of antipsychotic medication and risk/benefits were identified for consent for the use of psychotropic medication; 3. Resident #301, the Health Care Proxy (health care agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions) was given information necessary to make health care decisions, including the risks and benefits of psychotropic medications and provide consent for their use; and 4. Resident #44, the legal guardian was given information necessary to make health care decisions, including the risks and benefits of psychotropic medications and provide consent for their use. Findings include: 1. Resident #13 was admitted to the facility in May 2022 with diagnoses including altered mental status, depression, Alzheimer's disease and dementia with behavioral disturbance. Court documents in the medical record indicated the Resident was appointed a legal guardian on 3/17/22. Review of the medical record indicated the following documents were signed by Resident #13 although he/she was deemed incapacitated by the court and had a legal guardian: -Consent for the Use of Side Rails (signed by the Resident and Facility Representative on 5/19/22) -Informed Consent for Nursing and Certified Nursing Assistant Students (signed by the Resident and Facility Representative on 5/19/22) (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER: Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 305 Walpole Street Norwood, MA 02062	

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Laundry Services, Hairdresser/Barber, Request for Bed Side Key (signed by the Resident on 5/19/22) -Informed Consent for Influenza Vaccine (signed by the Resident and Facility Representative on 5/19/22) -Request for service from the consultant Behavioral Health provider (signed by the Resident and Facility Representative on 5/19/22) -Request for service, consent for release of medical and insurance information and payment to the consultant Podiatrist (signed by the Resident and Facility Representative on 5/19/22) Further review of the medical record indicated Physician's Orders for the following psychotropic medications: -Divalproex Sodium (used to treat depression) 125 milligrams (mg), give four tablets at bedtime for depression (5/19/22) -Divalproex Sodium 250 mg, give one tablet one time a day for depression (5/19/22) -Sertraline HCl 25 mg, give one tablet one time a day for mood (5/19/22) -Trazodone HCl 150 mg, give 225 mg at bedtime for mood (5/19/22) Review of May through August 2022 Medication Administration Records indicated Divalproex Sodium, Sertraline, and Trazodone were administered as ordered by the Physician. Further review of Resident #13's medical record failed to indicate that the legal guardian was aware or had consented to the use of psychotropic medications. During an interview on 8/24/22 at 8:40 A.M., the surveyor reviewed Resident #13's medical record with Nurse #9. Although the medical record indicated the Resident had a legal Guardian, Nurse #9 said that he was not aware that Resident #13 had a Legal Guardian. During an interview on 8/25/22 at 11:05 A.M., the Social Worker said Resident #13's legal guardian should have signed all of the consents, and not the Resident. 2. Resident #102 was admitted to the facility in June 2022 with diagnoses including bipolar disorder and major depressive disorder. The Resident passed away at the facility in July 2022. Review of the medical record indicated Resident #102 was appointed a legal guardian with a [NAME] Monitor (authority for guardians to make decisions about medical treatment for a person with mental illness that is considered extraordinary including use of antipsychotic medication in the court-approved treatment plan) on 11/29/19, with a review date of 11/25/20. There was no [NAME] treatment plan in the medical record and no additional documentation to indicate a [NAME] treatment plan was reviewed by the court on 11/25/20 or was otherwise extended. Further review of the medical record indicated Physician's Orders for the following psychotropic medications: (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Depakote (used to treat depression) 500 mg, one tablet two times a day for bipolar disorder (6/6/22) -Zoloft (antidepressant) 25 mg, half tablet one time a day for major depressive disorder (6/6/22) -Latuda (antipsychotic) 20 mg, one tablet one time a day for schizophrenia (6/6/22) Review of the June 2022 Medication Administration Record indicated the psychotropic medications were given as ordered by the Physician, including the antipsychotic medication for which there was no court approved [NAME] treatment plan. Review of Resident #102's medical record indicated three Informed Consent for Psychotropic Administration Forms for Depakote, Zoloft, and Latuda. All three forms were signed by the Resident's legal guardian on 6/9/22. However, the consent forms were incomplete and were missing the following required information: -Depakote: benefits of treatment -Zoloft: benefits of treatment -Latuda: dose and frequency, purpose of the medication, risks and benefits During an interview on 8/26/22 at 12:30 P.M., the Director of Nursing said she did not know why there was no court approved, valid [NAME] treatment plan for administration of antipsychotic medications in the medical record. She said the nurse should have included all of the required information on the psychotropic consent forms. 3. Resident #301 was admitted to the facility in August 2022 with diagnoses including dementia with behavioral disturbance and Alzheimer's disease and had an activated HCP. Review of the medical record indicated Physician's Orders for the following psychotropic medications: -Lorazepam (antianxiety) 1 mg, give one tablet every six hours as needed for psychosis (5/19/22) -Risperidone (antipsychotic) 1 mg, give one tablet two times a day for anxiety/agitation (8/11/22) -Seroquel (antipsychotic) 25 mg, give one tablet at bedtime for anxiety (8/11/22) -Trazodone (antianxiety) 50 mg, give 0.5 tablet every 12 hours as needed for anxiety/agitation for 14 days (8/18/22) -Trazodone 50 mg, give 0.5 tablet two times a day for anxiety/agitation (8/11/22) Review of the August 2022 Medication Administration Record indicated the psychotropic medications were given as ordered by the Physician. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 305 Walpole Street Norwood, MA 02062	

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #301's medical record indicated three Informed Consent for Psychotropic Administration Forms. All three forms were signed by the Resident's HCP and Facility Representative on 8/15/22. However, the consent forms were otherwise blank and failed to identify as required: -Resident's name -Date/Time discussion with Prescriber -Prescriber name -Facility Representative Name/Title -Name of the medication -Dose and frequency -How administered -Purpose of the medication -Risks -Benefits During an interview on 8/19/22 at 12:10 P.M., Resident #301's HCP said that when the Resident was admitted , she was asked to sign a lot of paperwork and was not informed about risks and benefits of the psychotropic medications being administered to Resident #301. During an interview on 8/24/22 at 2:36 P.M., Nurse #13 reviewed Resident #301's medical record. Nurse #13 said she did not know why the psychotropic consent forms were blank. 36542 4. Resident #44 was admitted to the facility in September 2021 with diagnoses of depression and anxiety. Review of the medical record for Resident #44 indicated the Resident had a permanent court appointed legal guardian to make medical decisions. Review of the Physician's Orders indicated Resident #44 was taking the following psychotropic medications: Clonazepam tablet 0.5 mg at bedtime Fluoxetine tablet 20 mg once per day Trazodone 50 mg; half tablet twice per day (continued on next page)

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	225208	A. Building B. Wing	09/01/2022

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Informed Consent for Psychotropic Administration Forms in the medical record indicated on 2/2/22, Resident #44 signed the forms to consent to the use of the three psychotropic medications. The medical record failed to indicate the legal guardian was aware or had consented to the medical treatment of psychotropic medications. During an interview on 8/24/22 at 8:49 A.M., the Social Worker said the Resident had a court appointed legal guardian to make healthcare decisions and the legal guardian should have consented to the use of psychotropic medications.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 34145 Based on record review, policy review, and interview, the facility failed to ensure residents were given information necessary to make health care decisions, including the risks and benefits of a psychoactive medication and consent for its use, prior to administration, for one Resident (#103) of three closed records reviewed, out of a total sample of 22 residents. Findings include: Resident #103 was admitted to the facility in June 2022 with diagnoses including anxiety. The Resident was discharged from the facility in June 2022. Review of June 2022 Physician's Orders included, but was not limited to: -Venlafaxine HCl ER (antidepressant) 150 milligrams (mg) one time a day for depression (6/2/22) -Venlafaxine HCl ER 75 mg one time a day for depression (6/2/22) Review of the June 2022 Medication Administration Record indicated Resident #103 was administered Venlafaxine on 6/4/22 and 6/5/22. Review of the History and Physical note, dated 6/3/22, written by Resident #103's attending Physician indicated the Resident had decisional capacity and the only consent form discussed was the Massachusetts Orders for Life Sustaining Treatment (MOLST). Further review of Resident #103's medical record indicated an Informed Consent for Psychotropic Administration Form. The form was signed by the Resident on 6/2/22. However, the consent form was otherwise blank and failed to identify as required: -Resident's name -Date/Time discussion with Prescriber -Prescriber name -Facility Representative Name/Title -Name of the medication -Dose and frequency -How administered -Purpose of the medication -Risks (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Benefits -Signature of Facility Representative During an interview on 8/26/22 at 12:30 P.M., the Director of Nursing said she did not know why the psychotropic consent form was blank and Nursing staff should have made sure it was complete before the medication was administered.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 42742 Based on observation, interview, and record review, the facility failed to ensure staff treated each resident with respect and dignity including the right to use their own clothing for one Resident (#402), out of a total sample of 22 residents. Findings include: Resident #402 was admitted to the facility with diagnoses including Parkinson's disease (a disorder of the central nervous system that affects movement). Review of the Minimum Data Set (MDS) assessment, dated 8/18/22, indicated Resident #402 had severe cognitive impairment as evidenced by the Brief Interview for Mental Status (BIMS) which was unable to be completed due to the Resident being rarely understood. On 8/18/22 at 12:30 P.M., the surveyor observed Resident #402 sitting in his/her wheelchair at a table in the Unit B dining room while staff was assisting him/her with lunch. Resident #402 was observed wearing an open back johnny (a long loose piece of clothing), not his/her own clothing. On 8/18/22 at 3:21 P.M., the surveyor observed Resident #402 sitting in his/her wheelchair in the Unit B dining room wearing a johnny, not his/her own clothing. On 8/23/22 at 9:54 A.M., the surveyor observed Resident #402 sitting in his/her wheelchair in the unit B dining room wearing sweatpants and a johnny covering his/her torso. A staff member walked over to the Resident and placed another johnny around the Resident's shoulders. During an interview on 8/24/22 at 2:11 P.M., Nurse #8 said residents were supposed to be dressed in their own clothes, not johnnies. Nurse #8 said Resident #402 could not speak for him/herself. During an interview on 8/25/22 at 2:00 P.M., the Director of Nursing (DON) said she had noticed earlier that week that Resident #402 was still in his/her johnny in the dining room and had asked staff to get him/her dressed for the day. The DON said staff told her the Resident did not have any clean clothes. She said she instructed staff to go down to the laundry room and obtain the Resident's clean clothes and dress the Resident. The DON said the Resident should have been dressed in his/her own clothing, not a johnny, but was not.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 27189 Based on observation and interviews, the facility failed to make the most recent survey results of the facility available in a place readily accessible to residents, family members, and legal representatives of residents. Findings include: On 8/31/22 at 8:32 A.M., the surveyor observed an informational bulletin board located across from the receptionist's desk in the lobby. A sign posted on the bulletin board indicated the following: If you would like to review our State Survey results, they are in a binder across from the Receptionist. If you have any questions, please ask for the Administrator or Director of Nurses. On 8/31/22 at 8:28 A.M., the surveyors were unable to locate the survey results binder in the lobby. During an interview on 8/31/22 at 8:32 A.M., Receptionist #1 searched the reception desk drawers and surrounding area for the survey results binder and was unable to find them. The surveyors directed her to the posting on the bulletin board which identified the location of the survey results and she said she did not know where they were and had never seen the binder. During an interview on 9/1/22 at 11:58 A.M., the Administrator said she was not aware that the survey results binder was not in the lobby area across from the receptionist and she didn't know where it was.

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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. 34145 Based on record review and interviews, the facility failed to ensure the Physician was notified that treatments were not administered as ordered for one Resident (#58), out of a total sample of three residents. Specifically, the facility failed to notify the Physician/Nurse Practitioner that treatment orders were not transcribed accurately resulting in the Resident receiving only 20 of 42 prescribed doses of antifungal treatments. Findings include: Resident #58 was admitted to the facility in March 2022 with diagnoses including dementia and diabetes mellitus. Review of the medical record indicated a Weekly Skin Check document, dated 12/11/22, in which the Nurse identified redness under the Resident's left breast and left armpit. The Nurse indicated that the Nurse Practitioner (NP) ordered Nystatin/Triamcinolone cream (antifungal) every shift for two weeks. Further review of the medical record indicated the following orders: -12/12/22 Nystatin-Triamcinolone Cream 100000-0.1 unit/GM (gram)-% Apply to left breast, left armpit topically every shift for fungal rash for two weeks. Apply cream after washing with soap & water pat dry. Discontinued 12/12/22 -12/12/22 Nystatin Powder 100000 unit/GM Apply to left breast, left armpit topically every shift for fungal rash for 21 administrations x 14 days -12/12/22 Triamcinolone Acetonide Cream 0.1% Apply to left breast, left armpit topically every shift for fungal rash for 21 administrations x 14 days Review of the December 2022 Medication/Treatment Administration Record (MAR/TAR) indicated Nursing staff applied Nystatin Powder and Triamcinolone cream to Resident #58's left breast and left armpit every shift over seven days from 12/12/22 to 12/19/22 and not two weeks as ordered by the NP. The last treatments were administered on 12/19/22 on the evening shift. The remaining boxes on the MAR/TAR had an X in them, indicating the treatment was discontinued. During an interview on 12/23/22 at 9:42 A.M., the surveyor and Nurse #1 reviewed Resident #58's medical record. She said the topical treatments prescribed for the Resident's fungal rash were initiated on 12/12/22 and last administered on 12/19/22 and were not administered for two weeks as ordered. Nurse #1 said there was no documentation in the medical record to indicate the Physician or NP discontinued the treatments or was notified that the Resident only received treatments every shift for seven days and not every shift for two weeks as ordered.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on observations and interviews, the facility failed to ensure that residents had a safe, clean, homelike environment on one unit (C Unit) out of three units in the facility. Findings include: On 8/24/22 at 7:34 A.M., the surveyor observed: -room [ROOM NUMBER]: dust and debris underneath the A and B beds and along the perimeter of the room at the coving; -room [ROOM NUMBER]: multiple areas of dried feces on the floor next to resident A's bed; dust and debris underneath the A and B beds and along the perimeter of the room at the coving; -room [ROOM NUMBER]: dust and debris underneath the A and B beds and along the perimeter of the room at the coving; large wet substance underneath the A bed; -room [ROOM NUMBER]: multiple areas of dried feces on the floor next to resident A's bed; dust and debris underneath the A and B beds and along the perimeter of the room at the coving; -room [ROOM NUMBER]: dust and debris underneath the A and B beds and along the perimeter of the room at the coving; -room [ROOM NUMBER]: multiple areas of dried feces on the floor in between the A and B beds; dust and debris underneath the A and B beds and along the perimeter of the room at the coving; -room [ROOM NUMBER]: mouse droppings on top of the radiator cover; dust and debris underneath the A and B beds and along the perimeter of the room at the coving; -room [ROOM NUMBER]: mouse droppings on top of the radiator cover; dried feces on the floor in between the A and B bed; dust and debris underneath the A and B beds and along the perimeter of the room at the coving; -room [ROOM NUMBER]: mouse droppings on the radiator cover; dust and debris underneath the A and B beds and along the perimeter of the room at the coving; -room [ROOM NUMBER]: dust and debris underneath the A and B beds and along the perimeter of the room at the coving; -room [ROOM NUMBER]: dust and debris underneath the A and B beds and along the perimeter of the room at the coving; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER]: dust and debris underneath the A and B beds and along the perimeter of the room at the coving; privacy curtain pulled alongside the A bed with several brown colored soiled areas; and -room [ROOM NUMBER]: dust and debris underneath the A and B beds and along the perimeter of the room at the coving. During an interview on 8/24/22 at 7:55 A.M., the Housekeeping Supervisor said that housekeeping staff sweep every room daily and one room a day is thoroughly cleaned. He said he maintains a log/checklist of cleaning tasks completed when a room is thoroughly cleaned that includes mopping the floors with a microfiber mop and cleaning solution, all furniture, bed frames and other equipment are cleaned, and mattresses are sanitized. The Housekeeping Supervisor said he monitors the housekeeping staff and verifies the cleaning of each room is acceptable before signing off on the log. On 8/24/22 at 8:27 A.M., the surveyors and the Housekeeping Supervisor inspected every room on the C Unit (rooms #39 through #56). The Housekeeping Supervisor confirmed that every room on the Unit had stains on the floor that appeared to be dried food, feces, urine, dust, and debris underneath residents' beds and along the perimeter of the rooms at the coving. Mouse droppings were observed in two rooms. He said all the rooms were dirty, unsanitary, and need to be cleaned. He was unable to provide the surveyor with cleaning logs that identified the last date each room was thoroughly cleaned.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 34145 Based on record review, interview, and policy review, the facility failed to ensure the resident and/or the resident's representative was provided written notice of a transfer, appeal rights, and Ombudsman contact information, as required for three Residents (#35, #49, and #22), out of a total sample of 22 residents. Findings include: Review of the facility's policies, Transfer-Notification (6/2017) and Discharge Planning and Rights (6/2017) included but was not limited to: -Emergency Transfers-When a resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident and resident representative as soon as practicable; -Written notice will include: -the reason for the transfer; -effective date of the transfer; -location to which the resident is transferred; -statement of the resident's appeal rights, including the name, address, and telephone number of the entity which receives such request; -information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; -the name, address, and telephone number of the Office of the State Long Term Care Ombudsman. 1. Resident #35 was admitted to the facility in September 2020 with diagnoses including psychosis and dementia. The Resident had a legal guardian. Review of the medical record indicated Resident #35 was transferred to the hospital and admitted in August 2022 after being found by staff to have a decline in medical status. Further review of the medical record failed to indicate required transfer notification documentation and appeal notification was provided to the Resident's legal guardian as required. 2. Resident #49 was admitted to the facility in June 2022 with diagnoses including major depressive disorder and psychotic disorder. The Resident had a legal guardian. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record indicated Resident #49 was transferred to the hospital and admitted in August 2022 after being found by staff to have a decline in medical status. Further review of the medical record failed to indicate required transfer notification documentation and appeal notification was provided to the Resident's legal guardian as required. During an interview on 8/31/22 at 12:09 P.M., Social Worker #1 said he faxes copies of the Notice of Intent to Transfer with Less Than 30 Days to resident representatives and keeps copies of the notices in a binder in his office. Social Worker #1 showed the surveyor a copy of the transfer document that he faxed to Residents #35 and #49's legal guardians on 8/17/22 and 8/26/22 respectively. He said he does not provide appeal information to residents or their representatives and said the Business Office Manager may send those notices. During an interview on 8/31/22 at 12:45 P.M., the Business Office Manager said she does not send residents or their representatives any notices related to appeal information. She said that she updates the resident's census status in the electronic medical record when residents are hospitalized . During an interview on 8/31/22 at 12:50 P.M., the Director of Nursing said she was not aware that residents and/or their representatives were not receiving appeal information. 28450 3. Resident #22 was admitted to the facility in November 2021 with medical diagnoses including anxiety disorder, dementia, and psychosis. Review of the clinical record indicated Resident #22 was hospitalized in the past 120 days. Review of the Clinical Record indicated, at the time of the Resident's transfer to the Hospital Emergency Department (ED) in May 2022, there was no documentation to support that he/she was provided with a Notice of Intent to Discharge or that the facility informed him/her of their intent to discharge. During an interview on 08/30/22 at 3:10 P.M., Nurse #13 said Resident #22 was transferred to the hospital for evaluation in May 2022. Nurse #13 said the discharge transfer paperwork was not available for review, and she believed the paperwork was not completed. Further review of the clinical record included no evidence that the notice transfer and a copy of the emergency transfer were sent to the ombudsman office. During an interview on 08/30/22 at 03:50 P.M., the Social Worker said the Nursing Department did not inform the Social Services department when the Resident was transferred to the hospital in May 2022. He said if he was informed, then he would have done the paperwork. He then reviewed his log and said the Resident was not given a Notice of Intent to Discharge. During an interview on 08/30/22 at 4:30 P.M., the Director of Nurses (DON) said she was not sure if any discharge notices had been given to Resident #22 at the time of his/her transfer to the ED.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 34145 Based on record review and interview, the facility failed to ensure the resident and/or the resident's representative was provided a written notice of a bed hold transfer as required for three Residents (#35, #49, and #22), out of a total sample of 22 residents. Findings include: Review of the facility's policy titled Transfer-Bed Hold (6/2017), included but was not limited to: -It is the policy of this facility to provide the resident, responsible party, or legal representative with notice of the facility's bed-hold policy upon admission and at the time of transfer or therapeutic leave from the facility to ensure continuity of care and residence post therapeutic leave or hospitalization . -Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies: -the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; -the nursing facility's policies regarding bed-hold periods; -Nursing will include a copy of the bed-hold policy with other papers accompanying resident to the hospital, and will document such in the Nurses' Note; -Nursing will alert the Business Office of the transfer. The Business Office will mail a bed-hold notice to the resident representative/legal representative within 24 business hours and keep a record of such action. 1. Resident #35 was admitted to the facility in September 2020 with diagnoses including psychosis and dementia. The Resident had a legal guardian. Review of the medical record indicated Resident #35 was transferred to the hospital and admitted in August 2022 after being found by staff to have a decline in medical status. Further review of the medical record failed to indicate a copy of the bed-hold policy or documentation in the Nurses' Notes that a copy of the bed-hold policy was sent along with Resident #35 to the hospital as required and according to facility policy. 2. Resident #49 was admitted to the facility in June 2022 with diagnoses including major depressive disorder and psychotic disorder. The Resident had a legal guardian. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record indicated Resident #49 was transferred to the hospital and admitted in August 2022 after being found by staff to have a decline in medical status. Further review of the medical record failed to indicate a copy of the bed-hold policy or documentation in the Nurses' Notes that a copy of the bed-hold policy was sent along with Resident #35 to the hospital as required and according to facility policy. During an interview on 8/31/22 at 12:09 P.M., Social Worker #1 said he does not provide bed-hold notices/policy to residents or their legal representatives. He said the Business Office Manager may send those notices. During an interview on 8/31/22 at 12:45 P.M., the Business Office Manager said she does not send residents or their representatives any notices related to bed holds. She said she updates the resident's census status in the electronic medical record when residents are hospitalized . During an interview on 8/31/22 at 12:50 P.M., the Director of Nursing said she was not aware that residents and/or their representatives were not receiving bed-hold notices. 28450 3. Resident #22 was admitted to the facility in November 2021 with medical diagnoses including anxiety disorder, dementia, and psychosis. Review of a Nursing Discharge Note, dated 05/2022, indicated Resident #22 was transferred to the hospital after a resident-to-resident altercation. During an interview on 08/30/22 at 3:10 P.M., Nurse #13 said Resident #22 was transferred to the hospital for evaluation in May 2022, and she was not sure if a Notice of Bed Hold was provided to Resident #22, prior to or upon transfer to the hospital. Review of the clinical record indicated, at the time of the Resident's transfer to the hospital Emergency Department in May 2022, there was no documentation to support the Resident was provided a Notice of Bed Hold policy and Authorization Form, prior to or upon transfer to the hospital. During an interview on 08/30/22 at 03:50 P.M., the Social Worker said the Nursing Department is responsible to complete the Notice of Bed Hold and provide it to the Resident/Representative prior to and upon transfer to the hospital. The Social Worker said it was not completed and provided to the Resident. During an interview on 08/30/22 at 4:30 P.M., the Director of Nurses (DON) said the Notice of Bed Hold was not provided to Resident #22, prior to or upon transfer to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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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

34145

Based on record review and interview, the facility failed to ensure that staff developed and provided to residents, a baseline care plan within 48 hours of the resident's admission, that included but was not limited to the initial goals of the resident, summary of the resident's medications and dietary instructions, and services and treatments to be administered by the facility, for two Residents (#76 and #103), out of a total sample of 22 residents.

Findings include:

1. Resident #103 was admitted to the facility in June 2022 with diagnoses including influenza, pneumonia, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, chronic pancreatitis, low back pain, and cervicalgia (neck pain).

Review of the medical record indicated a care plan with one identified area as follows:

-Focus: Resident is at risk for falls related to new an unfamiliar environment (6/3/22).

-Interventions: Be sure that the call bell and personal items are in reach before leaving the room; encourage proper footwear, with proper fit and skid resistant soles.

No other care plans had been developed for the 48-hour Baseline Care Plan to address the Resident's immediate needs as required.

During an interview on 8/24/22 at 10:30 A.M., Minimum Data Set (MDS) Nurse #1 said she initiates 48-hour care plans in the electronic medical record, and nursing staff take it from there. She could not explain why the base line care plan had not been developed to address the Resident's immediate needs.

28450

2. Resident #76 was admitted to the facility in July 2022 with medical diagnoses that included atrial fibrillation, presence of cardiac pacemaker, and presence of heart-valve replacement.

Review of the clinical record included no baseline care plan that addressed the presence of a cardiac pacemaker which will require periodic surveillance of the following: heart rhythm, the functioning of the pacemaker leads, the frequency of utilization of the pacemaker, the battery life, and the presence of any abnormal heart rhythms.

During an interview on 8/25/22 at 4:45 P.M., the Director of Nurses said the facility staff failed to assess the presence of the pacemaker. She said the baseline care plan was not developed and implemented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34145 Based on record review and interview, the facility failed to ensure that individualized, comprehensive care plans were developed and consistently implemented for seven Residents (#13, #35, #49, #65, #93, and #76), out of 22 sampled residents. Specifically, the facility failed 1. For Resident #13, to develop a care plan for the use of psychotropic medications that identified target behaviors, non-pharmacological interventions, and measurable goals of treatment; 2. For Resident #35, to develop a care plan for the use of psychotropic medications that identified target behaviors, non-pharmacological interventions, and measurable goals of treatment; 3. For Resident #49, to: a. develop a care plan for the use of psychotropic medications that identified target behaviors and measurable goals of treatment; and b. implement non-pharmacological interventions for behaviors; 4. For Resident #65, to develop a care plan for the use of psychotropic medications that included non-pharmacological interventions and measurable goals of treatment; 5. For Resident #93, to develop a care plan for the use of psychotropic medications that identified target behaviors, non-pharmacological interventions, and measurable goals of treatment for suicidal and homicidal ideations; and 6. For Resident #76, to implement care plan interventions for bowel incontinence. Findings include: Review of the facility's policy titled, Care Planning, last revised 9/2017, included but was not limited to: -The facility will develop a comprehensive, resident centered care plan for each resident; -The goals should be specific, realistic, measurable and agreed upon by the resident, family and staff; -All resident care and interventions must be carried out per the care plan. 1. Resident #13 was admitted to the facility in May 2022 with diagnoses including depression and dementia with behavioral disturbance. Review of the medical record indicated the following Physician's Orders for psychotropic medications: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Divalproex Sodium (used to treat depression) 125 milligrams (mg), give four tablets at bedtime for depression (5/20/22) -Divalproex Sodium 250 mg, give one tablet daily for depression (5/20/22) -Sertraline (antidepressant) 25 mg, give one tablet daily for mood (5/20/22) -Trazodone (antidepressant) give 225 mg at bedtime for mood (5/20/22) Review of Resident #13's Comprehensive Care Plans included but was not limited to: -Focus: Psychotropics- I have a diagnosis of depression, anxiety, Alzheimer's disease. I take daily medications to help me feel better and stabilize my mood (5/20/22) -Interventions: -Coordinate follow up with psych doctor as ordered and recommended for follow up (5/20/22); -Give me my medications as ordered (5/20/22); -Monitor that I am eating and sleeping per my norm (5/20/22); -Monitor that my medication is effective and treating my symptoms and that I am tolerating it without any side effects or adverse reactions. Report any findings to the Nurse and Physician (5/20/22) -Goal: I want to have my symptoms controlled and have no side effects of adverse reactions to my mediations through the next review period (revised 6/8/22) Further review of the care plan failed to identify Resident specific targeted signs and symptoms of depression, any non-pharmacological approaches in addition to antidepressant therapy, and measurable goals to meet the Resident's needs. 2. Resident #35 was admitted to the facility in September 2020 with diagnoses including anxiety disorder, psychosis, dementia with behavioral disturbance, and paranoid personality disorder. Review of the medical record indicated the following Physician's Orders for psychotropic medications: -Remeron (antidepressant) 30 mg at bedtime for appetite stimulant (6/16/22, discontinued 8/22/22) -Remeron 7.5 mg at bedtime for appetite stimulant (8/23/22) -Risperdal 1 mg, give half tablet in the evening for psychosis (7/20/22, discontinued 8/22/22) -Risperdal 0.5 mg, give one tablet at bedtime for dementia with behavioral disturbance (8/23/22) Review of Resident #35's Comprehensive Care Plans included but was not limited to: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER: Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 305 Walpole Street Norwood, MA 02062	

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

-Focus: Psychotropic medications- Resident has a diagnosis of depression and paranoia. He/she takes antidepressant and antipsychotic medications (9/18/20)

-Interventions:

-Administer psych medications as ordered (9/18/20);

-Coordinate follow up with psych doctor as ordered and recommended for follow up (9/18/20);

-Monitor mood and behaviors for changes and notify the Physician/Psych with any concerns (9/18/20);

-Monitor that medications are effective and treating symptoms and that they are being tolerated without any side effects or adverse reactions (9/18/20);

-Monitor that resident is eating and sleeping per my norm (9/18/20)

Goal: Resident's symptoms will be controlled, and he/she will have no side effects or adverse reactions to his/her psych medications through the next review period (revised 9/20/21)

Further review of the care plan failed to identify Resident specific targeted signs and symptoms of depression, any non-pharmacological approaches in addition to antidepressant therapy, and measurable goals to meet the Resident's needs.

3. Resident #49 was admitted to the facility in June 2022 with diagnoses including psychosis and dementia with behaviors.

a. Review of the medical record indicated the following Physician's Orders for psychotropic medications:

-Trazodone 50 mg, give 12.5 mg every morning for dementia with behaviors (7/1/22 - 8/1/22)

-Trazodone 50 mg, give one tablet in the evening for dementia with behaviors (7/1/22 - 8/1/22)

-Ativan Solution 2 mg/milliliter (ml), give 0.25 ml sublingually three times a day for anxiety (7/20/22)

Review of Resident #49's Comprehensive Care Plans included but was not limited to:

-Focus: My mood and behavior: I am taking an antipsychotic, antidepressant medication for agitation, mood and behaviors (7/18/22)

-Interventions:

-Assure that the Nurse, Social Worker, Physician and family are aware of my behaviors (7/18/22);

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-I will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through the review date (7/18/22); -Reassure me and direct me when I am behavioral (7/18/22) Further review of the care plan failed to identify Resident specific targeted signs and symptoms of depression and measurable goals of treatment to meet the Resident's needs. b. On 8/19/22 at 2:00 P.M., the surveyor observed Resident #49 reclined in a chair against the wall in the unit hallway sleeping. At 2:08 P.M., the Resident woke up and began yelling out and trying to remove his/her clothing. Nurse #9 brought the Resident to his/her room. Resident #49 continued to yell out unabatedly. At 2:50 P.M., the surveyor entered Resident #49's room and saw Nurse #9 standing at the Resident's bedside while the Resident continued to yell out, Help me! Help me! continuously. The surveyor asked Nurse #9 what interventions staff attempt to soothe the Resident, and he said they give him/her Morphine and Ativan. The surveyor asked what types of non-pharmacological interventions they use to try and soothe the Resident, and he said they do not use non-pharmacological interventions. 4. Resident #65 was admitted to the facility in July 2022 with diagnoses including anxiety and depression. Review of the medical record indicated the following Physician's Orders for psychotropic medications: -Trazodone (antidepressant) 50 mg, give one tablet at bedtime for anxiety/insomnia (7/1/22) -Citalopram Hydrobromide (antidepressant) 30 mg, give one capsule one time a day for depression (7/14/22) Review of Resident #65's Comprehensive Care Plans included but was not limited to: -Focus: My mood and behavior: I am taking antidepressant medication related to mood (7/22/22) -Interventions: -Administer psychotropic medications as ordered by the Physician. Monitor for side effects and effectiveness every shift (7/22/22); -Assure that the Nurse, Social Worker, Physician and family are aware of my behaviors (7/22/22); -I will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through the review date (7/22/22); -Refer me to Dr. Handler as needed with the direction of my primary care doctor for potential adjustments to my medications and let my family know of the plan (7/22/22) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER: Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 305 Walpole Street Norwood, MA 02062	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Goal: My doctors will monitor my medications and attempt to reduce the use of psychotropic medication through the review date (revised 8/18/22) -Focus: The resident uses antidepressant medication related to depression (8/18/22) -Interventions: -Give antidepressant medication as ordered by the Physician (8/18/22); -Monitor/document/report to Physician ongoing signs/symptoms of depression unaltered by antidepressant medications: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations . (8/18/22) -Goal: Resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date (8/18/22) Further review of the care plan failed to identify any non-pharmacological approaches in addition to antidepressant therapy, and measurable goals to meet the Resident's needs. During an interview on 8/24/22 at 8:20 A.M., the surveyor reviewed Residents' #13, #35, #49 and #65 medical record with Nurse #13. She said the Resident's symptoms, behaviors, behavioral interventions, and measurable goals are supposed to be in the care plan and they were not. 5. Resident #93 was admitted to the facility in May 2022 with diagnoses including both suicidal and homicidal ideations. Review of 6/7/22 and 6/13/22 Physician's Progress Notes indicated Resident #93 was prescribed Zyprexa and Haldol (antipsychotics) for schizophrenia with suicidal and homicidal ideations. Review of Resident #93's Comprehensive Care Plans included but was not limited to: -Focus: My mood and behavior: I am taking an antipsychotic, antidepressant medication for agitation, mood and behaviors. My behaviors include: periodic agitation and impulsive behavior (5/3/22) -Interventions: -Administer psychotropic medications as ordered by the Physician. Monitor for side effects and effectiveness (5/3/22); -Assure that the Nurse, Social Worker, Physician and family are aware of my behaviors (5/3/22); -I will be/remain free of psychotropic drug related complications .cognitive/behavioral impairment through the review date (5/3/22); -Monitor/document/report as needed any adverse reactions of psychotropic medications (5/3/22); -Provide me with 1:1 monitoring when I am in danger of hurting myself with my behaviors (5/3/22) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the care plan failed to address the Resident's history of suicidal and homical ideations, identify Resident specific target behaviors, and measurable goals to meet the Resident's needs. During an interview on 8/24/22 at 8:20 A.M., the surveyor reviewed Resident #93's medical record with Nurse #13. Nurse #13 said the care plan should address the Resident's history of suicidal and homicidal ideations and should include specific behaviors for staff to monitor and have measurable goals. 28450 6. Resident #76 was admitted to the facility in July 2022 with medical diagnoses that included muscle weakness. Review of the Minimum Data Set (MDS) assessment, dated 08/02/22, indicated Resident #76 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15. The MDS indicated the Resident was always incontinent of bowel. Review of the Comprehensive Care Plan included no care plan that addressed the presence of bowel incontinence. During an interview on 8/25/22 at 12:30 P.M., Resident #76 said he/she was tired of lying in his/her diarrhea. Resident #76 said that since his/her hospitalization he/she can no longer control his/her bowels. The Resident said he/she would prefer to be at home because he/she was not receiving the proper care. On 8/25/22 at 2:05 P.M., Resident #76 said, It has been over an hour since I requested to be cleaned. I am lying in diarrhea. The Resident said, I asked the nurses if they could ask the doctor if he could increase the dose of the medication, as it decreases the frequency of my liquid stool; they never updated me. The surveyor reported the Resident's concerns to the Unit Manager who said he was not aware about the medication and would contact the physician. During an interview on 8/25/22 at 2:45 P.M., Nurse #8 said she did not know that the Resident had bowel issues. During an interview on 8/25/22 at 2:55 P. M., the Unit Manager said he was not aware of the Resident's bowel incontinence, and that there was no care plan addressing the Resident's bowel incontinence care. During an interview on 8/25/22 at 4:45 P.M., the Director of Nurses said the staff failed to assess and implement a care plan for the Resident's bowel care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on observation, record review, policy review, and interview, the facility failed to ensure that staff provided care and services according to accepted standards of clinical practice for five Residents (#13, #28, #103, #301, and #92), out of a total sample of 22 residents. Specifically, the facility failed 1. For Resident #13, a. To ensure psychotropic medications were not administered without signed, informed consent from the legal Guardian; b. To ensure specialized compression wraps were obtained according to physician's orders; 2. For Resident #28, to ensure the Resident's pacemaker was monitored and evaluated as per the facility policy and standards of practice; 3. For Resident #103, to ensure psychotropic medications were not administered without signed, informed consent; 4. For Resident #301, to ensure psychotropic medications were not administered without signed, informed consent from the activated HCP; and 5. For Resident #92, to follow physician's orders for prescribed wound dressings. Findings include: 1. Resident #13 was admitted to the facility in May 2022 diagnoses including altered mental status, depression, Alzheimer's disease, and dementia with behavioral disturbance. The Resident was appointed a legal Guardian on 3/17/22. a. Review of the medical record indicated Physician's Orders for the following psychotropic medications: -Divalproex Sodium (used to treat depression) 125 milligrams (mg), give four tablets at bedtime for depression (5/19/22). -Divalproex Sodium 250 mg, give one tablet one time a day for depression (5/19/22). -Sertraline HCl 25 mg, give one tablet one time a day for mood (5/19/22) -Trazodone HCl 150 mg, give 225 mg at bedtime for mood (5/19/22) Review of the May through August 2022 Medication Administration Records indicated Divalproex Sodium, Sertraline, and Trazodone were administered as ordered by the Physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER: Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 305 Walpole Street Norwood, MA 02062	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the medical record failed to indicate that consent for the use of psychotropic medications was provided by Resident #13's legal guardian. During an interview on 8/24/22 at 8:40 A.M., the surveyor reviewed Resident #13's medical record with Nurse #9. Nurse #9 said that he was not aware that Resident #13 had a legal guardian and could not sign consents. During an interview on 8/25/22 at 11:05 A.M., the Social Worker said Resident #13 should not have been administered psychotropic medication without signed informed consent from the Resident's legal guardian. b. Review of the Physician's Orders indicated: -Ace wraps to both legs daily in A.M., remove at bedtime until Circaid leg wraps available (6/29/22) -Circaid compression leg wraps-1 pair for lymphedema (6/29/22) During an interview on 8/18/22 at 11:49 A.M., the surveyor observed Resident #13 seated in a wheelchair at the table in the dayroom. The Resident's pant legs extended to just below their knee, exposing his/her calves. The Resident had Ace wraps applied to both legs as ordered by the Physician. Resident #13 said that he/she has not received the special leg wraps the Physician ordered for his/her legs to treat lymphedema. On 8/19/22 at 8:48 A.M., the surveyor observed Resident #13 seated in a wheelchair at the table in the dayroom. The Resident's pant legs extended to just below their knee, exposing his/her calves. The Resident had Ace wraps applied to both legs as ordered by the Physician. During an interview 8/24/22 at 9:40 A.M., Nurse #9 said that he did not know anything about the Physician's Order for Circaid wraps, and the Resident did not have Circaid wraps. 2. Review of the facility's policy titled Pacemaker-ICD Management, revised 4/2020, included but was not limited to: -It is the policy of this facility that residents with a pacemaker be managed for safe operation and equipment functionality. -Any resident with a pacemaker will have their pacemaker checked in accordance with standards of practice as outlined below or sooner if symptoms develop. -Upon admission residents should be observed for the presence of a pacemaker. This can be obtained through resident history interview, family interview or hospital referral paperwork. -If a pacemaker is present, it should be documented in the medical record. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A photocopy of the ID card or obtain information regarding the pacemaker such as model, make, and date of insertion and special precautions should be placed in resident's record and subsequent physician orders. -Obtain orders for pacemaker management and telephonic/office monitoring as applicable. Orders may include but are not limited to: -Contact number, frequency of telephonic checks -Instructions on how to use the transmitter -Schedule of planned phone checks -Physician order for consult with the Cardiologist for device checks at the office -Based on the physician's order, an ongoing schedule will be established for each resident with the appropriate company -Monitor the resident for pacemaker failure by monitoring for signs and symptoms of [NAME] arrhythmia. Symptoms associated with [NAME] arrhythmia may include: syncope (fainting), shortness of breath, dizziness, fatigue, and/or confusion. -For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: a. The name, address, and telephone number of the cardiologist; b. Type of pacemaker; c. Type of leads; d. Manufacturer and model; e. Serial number; f. Date of implant; and g. Pace rate -When the resident's pacemaker is monitored by the Physician, document the date and results of the pacemaker surveillance, including: a. How the resident's pacemaker was monitored (phone, office, internet); b. Type of heart rhythm; c. Functioning of the leads; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Frequency of utilization; and e. Battery life Resident #28 was admitted to the facility in February 2020 with diagnoses including dementia with behavioral disturbance, sick sinus syndrome (heart rhythm disorder), bradycardia (slower-than-expected heart rate, generally beating fewer than 60 beats per minute), and presence of a cardiac pacemaker. During an interview on 8/18/22 at 11:56 A.M., the surveyor observed Resident #28 in his/her room. A white box was noted on the bedside table. The Resident said he/she did not know what it was. Review of Comprehensive Care Plans included but was not limited to: -Focus: Pacemaker Manufacturer; Model; Serial#; and Date implanted Transmitter: [company name]; Ref#; SN# (3/2/20) -Interventions: Educate Resident/family to avoid activities and equipment which interfere with pacemaker activity: large magnets, MRI scanner, TENS machine, radio frequency ablation (3/2/20); Observe for and report of altered cardiac output or pacemaker malfunction: complaints of dizziness, fainting, difficulty breathing, decrease in pulse rate and blood pressure; Set at high rate-100, low rate-85, Cardiologist-[Name of Cardiology firm] Goal: Resident will remain free from signs or symptoms of pacemaker malfunction or failure through the next review date (3/2/20) Review of Cardiology Associates documentation indicated Resident #28's last visit to the Cardiologist for pacemaker follow-up was on 2/18/21. However, there was no information in the Cardiologist's notes to indicate a process for the management and frequency of telephonic/office pacemaker monitoring, battery life, and no appointment date for follow up. Review of the medical record indicated a Physician's Order for Pacemaker checks as ordered (2/28/20). The Physician's Order failed to include frequency of telephonic checks, instructions on how to use the transmitter, schedule of planned phone checks, and an order for consult with the Cardiologist for device checks at the office. During an interview on 8/24/22 at 10:10 A.M., the Minimum Data Set (MDS) Nurse and the surveyor observed the transmitter box on the Resident's bedside table. The Nurse said the box is for pacemaker checks but did not know how frequently it was done and she thinks the Resident goes out to see the Cardiologist annually, but wasn't sure. 3. Resident #103 was admitted to the facility in June 2022 with diagnoses including anxiety. Review of June 2022 Physician's Orders included, but was not limited to: -Venlafaxine HCl ER (antidepressant) 150 mg one time a day for depression (6/2/22) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Venlafaxine HCl ER (antidepressant) 75 mg one time a day for depression (6/2/22) Review of the June 2022 Medication Administration Record indicated Resident #103 was administered Venlafaxine on 6/4/22 and 6/5/22. Further review of Resident #103's medical record failed to indicate that informed consent was obtained from the Resident prior to administration of psychotropic medications as required. During an interview on 8/26/22 at 12:30 P.M., the Director of Nursing said she did not know that consent was not obtained prior to administration of psychotropic medications and Nursing staff should not have administered psychotropic medication without ensuring the Resident was aware of the risks and benefits of treatment and received informed consent. 4. Resident #310 was admitted to the facility in August 2022 with diagnoses including dementia with behavioral disturbance and Alzheimer's disease. The Resident had an activated Health Care Proxy (HCP). Review of the medical record indicated Physician's Orders for the following psychotropic medications: -Lorazepam (antianxiety) 1 milligram (mg), give one tablet every six hours as needed for psychosis (5/19/22) -Risperidone (antipsychotic) 1 mg, give one tablet two times a day for anxiety/agitation (8/11/22) -Seroquel (antipsychotic) 25 mg, give one tablet at bedtime for anxiety (8/11/22) -Trazodone (antianxiety) 50 mg, give 0.5 tablet every 12 hours as needed for anxiety/agitation for 14 days (8/18/22) -Trazodone 50 mg, give 0.5 tablet two times a day for anxiety/agitation (8/11/22) Review of the August 2022 Medication Administration Record indicated the psychotropic medications were given as ordered by the Physician. Further review of Resident #301's medical record indicated blank psychotropic consent forms. During an interview on 8/19/22 at 12:10 P.M., Resident #301's HCP said that when the Resident was admitted , she was asked to sign a lot of paperwork and was not informed about risks and benefits of the psychotropic medications being administered to Resident #301. During an interview on 8/24/22 at 2:36 P.M., Nurse #13 reviewed Resident #301's medical record, and said she did not know why the psychotropic consent forms were blank, and Nursing staff should not have administered psychotropic medications without consent. 42742 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident #92 was admitted to the facility with diagnoses including Stevens-Johnson Syndrome-Toxic Epidermal Necrolysis Overlap Syndrome (life-threatening and severe adverse skin reactions characterized by blisters and areas of skin detachment) and chronic osteomyelitis (bone infection) of the right tibia (larger of the two bones between the knee and the ankle) and fibula (calf bone). Review of the current Physician's Orders indicated to cleanse the right and left heels with cleanser or normal saline, apply calcium alginate (highly absorptive dressing designed to manage moderate to heavy fluid) to wound base, cover with abdominal pad, and wrap with Kerlix (bandage) daily and as needed, with a start date of 8/19/22. There was also an order to provide wound care to the sacrum (bony structure located at the base of the lumbar vertebrae) with cleanser or normal saline, apply Santyl (ointment to remove dead tissue from wounds so they can start to heal) to the wound base followed by calcium alginate and cover with optifoam dressing daily and as needed, with a start date of 8/19/22. Review of Resident #92's comprehensive care plan indicated a care plan for an unstageable sacral, left and right heel pressure ulcers and potential for further pressure ulcer development related to impaired mobility, initiated 8/19/22. The goal was the Resident's pressure ulcer will show signs of healing and remain free from infection. Interventions to achieve this goal included to administer treatments as ordered and monitor for effectiveness, initiated 8/19/22. Review of the facility's policy titled Non-Sterile Dressing Change, dated August 2016, included but was not limited to the following: -Designated staff member will use non-sterile dressing technique for all dressing changes unless otherwise indicated by physician or manufacturer's guidelines. Clean aseptic technique should be used. In the event of multiple wounds, each wound is considered a separate treatment. -Apply prescribed topical agent to wound -Apply wound dressing On 8/24/22 at 11:15 A.M., the surveyor observed Nurse #8 perform dressing changes to Resident #92's bilateral heels and sacrum. Nurse #8 did not apply calcium alginate to the Resident's heels or sacrum as ordered by the physician. During an interview on 8/24/22 at 12:05 P.M., Nurse #8 said she reviewed the physician's orders prior to performing the dressing changes but said she knew she missed something. She said she realized she forgot the application of the calcium alginate to the sacrum after completion of the dressing change and went back into the Resident's room to do it, but the Resident became agitated and refused. Nurse #8 said she did not realize the bilateral heels were supposed to have the calcium alginate applied. During an interview on 8/25/22 at 11:00 A.M., the Director of Nurses (DON) said physician's orders with the prescribed wound dressings should have been followed during Resident #92's dressing changes.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 42742 Based on observation, interview, record review, and policy review, the facility failed to provide two Residents (#402 and #13), out of a total sample of 22 residents, an activity program that engaged the Residents and supported their physical, mental, and psychosocial well-being. Findings include: Review of the facility's policy titled Activity Programs, revised June 2018, indicated but was not limited to the following: -The activities program is provided to support the well-being of residents and to encourage both independence and community interaction. -Activities are offered based on the comprehensive resident-centered assessment and the preferences of each resident. -The activities program is ongoing and includes independent individual activities and assisted individual activities. -Activities are not necessarily limited to formal activities being provided only by activities staff. Other facility staff may also provide the activities. Review of the facility's policy titled Individual Activities and Room Visit Program, revised June 2018, indicated but was not limited to the following: -Individual activities will be provided for those residents whose situation or condition prevents participation in other types of activities, and for those residents who do not wish to attend group activities. -Individualized activities offered are reflective of the resident's activity interests, as identified in the activity assessment, progress notes, and in the comprehensive care plan. 1. Resident #402 was admitted to the facility with diagnoses including Parkinson's disease (a disorder of the central nervous system that affects movement). Review of the Minimum Data Set (MDS) assessment, dated 8/18/22, indicated Resident #402 had severe cognitive impairment as evidenced by the Brief Interview for Mental Status (BIMS) score was unable to be completed due to the Resident being rarely understood. Review of the Activities Progress Note, dated 8/17/22, indicated the Resident enjoyed the outdoors, reading, pets, music, live entertainment, following the news, and visiting with his/her friend. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Comprehensive Resident-Centered Assessment indicated an activity care plan for Resident #402 who enjoyed the outdoors, music, live entertainment, following the news, visiting with his/her friend, and Catholicism, initiated 8/17/22. Interventions indicated the Resident was a potential isolation risk due to impaired ability to communicate and move and staff would provide 1:1 activity, conversation, refreshments, recreational materials, and a daily chronicle, initiated 8/17/22. On 8/22/22 at 12:46 P.M., the surveyor observed Resident #402 sitting in his/her wheelchair alone at a table in the Unit B dining room with no staff nearby and did not have any recreational materials on the table. There was no music playing in the dining room and the television was not turned on. On 8/22/22 at 1:17 P.M. and 3:29 P.M., the surveyor observed Resident #402 sitting in his/her wheelchair alone at a table in the Unit B dining room and did not have any recreational materials on the table. There was no music playing in the dining room and the television was not turned on. Staff were observed nearby but did not provide Resident #402 with recreational materials and did not engage the Resident. On 8/23/22 at 9:54 A.M., the surveyor observed Resident #402 sitting in his/her wheelchair alone at a table in the Unit B dining room and did not have any recreational materials on the table. Resident #402 was observed nodding on and off to sleep. Two aides were observed sitting in the dining room but did not engage the Resident. On 8/23/22 at 1:55 P.M., the surveyor observed Resident #402 sitting in his/her wheelchair alone at a table in the Unit B dining room. Another resident was sitting directly across from him/her and the television was on. Resident #402 did not have any recreational materials on the table and did not interact with the resident sitting across from him/her. A staff member was sitting nearby but did not engage the Resident. The Resident was observed pulling at his/her clothing and playing with the corner of the table. During an interview on 8/23/22 at 3:52 P.M., Unit Manager (UM) #2 identified himself as the 3:00 P.M.-11:00 P.M. nursing supervisor and said, according to the activities care plan, staff were supposed to be providing the Resident with 1:1 visits, conversation, refreshments, recreational materials, the daily chronicle, music, television to watch the news, and provide communion. On 8/25/22 at 7:15 A.M., the surveyor observed various recreational materials in the Unit B dining room including a television, multiple books, and a clear plastic jug filled with colored blocks. During an interview on 8/25/22 at 10:25 A.M., UM #1 said activities staff was on the unit that morning but had not seen them the whole week prior to that. During an interview on 8/25/22 at 1:41 P.M., the Activities Director said Resident #402 was admitted a few weeks ago and she had not been on Unit B in about a week or so because of the recent COVID-19 outbreak and said she was discouraged from providing activities on that unit because it was an affected COVID-19 unit. During an interview on 8/25/22 at 2:00 P.M., the Director of Nursing (DON) said she did not instruct the Activities Director to not provide any activities on the affected COVID-19 units and said regardless, staff should have provided individualized activities for Resident #402 and engaged him/her in the absence of the activities staff. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/1/22 at 7:09 A.M., Unit Manager (UM) #1 said Resident #402 was resistant to care sometimes, was restless, and could become aggressive. He said the Resident could not be alone and needed to be continuously watched as he/she could not comprehend or understand and needed to be in the dining room where staff could continuously monitor him/her. 34145 2. Review of the facility policy, Activity Evaluation, last revised 6/2018, included, but was not limited to the following: -An activity evaluation is conducted as part of the comprehensive assessment to help develop an activities plan that reflects the choices and interests of the resident; -The resident's activity evaluation is conducted by the Activity Department personnel, in conjunction with other staff who evaluate related factors such as functional level, cognition and medical conditions that may affect activities participation; -The activity evaluation is used to develop individual activities care plan (separate from or as part of the comprehensive care plan) that will allow the resident to participate in activities of his/her choice and interest; -The completed activity evaluation is part of the resident's medical record and is updated as necessary, but at least quarterly. Resident #13 was admitted to the facility in May 2022 with diagnoses including altered mental status, depression, Alzheimer's disease, and dementia with behavioral disturbance. Review of the Minimum Data Set assessment, dated 5/26/22, indicated Resident #13 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 9 out of 15 and it was very important to Resident #13 to do his/her favorite activities. On 8/18/22 at 10:30 A.M., the surveyor observed Resident #13 seated at a table in the back of the unit dining room with nothing on the table in front of him/her. The television was on, but the Resident was not watching it. A Certified Nursing Assistant (CNA) was seated in the corner of the room and did not interact with Resident #13. On 8/19/22 at 8:48 A.M., the surveyor observed Resident #13 seated at a table in the back of the unit dining/day room with nothing on the table in front of him/her. The television was on, and the Resident was watching it. Resident #13 said that he/she is bored and can't continue to watch television day in and day out. The Resident said that he/she likes number puzzles, writing, art, and to do puzzles. There were no activity materials observed in the dining/day room to meet the Resident's interests. Further review of the medical record failed to indicate that neither an activities evaluation had been conducted nor an individualized activity care plan had been developed to address the Resident's activity needs according to facility policy. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/26/22 at 11:40 A.M., the Activity Director said an activity evaluation for Resident #13 had not been conducted and a program of activities had not been developed to meet his/her needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observation, interview, record review, and policy review, the facility failed to ensure quality care was provided for four Residents (#67, #60, #102, and #401), out of a total sample of 22 residents. Specifically, the facility failed to: 1. Follow policy and procedures during a medical emergency for Resident #67 in respiratory arrest; 2. Perform wound measurements and observation for Resident #60; 3. Follow policy and procedures during a medical emergency and death of the Resident #102 after being found unresponsive; and 4. Ensure adequate monitoring and documentation of respiratory services by a qualified staff member including prompt identification and response to changes in Resident #401's respiratory condition, resulting in a 911 call and subsequent transport to the hospital. Findings include: 1. Review of the facility's policy titled Code Blue/CPR, revised [DATE], indicated the following: - if resident is found turning blue, unresponsive, not breathing normally (gasping), not breathing, having no palpated pulse within 10 seconds, or choking- the staff member is to stay with the resident, call for assistance, have staff members check for advanced directives and call Code Blue. -Code Blue is announced through the overhead paging system. -staff assigned or identified to assist during a Code Blue should be responsible for bringing crash cart and AED [automated external defibrillator] to the scene of the code. -the first licensed nurse certified in CPR or Basic Life Support on the scene is the leader of the Code Blue and will direct the code. -leader responsibilities include: instruct staff to call 911, instruct staff to bring medical record to verify code status, designate staff to take detailed notes and tracking during the code, assign staff to prepare paperwork, assign staff to utilize notes to complete Code Blue Review Tool. -documentation in resident's medical record should include at a minimum: resident condition when found, time of specific details (code called, 911 called, AED, etc.). -paperwork and details from the incident and staff interviews should be reviewed by Facility Clinical Administration to identify concerns and be presented to QAPI. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:57 P.M., the surveyor observed the Administrator at the reception area. Four Emergency Medical Technicians (EMTs) were observed to walk into the facility and were instructed by the Administrator to head to Unit B. The surveyor followed the EMTs to Unit B. During an interview at this time, EMT #1 said the Dispatcher was having trouble obtaining information from the facility when they called 911. When the surveyors and the EMTs arrived at the room of Resident #67, EMT #2 turned and notified the other EMTs there was a Code Blue in progress. The surveyor observed EMT #1 run out to their emergency vehicle and return with a mechanical chest compression system, which had not been with them upon arrival as the call did not come in as a Code Blue. The surveyor observed EMT #3 call to notify [NAME] Fire Department there was CPR in progress and requested additional assistance. At 1:01 P.M., the EMTs had taken over the Code Blue. At 1:19 P.M. Resident #67 was pronounced dead. During an interview on [DATE] at 1:21 P.M., EMT #2 said the call to 911 did not indicate there was a Code Blue in progress. During an interview on [DATE] at 1:15 P.M., Nurse #2 said a Certified Nursing Assistant (CNA) went in the room of Resident #67 and found him/her unresponsive. She said the CNA immediately informed Nurse #2, who went to the room. Upon entering the room she found that Resident #67 was unresponsive and had defecated him/herself. Nurse #2 said she yelled into the hallway there was a Code. During an interview on [DATE] at 1:45 P.M., the Nursing Supervisor said he heard Nurse #2 yell down the hallway, overhead paged there was a Code Blue, called 911, and told Nurse #10 to bring oxygen to the room. He said he did not notify 911 there was a Code Blue as he did not know it was a Code Blue and told 911 the resident was in respiratory distress. He said 911 was asking him a lot of questions, he told them it was an emergency and hung up the phone. He said after overhead paging and calling 911, he then brought the code cart to the room of Resident #67. During an interview on [DATE] at 1:50 P.M., Nurse #10 said she had brought the oxygen to the room of Resident #67 and the nursing staff had taken turns performing CPR prior to the arrival of the EMTs. During an interview on [DATE] at 2:55 P.M., the [NAME] Fire Department 911 Dispatcher said he had taken the call from the Nursing Supervisor on [DATE] at 12:51 P.M. The Dispatcher said the Nursing Supervisor said a resident was in respiratory distress and needed an ambulance. The Dispatcher said the Nursing Supervisor started yelling and when the Dispatcher inquired what he was yelling about, the Nursing Supervisor said he was telling the nurse to bring the oxygen. The Dispatcher said the Nursing Supervisor never said it was a Code Blue or that CPR had been initiated. Review of the Patient Care Record from the [NAME] Fire Department indicated a call came into 911 at 12:51 P.M. indicating Resident #67 was in respiratory distress, possibly COVID-19. The report indicated upon arrival facility staff indicated they had been performing CPR for 4 or 5 minutes and EMTs contacted [NAME] Fire Department for additional assistance. After performing CPR for 20 minutes, Resident #67 was pronounced dead. Following the death of Resident #67, the surveyor requested a review of all documentation regarding the Code Blue for the Resident. The surveyor was provided with a nursing progress note and a Code Blue Protocol Review Tool. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of the Nursing Progress Note, dated [DATE], written by the Nursing Supervisor, indicated Resident #67 was having difficulty breathing and upon assessment had a change in mental status and was unresponsive. This nurse rushed to the room and found unresponsive to external stimuli, this nurse called for then initiated CPR. This writer called 911 and announced code blue.

Review of the Code Blue Protocol Review Tool for Resident #67 on [DATE] indicated a check mark that the facility had documented the start of the beginning of the incident to include resident condition, time CPR was initiated and discontinued, observations, and any treatment given.

Review of the documentation provided to the surveyor by the facility failed to include any documentation of time of events, failed to include the status of Resident #67 including any vital signs taken (respiratory rate, oxygen saturation, etc.) and failed to indicate who was involved in the Code Blue (Nurse #2, Nurse #10, Director of Nurses) and what roles were taken (who found resident, who provided CPR, etc.).

During an interview on [DATE] at 8:30 A.M., the Director of Nurses said there was no additional documentation regarding the Code Blue per the facility policy to include timing of the Code Blue, the presentation of Resident #67 when found (as different during surveyor interview than documentation) or staff statements to include all staff involved. She said a Code Blue had been paged on the overhead system and she responded to the Code Blue. She said the Nursing Supervisor should have informed the emergency dispatcher that it was a Code Blue and not respiratory distress.

During this interview, the Director of Nurses said she was already in the room of Resident #67 with Nurse #10 when the Nursing Supervisor brought the code cart. She said the code cart should have been one of the first items to be brought to the room, per Code Blue protocol.

2. Review of the facility's policy titled Skin Integrity Management, updated [DATE], indicated to perform wound observations and measurements and complete the Skin Integrity Report weekly.

Resident #60 was admitted to the facility in [DATE] with diagnoses including diabetes and diabetic wounds with sepsis and osteomyelitis (bone infection).

On [DATE], review of the medical record included a Wound Evaluation and Management Summary, dated [DATE], from the wound consultant. The summary indicated Resident #60 had the following wounds:

-post-surgical wound of the right, plantar foot measuring 6.5 centimeters (cm) length by 7.5 cm width by 4.0 cm depth.

-diabetic wound of the left heel 0.8 cm length by 0.8 cm width by not measurable depth.

There were no further Wound Evaluation and Management Summaries after [DATE], in the medical record.

Review of the Nursing Progress Notes, Treatment Administration Record, and Weekly Skin Check forms failed to include wound observation and measurement information after [DATE].

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 8:27 A.M., the Administrator said the wound consultant normally comes to the facility weekly to complete wound rounds with the Nursing Supervisor. She said the wound consultant was on vacation on [DATE] and was unable to come to the facility on [DATE]. During an interview on [DATE] at 10:30 A.M., the Director of Nurses (DON) said the Nursing Supervisor was responsible for documenting wound rounds when the wound consultant was at the facility and for completing wound rounds weekly (observing wounds, measuring wounds) when the wound consultant was unable to come to the facility. During an interview on [DATE] at 12:02 P.M., the DON said she was unable to locate any documentation to indicate wound observations or measurements were conducted for Resident #60, after [DATE]. 34145 3. Review of the facility's policy titled Death of a Resident/Patient, dated ,d+[DATE], included but was not limited to: -Assess the resident/patient for vital signs: apical pulse, respirations, blood pressure -Document the following in the Nurse's Note: -Time absence of vital signs was determined -Time and name of Physician notified -Time and name of family member notified -Name of designated funeral home and time notified -Name of funeral home representative and time body released -Status of deceased resident/patient's personal possessions and what was sent with the body (i.e., glasses, dentures, etc.) Resident #102 was admitted to the facility in [DATE] with diagnoses including a history of a stroke, hypertension, and diabetes mellitus. Review of the medical record indicated a [DATE] Clinical Nurse's Note indicated: Resident found at 6:15 A.M. with no pulse, no respirations, lack of pupillary response at this time. Resident is a full code. Cardiopulmonary resuscitation (CPR) was initiated immediately after code blue was called. 911 was notified and so was the doctor and the Resident's guardian. 15 minutes later, Emergency Medical Technicians (EMT) arrived on scene and took over CPR. EMTs attempts to resuscitate unsuccessful and they departed the building. Time of death: 7:15 A.M. Order given for RN pronouncement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Name of HCP/responsible person notified: Guardian. Name of Funeral Home body released to: Funeral Home. Will be on way to pick up body. The surveyor requested a review of all documentation regarding the Code Blue and pronouncement of death for the Resident. The surveyor was provided a copy of the [DATE] Clinical Nurses Note and no additional information. Review of the Patient Care Record from the [NAME] Fire Department indicated that upon arrival, facility staff told them that CPR was started on Resident #102 at 6:00 A.M., and they did not call 911 until 45 minutes later because they were trying to find the patients' code status and they are understaffed. The report indicated that staff stated they were doing CPR for 30 to 45 minutes prior to calling 911 and had applied the AED (automated external defibrillator). After performing CPR for 15 minutes, Resident #102 was pronounced dead. The facility failed to record time of specific details (911 called, AED, etc.) and failed to record the status of Resident #102 including any vital signs taken during the code (respiratory rate, oxygen saturation, etc.), failed to indicate who was involved in the Code Blue and what roles were taken, and failed to include any information required for the pronouncement of death. During an interview on [DATE] at 12:30 P.M., the Director of Nursing said there was no additional documentation regarding the Code Blue and Resident #102's death. She could not explain why staff did not call 911 for more than 30 minutes after the Resident was found unresponsive, and why staff failed to accurately and completely document the code and pronouncement of death according to facility policy. 42742 4. Review of Blipping Nursing Procedures, Eight Edition 2019, indicated but was not limited to the following: Tracheostomy Care, Preparation of Equipment: -Make sure the extra tracheostomy tubes and arbitrator and the handheld resuscitation bag attached to an oxygen source are readily available in case of an emergency. Special Considerations -Make sure suctioning equipment is always at the patient's bedside because the patient may need the airway cleared at any time Implementation: -Elevate the head of the bed to 30 to 45 degrees to decrease abdominal pressure on the diaphragm, promote lung expansion, and reduce the risk of aspiration -Assess the need for suctioning (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hyperextend the patient for 30 to 60 seconds before suctioning (if needed) -If needed, suction the tracheostomy tube by inserting the suction catheter to a premature distance to clear the airway of any secretions that may hinder oxygenation -Reassess the patient's respiratory status and compare the findings to baseline findings -Replace all equipment, including solutions, regularly according to your facility's policy to reduce the risk of health care-acquired infections. Documentation: -Record the date and time of the procedure; the type of procedure; the amount; consistency, color, and odor of secretions, stoma and skin conditions; the patient's respiratory status. Note complications and nursing actions taken, and the patient's tolerance of the procedure. Review of American Nurses Association guide titled Tracheostomy Care: An evidence-based guide, Dated [DATE], indicated but was not limited to the following: Suctioning Technique: Before suctioning, hyperextend the patient. Ask a spontaneously breathing patient to take two to three deep breaths; then administer four to six compressions with a manual ventilator bag. For each session, limit suctioning to a maximum of three catheter passes. During catheter extraction, suctioning can last up to 10 seconds; allow 20 to 30 seconds between passes. Evaluation: When evaluating the patient after suctioning, assess and document physiologic and psychological responses to the procedure. Convey your findings verbally during nurse-to-nurse shift report and to the interdisciplinary team during daily rounds. Resident #401 was admitted to the facility in [DATE] with diagnoses including dependence on supplemental oxygen, chronic obstructive pulmonary disease (COPD) (lung disease that blocks airflow and makes it difficult to breathe), pneumonitis (inflammation of lung tissue) due to inhalation of food and vomit, acute and chronic respiratory failure with hypoxia (lack of oxygen) and hypercapnia (excessive carbon dioxide in bloodstream), emphysema (air sacs of the lungs are damaged and enlarged causing breathlessness), neoplasm (abnormal growth of tissue characteristic of cancer) of trachea, bronchus, and lung, and tracheostomy (opening created at the front of the neck so a tube can be inserted to help you breathe). Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #401 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15, had a tracheostomy, and required oxygen. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:20 A.M., the surveyor observed Resident #401 lying in bed receiving 2 liters (L) of oxygen via a nasal cannula (tube that splits into two prongs which are placed in the nostrils). The Resident had a tracheostomy tube. A suction cannister was observed on top of the Resident's nightstand unplugged. A bag-valve-mask (Ambu bag for manual oxygenation and ventilation) and spare trach were not observed at the Resident's bedside. Resident #401 said he/she had had a trach for three years secondary to his/her COPD. Review of current Physician's Orders indicated the following: -Oxygen 2.5 liters (L) /minute continuous as needed to keep oxygen saturation above 90% every shift, order date [DATE] -Head of bed maintained greater than 30 degrees every shift, order date [DATE] (two weeks after admission) -Obtain vital signs every day shift for monitoring, order date [DATE], start date [DATE] -Suction trach for increased secretions as needed, order date [DATE] (two weeks after admission) -Trach type: Shiley Trach size 5, uncuffed, order date [DATE] (two weeks after admission) -Trach: Ambu bag, oxygen, suction canister and catheters in room at all times every shift, order date [DATE] (over two weeks after admission) Review of the Comprehensive Care Plan indicated Resident #401 had a care plan for a tracheostomy related to impaired breathing mechanics and had an uncuffed Shiley Trach-capped 4fr 5MM-LDA, initiated on [DATE]. The goal was for Resident #401 to have clear and equal breath sounds bilaterally. Interventions included to keep a replacement trach, ambu bag, oxygen, suction canister, and catheters in the room at the bedside at all times, initiated [DATE] (after the surveyor's initial observations), monitor/document for restlessness, agitation, confusion, increased heart rate and bradycardia, initiated [DATE], and suction as needed, initiated [DATE]. During an interview on [DATE] at 2:35 P.M., the Director of Nursing (DON) said no staff had been trained to care for a resident with a tracheostomy as long as she had been there (since [DATE]). Review of the Vitals Summary for Resident #401 indicated a room air oxygen saturation (O2 Sat) (percentage of oxygen bound hemoglobin in the blood) level of 87% was documented in the electronic medical record by Nurse #16 on [DATE] at 00:45 A.M. The room air (no oxygen use) saturation level did not reflect Resident #401 was receiving the ordered 2.5 oxygen liter flow. The Vitals Summary failed to indicate documentation of a reassessment of the low oxygen level until 6:28 A.M. that morning. Review of Resident #401's medical record failed to indicate any further documentation by Nurse #16 throughout his 11:00 P.M.-7:00 A.M. shift, [DATE] into [DATE]. Review of Nursing Progress Notes for Resident #401 indicated but was not limited to the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225208	A. Building B. Wing	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] at 7:15 A.M. - Resident was noted with difficulty breathing. O2 Sat 87% 2L nasal cannula. Heart rate (HR) 121. Order to send resident out due to respiratory distress and hypoxia (oxygen deficient) in place. [DATE] at 8:53 A.M. - Resident was sent out to hospital secondary to hypoxia and respiratory distress. Review of the Situation, Background, Assessment, Recommendation (SBAR) Communication Form (tool used to provide essential, concise information, usually during crucial situations) and Progress Note completed by Unit Manager (UM) #1, dated [DATE] at 8:09 A.M., indicated but was not limited to the following: Situation -respiratory distress started on [DATE], low oxygen, tracheostomy resident Background -primary diagnosis hypoxia, COPD Vital Signs -Most recent pulse: 121 on [DATE] at 12:29 P.M. -Most recent respiration: 18 on [DATE] at 4:05 P.M. -Most recent temperature: 98.5 on [DATE] at 4:05 P.M. -Most recent O2 Sat: 87% on RA on [DATE] at 00:45 A.M. Mental Status Changes -decreased consciousness, unresponsiveness Assessment (RN) or Appearance (LPN) -Not completed Nursing Notes -Not completed (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:26 P.M., the Director of Nursing (DON) said the SBAR Communication Form was incomplete and did not include a narrative of the events leading up to the 911 call and subsequent transport of the Resident to the hospital. She said there was no documentation throughout Nurse #16's shift including nursing progress notes, a change in condition, or physician notification but there should have been. The DON said Nurse #16 told her that he had not done vital signs that night and documented just the O2 Sat of 87% RA at 00:45 A.M. as a late entry. The DON said the O2 Sat was not reflected as a late entry and said she asked Nurse #16 to stay and complete his documentation prior to leaving his shift that morning, but he did not, so Unit Manager #1 completed the SBAR after he arrived that morning. Review of the [NAME] Fire Department report, dated [DATE], indicated but was not limited to the following: -Staff state they found the patient with a change in mental status and difficulty breathing this morning (around 7:30 A.M.). Staff called 911 and placed the patient on high flow oxygen. -Upon our arrival (QUOTA) we found the patient lying supine in bed, with a room air saturation of , d+[DATE]%. Respiratory rate (RR) of ,d+[DATE] with shallow breaths and bradycardia (fast heart rate). Lung sounds clear throughout. Patient is semi-responsive to painful stimulation -Patient has a tracheostomy -Staff deny any events leading up to them finding the patient with a change in mental status and difficulty breathing. Staff state they did not attempt any type of suctioning. -Patient's trach was deep suctioned and patient's breathing improved minimally (patient reacted well to being suctioned). During an interview on [DATE] at 11:58 A.M., Nurse #16 said he worked the 11:00 P.M.-7:00 A.M. shift on Unit B the night of [DATE] into [DATE] and was assigned to Resident #401. He said it was the first time the Resident was assigned to him and he had not received education or training to care for a Resident with a trach at the facility. Nurse #16 said there was a change in the Resident's respiratory condition at 4:00 A.M. and at 6:30 A.M. but did not notify the physician or supervisor. Nurse #16 was unable to tell the surveyor the proper steps to provide deep suctioning per standards of practice or facility policy. Nurse #16 said at 6:45 A.M., an aide was washing up the Resident and told him the Resident did not look ok. He said the Resident was found in a supine position (lying flat, face upward) without oxygen on. Nurse #16 said he/she was breathing really fast and was unconscious and didn't respond to me. He said the Resident should have had oxygen on and should not have been in a supine position because he/she had a trach. Nurse #16 said he said he did not document his baseline findings, vital signs including respiratory rate, reassessment of the Resident's respiratory status for comparison, behavioral changes that could indicate hypoxia, the date and times he performed deep suctioning and details, any complications, or how the Resident tolerated the procedures because he was very busy then had to go. He said he had asked another staff member to document for him so he could go home.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 28450 Based on record review, interview, and observation, the facility failed for one Resident (#78), out of a total of 22 sampled residents, to a. Initiate treatment to the Resident's mid coccyx to promote wound healing, and b. Ensure the Resident was evaluated by the wound practitioner for multiple pressure ulcers (stage 2 and 3). Findings include: Review of the facility's policy titled Skin Assessment and Risk, dated November 2019, indicated assess existing pressure ulcers, obtain history of pressure ulcers, perform the risk assessment on admission along with the Braden or Norton Scale, obtain risk score, and evaluate its meaning based on resident's unique characteristics. The skin condition is recognized, evaluated, and reported to the practitioner, and addressed. Resident #78 was admitted to the facility in July 2022 with diagnoses including adult failure to thrive and type 2 diabetes. Review of the Wound Evaluation and Progress Note from the Hospital Emergency Department (ED), dated 7/2022, indicated Resident #78 had multiple wounds: a.) a wound to the left anterior ankle as active. The wound progress note indicated the stage 2 pressure area to the left ankle measuring 2.5 centimeters (cm) (length) by 3.1 cm (width) by 0.5 cm (depth), a surface area of 3.88 cm squared; with small seropurulent drainage. The treatment recommendations included cleanse the wound, apply Santyl; then Adaptic; and cover with Dry dressing. b.) a wound to the left buttocks as active. The wound progress note indicated the stage 3 pressure area to the left buttock area measuring 1.3 centimeters (cm) (length) by 4.7 cm (width) by 0 cm (depth), a surface area of 0.3 cm squared; with scant seropurulent drainage. The treatment recommendations included to cleanse the wound, apply Therahoney sheet, cover with Foam. c.) a wound to the mid coccyx as active. The wound progress note indicated the stage 2 pressure area to the to the coccyx mid area measuring 1 centimeter (cm) (length) by 1 cm (width) by 0 cm (depth), a surface area of 0.3 cm squared; with scant serous drainage. The treatment recommendations included cleanse the wound, apply Therahoney sheet, cover with Foam. Review of the medical record indicated would treatment was initiated for: - left coccyx (buttocks) wound treatment begun as ordered on 7/11/22 - left lateral (anterior) ankle wound treatment begun as ordered on 7/10/22 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Further review of the medical record failed to indicate wound treatment was initiated for the mid-coccyx wound identified in the July 2022 ED summary. Review of the Resident Weekly Skin Assessment, dated 8/27/22, indicated the Resident had no skin issues; skin on his/her heels and coccyx were intact. During an interview with Nurse #2 and Resident #78 on 8/31/22 at 9:49 A.M., Nurse #2 said she had already applied protective cream to the Resident's coccyx area. Nurse #2 confirmed that the Resident had an open area to the mid coccyx. The Resident said the pressure area on the mid coccyx hurts so bad. The surveyor requested to see the area, but Resident #78 refused and said he/she was in pain. Review of the paper and electronic clinical record failed to include any documentation of the stage 2 pressure area to the to the mid coccyx and failed to include the treatment recommended by the hospital wound practitioner. Review of the Treatment Administration Record (TAR) failed to include any treatments to the mid coccyx. Further review of the clinical record indicated Resident #78 had not been evaluated by the Wound Care practitioner since admission to the facility. During an interview on 8/31/22 at 8:15 A.M., the Unit Manager said he was aware the Resident had pressure areas but not their location or staging. During an interview on 8/31/22 at 11:15 A.M., the Director of Nurses (DON) said the Wound Physician Consultant said they did not see the Resident or evaluate the wounds. The Attending Physician told her there was no recommendation for him to evaluate the Resident's wounds or skin from admission until this morning (8/31/22). During an interview on 8/31/22 at 11:25 A.M., the DON said she was not aware the Resident had pressure areas on the coccyx that required treatment. The DON said she reviewed the documentation for Resident #78, and she could not locate any treatments or documentation for the mid coccyx. She said the facility failed to follow their policy for skin assessments and risk.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 15214 Based on observation, record review, and staff interview, the facility failed to ensure that for one Resident (#81), out of a total sample of 22 residents, the Resident received proper care and treatment to maintain mobility and good foot health. Findings include: Resident #81 was admitted in May 2022 with diagnoses which included Alzheimer's disease, anxiety disorder, depression, and psychotic disorder. Record review indicated the Resident's Health Care Agent had given the facility's podiatry service permission in May 2022, to examine and/or administer treatment as necessary in the diagnosis and treatment related to Podiatry. On 8/25/22 at 10:47 A.M. on the C-Wing, the surveyor observed the Resident walking with one slipper sock on his/her left foot. The right foot was bare. The surveyor observed all toenails on the right foot to be long, curled over the end of the toes, and had a yellowish-brown color to them. On 8/30/22 at 7:20 A.M., the surveyor observed the Resident seated in a chair in the hallway of the C-Wing. The Resident's feet were bare. The surveyor observed all the toenails on both feet to be long and curled over the ends of the toes. The toenails appeared irregularly shaped and were yellowish-brown in color. Review of Resident #81's medical record failed to indicate the Resident was seen by a podiatrist since admission to the facility. Further review indicated the Resident was not scheduled to be seen by the podiatrist for foot care. During an interview on 9/1/22 at 2:45 P.M., neither the Director of Nursing nor the Administrator could explain why the Resident had not received foot care since admission to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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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 - Some	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** 34145 Based on observation and interview, the facility failed to ensure staff provided residents an environment free from accident hazards on two units (Unit B and Unit C) of three units in the facility. Specifically, the facility failed to: 1. ensure the clean utility room was securely locked and hazardous items were not easily accessible to wandering residents on the Unit C; and 2. ensure medication was properly disposed of and not accessible to wandering residents on Unit B. Findings include: 1. On [DATE] at 11:25 A.M., the surveyor observed four residents wandering the hallways and attempting to open closed doors on Unit C. On [DATE] at 11:28 A.M. on Unit C (secured unit), the surveyor approached a closed door labeled clean utility. The door had a numerical combination lock on it, but the door was not pulled tight and secured and was easily pushed open. The surveyor observed the following items in the unlocked and unsecured clean utility room: -2 oxygen concentrators -12 filled portable oxygen tanks -a treatment cart with several prescribed and over the counter house treatments on top of the cart including: -Four tubes of zinc oxide (1 with cap off), -One prescription tube of Betamethasone Dipropionate Cream 0.5%, -One prescription tube of Betamethasone Dipropionate Cream 1%, -19 3% Xerofoam Petrolatum Dressing (antimicrobial wound dressing), -10 packets A&D ointment (skin protectant), -Prescription Lidocaine cream 3% (topical anesthetic), -Prescription Nyamyc Nystatin powder (antifungal), and -Prescription Ketoconazole 2% cream (antifungal), (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Four-tiered metal shelving: -Three boxes of Bacitracin ointment, -One box of Voltaren (topical analgesic), -Five boxes of liquid skin prep & shield, -One razor, -Two boxes of alcohol prep pads, and -Two boxes of antiseptic towelettes. -Cabinets (unlocked) above the sink: shaving cream, disposable razors, and nail clippers. -Above sink: -Two boxes of disposable razors (50 count each), -Three boxes of nail clippers (12 count each) plus 6 clippers out on shelf, -Three cans of shaving cream, -16 bottles of roll-on antiperspirant/deodorant, and -16 bottles of shampoo. At the conclusion of the observation, the surveyor pulled the door closed tightly and ensured the clean utility room was secured. On [DATE] at 8:16 A.M., the surveyors approached the clean utility room door and easily pushed it open. All items identified on [DATE] were still present and easily accessible to all Residents on the unit. On [DATE] at 8:18 A.M., the surveyors showed Nurse #13 the unsecured clean utility room door. Nurse #13 said the room is supposed to be locked at all times, especially on a unit like this with residents with dementia. 42742 2. During an interview on [DATE] at 8:59 A.M., on Unit B, the surveyor observed Nurse #9 dispose of an over the counter (OTC) bottle of Vitamin D, 1000 units, into an open trash container that was attached to the right side of the medication cart. Nurse #9 said the bottle was expired. Contents of loose tablets were heard inside the bottle as she disposed of it into the trash. A resident was observed standing at the same side of the medication cart attempting to touch loose items stored on top before being re-directed by staff. The OTC bottle was observed at the top of the trash container and easily accessible to residents nearby. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a National Institutes of Health (NIH) article titled, Vitamin D Fact Sheet for Professionals, updated [DATE], indicated but was not limited to the following: Health Risks from Excessive Vitamin D: -Excessive amounts of vitamin D are toxic and can result in hypercalcemia (buildup of calcium in the blood) which can lead to nausea, vomiting, muscle weakness, neuropsychiatric disturbances, pain, loss of appetite, dehydration, excessive thirst, and kidney stones. In extreme case, vitamin D toxicity causes renal failure, cardiac arrhythmias, and even death. During an interview on [DATE] at 11:00 A.M., the Director of Nursing (DON) said the OTC Vitamin D bottle should not have been disposed of in the general trash on Nurse #2's medication cart. She said it should have been opened and the pills poured into a liquid destroyer to ensure resident safety.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42742 Based on observation, interview, and record review, the facility failed to provide treatment and services for one Resident (#78), out of four residents with indwelling catheters (tube inserted into the bladder to drain urine), out of a total sample of 22 residents. Specifically, the facility failed to obtain a physician's order for the Resident's Foley catheter upon admission to the facility including Foley catheter care and failed to provide Foley catheter care and ongoing assessment in order to prevent catheter-related urinary tract infections. Findings include: Resident #78 was admitted to the facility with diagnoses including acute cystitis (inflammation of the bladder) with hematuria (blood in urine), benign prostatic hyperplasia (BPH) (prostate gland enlargement) with lower urinary tract symptoms, urinary tract infection (UTI), and a nodular prostate. Review of the Comprehensive Resident-centered Care Plans indicated a Foley catheter care plan related to a specified diagnosis, initiated 7/25/22. The goal was for Resident #78 to have potential complications of urinary catheter mitigated (make less severe) through the review date. Interventions to achieve this goal included the following: -Foley Size: 16 Fr. Balloon: 10 cc, initiated 7/25/22 -Monitor skin around catheter insertion site for irritation and skin breakdown every shift as clinically indicated, initiated 7/25/22 -Observe for, document, and report to physician signs and symptoms of UTI, initiated 7/25/22 -Change catheter as needed for leaking or blockage, initiated 7/25/22 -Change dressing bag per facility policy, and as clinically indicated, initiated 7/25/22 Review of current Physician's Orders and the July and August 2022 Treatment Administration Records (TAR) failed to indicate Resident #78 had a Foley catheter order in place and failed to indicate orders for Foley catheter care, observation and monitoring, orders to change the catheter as needed, or orders to change the drainage bag. On 8/18/22 at 9:36 A.M., the surveyor observed Resident #78 lying in bed. A Foley catheter was hanging from the side of the bed draining yellow urine. During an interview on 8/31/22 at 8:51 A.M., Resident #78 said he/she was not having any urinary symptoms that he/she knew of, but staff had not cared for his/her Foley catheter. Resident #78 said, They never clean it; they never do. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/31/22 at 8:58 A.M., Nurse #2 said she was assigned to the Resident that day and was familiar with him/her and said the Resident's Foley catheter bag was changed every night during the 11:00 P.M.-7:00 A.M. shift. The surveyor reviewed the current physician's orders and TAR with Nurse #2 who said there was nothing there but should have been. She said she knew the Resident had a Foley but did not know for what reason or what size. Nurse #2 said the Resident was admitted with it and she had never provided care for it when assigned to the Resident. During an interview on 8/31/22 at 9:05 A.M., Unit Manager (UM) #1 said he was not here when the Resident was admitted so he did not know the details of the Resident's Foley catheter. The surveyor reviewed the Resident's medical record with UM #1 who said, I don't see anything about the Foley. He said Resident #78 was care planned for a Foley, but the interventions were not ordered as far as Foley catheter care, changing the bag, and the Foley catheter itself. During an interview on 8/31/22 at 9:15 A.M., Physician #1 said Resident #78 had a Foley catheter when he/she was admitted , and orders should have been entered but were not. She said she was unsure if any Foley catheter care had been provided to the Resident since he/she was admitted , approximately two months ago. Physician #1 said she believed the Resident had a urologist but could not be sure.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 27189 Based on observation, record review, policy review, and interview, the facility failed to ensure that care and treatment of a tracheostomy (a surgically created opening in the windpipe to keep it open) was provided in accordance with the facility policy/protocols and professional standards of practice for one of one Resident (#401) with a tracheostomy, out of a total sample of 22 residents. Specifically, the facility failed to: a.) Obtain physician's orders to provide a person-centered care plan for care of tracheostomy and tracheostomy tube and speaking valve; b.) Implement the facility protocol for scheduled tracheostomy tube, inner cannula, tube ties/holder and mask changes, along with suctioning to prevent airway occlusion and respiratory infections; and c.) Provide emergency bedside tracheostomy equipment needed for accidental decannulation (the inadvertent removal of tracheostomy tube out of the stoma) or mucus plugging (buildup of thick mucus). Findings include: Review of The National Tracheostomy Safety Project manual dated 2013 indicated but was not limited to the following: Day-to-day management of Tracheostomies: -Daily Checks-There should be a detailed plan of care for all patients with a tracheostomy. The plan of care should be reviewed daily and updated if there is any change. A full assessment of the patient should include: -Why does the patient have a tracheostomy and when was it performed. -Type and size of tracheostomy tube & availability of spare & emergency equipment -Sputum characteristics (Color, Volume, Consistency, Odor) -Check and change inner cannula -Check tracheostomy ties [used to hold the tracheostomy tube in place] are secure and clean -Check stoma dressing is clean -Routine observations -This assessment should be documented (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Tracheostomy Care, dated August 2016, indicated but was not limited to the following: -To maintain patency of the airway, to prevent infection of the airways and the area around tracheostomy tube, and to prevent excoriation of the area around the tracheostomy tube. -Licensed nursing staff have the responsibility for providing maintenance trach care for patients who have a stable pulmonary condition. Resident #401 was admitted to the facility in August 2022 with diagnoses including acute exacerbation of chronic obstructive pulmonary disease, respiratory failure with hypoxia, neoplasm of the trachea, bronchus, and lung with a tracheostomy in place. Record review of the August 2022 Physician's Orders indicated the following: -Inhale Oxygen 2.5 liters/minute continuous as needed to keep oxygen saturation above 90% every shift Start date 8/5/22 at 11:00 P.M. -Change Trach dressing 7-3 shift and PRN The box where the time/frequency is entered for the treatment to be completed, indicated the frequency as PRN. Start 8/8/22 at 10:00 A.M. -Change Trach dressing 7-3 shift and as needed (PRN) The box where the time/frequency is entered for the treatment to be completed, indicated the frequency as PRN. Start 8/5/22 at 10:00 P.M. Discontinue date 8/6/22 at 8:25 P.M. -Change Trach dressing 7-3 shift and PRN one time a day every 3 days - 2 nurses at all times Start 8/8/22 10:00 A.M. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) indicated the orders were written as PRN (as needed) and not standing orders. Further review of the Physician's orders indicated the following orders were put into place two weeks after admission: -Trach type: Shiley Trach size: 5, Uncuffed Order obtained on 8/19/22 at 10:34 A.M. -Head of bed maintained greater than 30 degrees every shift Start date 8/19/22 at 3:00 P.M. -Suction Trach for increased secretions as needed Start Date 8/19/22 at 10:45 A.M. -Trach: Ambu bag, oxygen, suction canister, and catheters in room at all times every shift Start date 8/20/22 at 11:00 P.M. During an interview on 8/23/22 at 2:22 P.M., the Director of Nursing (DON) and the surveyor observed that the Resident's room did not contain any spare trachs for insertion in the event of decannulation (the inadvertent removal of tracheostomy tube out of the stoma). The DON said the spare Trachs are stored in central supply and not at the Resident's bedside. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/24/22 at 8:01 A.M., the Resident said the tracheostomy has been in place for three years because of the chronic obstructive pulmonary disease. The Resident further stated that she/he manages the care of the tracheotomy independently at home. The Resident stated that a number 5 was in place and that it had an inner cannula. The Resident also indicated that she/he has a speaking valve. Review of the August 2022 Physician's Orders did not indicate the size/type of trach in place until 8/19/22 and did not indicate as to whether the Resident's trach had an inner cannula and if so, whether it was disposable. During an interview on 8/31/22 at 2:52 P.M., the DON said the orders for Resident #401's tracheostomy care were incomplete. The DON said there is a standard set of orders which, at a minimum should be put into place when a resident is admitted to the facility with a trach which include but are not limited to the following: -Trach type and size -Change Inner Cannula -Cleanse Trach site with Normal Saline (NS), pat dry, cover with drain sponge (Exilon-type of drain sponge that will not fray) daily as well as PRN -Change Trach collar/ Mask (a device that goes over the tracheostomy and provides humidification and supplemental O2 if needed), mask and O2 weekly as well as PRN -Maintain Ambu bag at bedside and replacement Trach of equal size and one size down maintained at the bedside -Suction Trach every shift as well as PRN. Dispose of suction catheter tubing after each use and document suctioning reason for care (routine, cleaning, secretions, obstruction, a respiratory distress, and amount) suctioned, characteristics of secretions (color, odor, viscosity) resident tolerance to procedure. The DON said that the orders should have included all the above at a minimum and because the Resident had a speaking valve, an order for the wearing schedule and cleaning of the speaking valve should have been obtained. There was also no order for changing of the trach ties, which should have been in place/obtained. The DON was aware that changing/cleaning of the inner cannula was never addressed, and that the oxygen order did not indicate a delivery method. She further stated that the Resident should have had a number 5 spare trach and a size below (number 4) available for emergencies/decannulation at the Resident's bedside, at all times, and that the number 4 was still not available. The DON said that the facility failed to provide proper care and treatment for Resident #401's tracheostomy as per professional standards of practice for a tracheostomy and did not obtain the standard orders for care of the Resident's tracheostomy.

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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. 42742 Based on interview, record review, and policy review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, for one Resident (#39), of one resident receiving dialysis, out of a total sample of 22 residents. Specifically, the facility failed to ensure ongoing communication and collaboration between the facility and the dialysis center. Findings include: Review of the facility's policy titled Dialysis Management, revised May 2019, included but was not limited to the following: -Facility will establish open communication with the Resident's Dialysis Center utilizing a Dialysis Communication Book completing the Dialysis Communication Form -The nurse will establish pre-dialysis vital signs (blood pressure, pulse, temperature, respirations), any pertinent resident information -On return from the Dialysis Center the nurse will review the communication returning from the Dialysis Center. The nurse should review specifically for pre- and post-vital signs, treatment tolerance, any medication given, and any new orders for resident care. Review of the Dialysis Agreement, dated 1/6/15, indicated but was not limited to the following: Mutual Obligations, Collaboration of Care -Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Nursing Facility and the end stage renal disease (ESRD) Dialysis Unit Resident #39 was admitted to the facility with diagnoses including end stage renal disease and dependence on renal dialysis. Review of current Physician's Orders indicated an order for Resident #39 to attend dialysis three times a week on Tuesday, Thursday, and Saturday, ordered on 7/4/22. Review of Resident #39's July and August 2022 Dialysis Communication Book indicated the following dialysis communication forms: 7/2/22, 8/16/22 -Nursing Facility communication section with the Dialysis Center not completed (resident returned stable, did the resident return with paperwork, new orders, new appointment, labs to be drawn) upon the Resident's return (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dialysis Center lower portion incomplete (pulse, respiratory rate, oxygen saturation level, lung sounds, and pain level not documented) 7/5/22 -Nursing Facility communication section with the Dialysis Center not completed -Dialysis Center lower portion not completed 7/7/22 -No Dialysis Communication Form 7/9/22, 7/14/22, 7/19/22, 7/23/22, 8/13/22 -Nursing Facility communication section with the Dialysis Center not completed 7/12/22, 7/26/22, 7/30/22, 8/20/22 -No Dialysis Communication Form -Handwritten pre- and post-weights and vital signs on a separate piece of paper, unclear if Nursing Facility or Dialysis Center 7/16/22, 8/6/22, 8/23/22 -Nursing Facility upper portion incomplete -Nursing Facility communication section with the Dialysis Center not completed -Dialysis Center lower portion not completed 7/21/22, 8/2/22, 8/4/22, 8/9/22 -Nursing Facility upper portion incomplete (MD/NP and HCP/Family/Guardian aware or resident appointment, reason for transfer) -Nursing Facility communication section with the Dialysis Center not completed 8/4/22, 8/6/22 -Nursing Facility upper portion incomplete 8/11/22 -Nursing Facility upper portion not completed (resident's name, emergency or non-emergency transport, vital signs, lung sounds, pain scale, any resident concerns, any mental status change from baseline, MD/NP and HCP/Family/Guardian aware or resident appointment, reason for transfer) (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nursing Facility communication section with the Dialysis Center not completed 8/18/22 -Nursing Facility upper portion incomplete -Nursing Facility communication section with the Dialysis Center not completed -Dialysis Center lower portion incomplete During an interview on 8/24/22 at 11:05 A.M., the surveyor reviewed Resident #39's Dialysis Communication Book with Unit Manager (UM) #1. UM #1 said the forms were not completed as they should have been. He said the receiving nurse is expected to review the Dialysis Center communication upon the Resident's return and call the Dialysis Center for any missing documentation. UM #1 could not answer if that had been done. During an interview on 8/25/22 at 11:00 A.M., the Director of Nursing (DON) said the expectation is that the staff at the nursing facility complete the top part of the communication form prior to the Resident leaving for dialysis on Tuesdays, Thursdays, and Saturdays and the Dialysis Center staff complete the lower portion of the communication form prior to the Resident's return. She said the expectations were not met by the nurses and the forms were not completed as they should have been.

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Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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F 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34145

Based on interview, record review, review of employee education files, and policy review, the facility failed to:

1. Ensure 5 out of 5 staff nurses had completed training and competencies for specialized respiratory care, specifically tracheostomy care; and

2. For Resident #401, provide competent nursing care for a Resident with a tracheostomy.

Findings include:

1. According to the Board of Registration in Nursing, 244 CMR 9.00: Standards of Conduct, a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice.

Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully.

Review of the employee education files indicated the following:

a. Unit Manager #1 was hired in August 2022. Review of the education file for the nurse failed to include training and/or clinical competency in tracheostomy care.

b. Nurse #8 was hired in July 2022. Review of the education file for the nurse failed to include training and/or clinical competency in tracheostomy care.

c. Nurse #14 was hired in June 2022. Review of the education file for the nurse failed to include training and/or clinical competency in tracheostomy care.

d. Nurse #15 was hired in May 2022. Review of the education file for the nurse failed to include training and/or clinical competency in tracheostomy care.

e. Nurse #16 was hired in June 2022. Review of the education file for the nurse failed to include training and/or clinical competency in tracheostomy care.

During an interview on 8/25/22 at 11:45 A.M., the Director of Nursing (DON) said there is no staff development coordinator and she is responsible for education and competencies for Nursing staff. She said that she assesses competencies upon hire only. Review of education and competency documentation provided by the DON indicated that five of five Nursing staff did not have training and/or competency in caring for residents with a tracheostomy.

42742

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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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 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

2. Resident #401 was admitted to the facility with diagnoses including dependence on supplemental oxygen, chronic obstructive pulmonary disease (COPD) (lung disease that blocks airflow and makes it difficult to breathe), pneumonitis (inflammation of lung tissue) due to inhalation of food and vomit, acute and chronic respiratory failure with hypoxia (lack of oxygen) and hypercapnia (excessive carbon dioxide in bloodstream), emphysema (air sacs of the lungs are damaged and enlarged causing breathlessness), neoplasm (abnormal growth of tissue characteristic of cancer) of trachea, bronchus, and lung, and tracheostomy (opening/stoma created at the front of the neck so a tube can be inserted to help you breathe).

Review of the Minimum Data Set (MDS) assessment, dated 8/18/22, indicated Resident #401 had a tracheostomy and required oxygen.

During an interview on 8/18/22 at 9:20 A.M., the surveyor observed Resident #401 lying in bed receiving 2 liters (L) of oxygen via a nasal cannula (tube that splits into two prongs which are placed in the nostrils); a tracheostomy tube was in place. A suction cannister was resting on top of his/her nightstand. A spare trach and bag-valve-mask (Ambu bag to deliver manual positive pressure ventilation) was not observed at the Resident's bedside. Resident #401 said he/she had had a trach for three years secondary to his/her COPD and staff, thus far, had not needed to suction him/her since being admitted to the facility.

Review of current Physician's Orders indicated the following:

-Oxygen 2.5 L /minute continuous as needed to keep oxygen saturation above 90% every shift, order date 8/5/22

-Head of bed maintained greater than 30 degrees every shift, order date 8/19/22

-Obtain vital signs every day shift for monitoring, order date 8/5/22, start date 8/13/22

-Suction trach for increased secretions as needed, order date 8/19/22

-Trach type: [NAME] Trach size 5, uncuffed, order date 8/18/22

-Trach: Ambu bag, oxygen, suction canister and catheters in room at all times every shift

Review of the comprehensive care plan indicated Resident #401 had a care plan for a tracheostomy tube related to impaired breathing mechanics and had an uncuffed Shiley Trach-capped 4fr 5MM-LDA, initiated on 8/6/22. The goal was for Resident #401 to have clear and equal breath sounds bilaterally. Interventions including to keep a replacement trach, ambu bag, oxygen, suction canister, and catheters in the room at the bedside at all times, initiated 8/19/22, monitor/document for restlessness, agitation, confusion, increased heart rate and bradycardia, initiated 8/6/22, and suction as needed, initiated 8/6/22.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/23/22 at 1:36 P.M., Nurse #2 said she was assigned to the Resident that shift, but did not receive education since her hire date approximately one year ago to acquire the appropriate skills set and competencies to care for a Resident with a trach. She said in the event of an accidental decannulation (inadvertent removal of tracheostomy tube out of the stoma) she would try to change it, but there was not a spare in the room and was unable to answer any other emergency measures she would take. She said she had been assigned to the Resident a few times before as well without the proper training. Nurse #2 said she would not know what to do in the event of an emergency and did not know how to provide trach care including deep suctioning. She said she only knew how to orally suction. During an interview on 8/23/22 at 2:10 P.M., Unit Manager (UM) #1 said he was a Licensed Practical Nurse (LPN) and would not be providing trach care to a resident so he would not need any education or training. During an interview on 8/23/22 at 2:35 P.M., the Director of Nursing (DON) said no staff had been trained to care for a resident with a trach as long as she had been there since January 2022. Review of Nursing Progress Notes for Resident #401 indicated but was not limited to the following: 8/28/22 at 8:41 P.M. - Resident has no respiratory issues. Resident requires oxygen via nasal cannula. Resident is anxious. Resident has a tracheostomy. 8/29/22 at 7:15 A.M. - Resident was noted with difficulty breathing. O2 [oxygen] Saturation 87% 2L nasal cannula. Heart rate (HR) 121. Order to send resident out due to respiratory distress and hypoxia (oxygen deficient) in place. 8/29/22 at 8:53 A.M. - Resident was sent out to hospital secondary to hypoxia and respiratory distress. During an interview on 9/8/22 at 11:58 A.M., Nurse #16 said he worked the 11:00 P.M.-7:00 A.M. shift on Unit B on 8/28/22 and was assigned to Resident #401. He said it was the first time he was assigned to him/her and had not received education or training to care for a Resident with a trach at the facility, but he knew how from a separate facility. Nurse #16 said no one had asked him for any documentation supporting this or requested a return demonstration for competencies. Nurse #16 said he did not document his baseline findings, vital signs including respiratory rate, reassessment of the Resident's respiratory status for comparison, behavioral changes that could indicate hypoxia, the date and times he performed deep suctioning and details, any complications, or how the Resident tolerated the procedures because he was very busy then had to go.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 34145 Based on observation and interview, the facility failed to ensure Nurse staffing information posted was accurate and included the current date, total number and actual hours worked by licensed and unlicensed staff, Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nurse Aides (CNA), and the resident census as required. Findings include: On 8/18/22 at 7:35 A.M., the surveyors observed a Nurse staffing document posted in the lobby on a shelf across from the reception desk. The information on the document was as follows: Date: Thursday June 9, 2022 Census: 81 7:00 A.M. to 3:00 P.M. RN: blank, LPN: 4, CNA: 10 3:00 P.M. to 11:00 P.M. RN: 1, LPN: 4, CNA: 10 11:00 P.M. to 7:00 A.M. RN: blank, LPN: 2, CNA: 5 The inaccurate Nurse staffing document remained posted in the lobby across from the reception desk until 8/25/22. During an interview with the Administrator and Director of Nursing on 9/1/22 at 11:58 A.M., they said the Nurse staffing should be updated and posted daily.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 34145 Based on observation, interviews, and record review, the facility failed to ensure staff had the skills necessary to meet the behavioral healthcare needs of one Resident (#49), out of a sample of 22 residents. Findings include: Review of the Facility Assessment, dated as reviewed on 9/15/21, indicated the following in-services and competencies would be provided upon hire, annually, and as needed to all staff: -communication -person-centered care -caring for people with dementia, Alzheimer's, and cognitive impairment -caring for residents with mental and psychosocial disorders Resident #49 was admitted to the facility in June 2022 with diagnoses including psychosis and dementia with behaviors. On 8/19/22 at 8:42 A.M., the surveyor observed Resident #49 lying in bed yelling out help repeatedly. On 8/19/22 at 2:08 P.M., the surveyor observed Resident #49 reclined in a chair against the wall in the C unit hallway yelling out and trying to remove his/her clothing. Nurse #9 brought the Resident to his/her room, but the Resident continued to yell out unabatedly. At 2:50 P.M., the surveyor entered Resident #49's room and saw Nurse #9 standing at the Resident's bedside while the Resident continued to yell out help me, help me continuously. The surveyor asked Nurse #9 what interventions staff attempt to soothe the Residents, and he said they give him/her Morphine and Ativan. The surveyor asked what types of non-pharmacological interventions staff use to try and soothe the Resident, and he said they do not use non-pharmacological interventions. On 8/24/22 at 7:00 A.M., the surveyor observed Resident #49 lying in bed in his/her room. From 7:00 A.M. until 10:11 A.M., the surveyor heard Resident #49 yelling out help me and other repetitive vocalizations continuously. The surveyor observed no staff enter the Resident's room to interact with the Resident or otherwise implement non-pharmacological interventions to address the behavior. During an interview on 8/24/22 at 10:11 A.M., Nurse #13 said the Resident yells out all the time and has done so since he/she was admitted a few months ago. The Nurse said she just gave the Resident a full bed bath and repositioned the Resident, but it did not help. She was unable to identify any other non-pharmacological interventions in an attempt to comfort the Resident. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of employee education documents provided failed to indicate that Nurse #9 and Nurse #13 had in-servicing on communication, person-centered care, caring for people with dementia, Alzheimer's disease, and cognitive impairment, or caring for residents with mental and psychosocial disorders. During an interview on 8/25/22 at 11:45 A.M., the Director of Nursing (DON) said there is no staff development coordinator, and she is responsible for education and competencies for staff. She said she assesses competencies upon hire only. The DON confirmed that Nurse #9 and Nurse #13 did not have annual dementia training or any education on how to work with residents who demonstrated behaviors.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42742 Based on observation, interview, document review, and policy review, the facility failed to safely provide pharmaceutical services to ensure the provision of emergency medications and accurate acquiring, receiving, and dispensing of drugs to meet the needs of its residents on one (Unit B) of three units. Findings include: Review of the facility's policy titled Emergency Medications, revised April 2007, indicated but was not limited to the following: -The Pharmaceutical Services/Quality Assessment and Assurance Committee, with the input of the Consultant Pharmacist, Director of Nursing Services, and Medical Director, shall approve the contents of the emergency medication kit, and the dispensing pharmacy will stock it. -The emergency medication kit will include medications and biologicals that are essential in providing emergency treatment. - Required documentation after an emergency medication is the same as for any other medication. - Any medication that is removed from the emergency kit must be documented on the emergency medication administration log. -Medications and supplies used from the emergency medication kits must be replaced upon the next routine drug order. On 8/22/22 at 10:33 A.M., the surveyor reviewed the Unit B medication storage room with Nurse #2 and observed the following: - Insulin (regulates blood sugar levels) emergency kit (e-kit) #1 opened. Review of the Insulin Kit Usage Report document stored inside indicated that a Lantus Pen (type of insulin) had been removed for a resident on 7/26/22. The time was not documented. Review of the Emergency Kit Exchange Form, also inside the e-kit, was blank and a replacement e-kit had not yet been received, approximately one month later. -Insulin e-kit #2 opened. Review of the Insulin Kit Usage Report document stored inside indicated that a Lantus Pen and an Insulin Glargine Pen (type of insulin) had been removed for two separate residents. The document failed to indicate the date and time the medications were removed. Review of the Emergency Kit Exchange Form, also located inside the e-kit, was blank and a replacement e-kit had not yet been received by the pharmacy. -An intravenous (IV) therapy e-kit opened. Review of the Cubex Kit Usage Report attached to the e-kit did not indicate any of its contents were removed. There was no Emergency Kit Exchange Form located. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/22/22 at 10:35 A.M., Nurse #2 said the e-kits are sealed when delivered by pharmacy and, after an emergency medication is removed, the nurse is supposed to document what medications were removed including the resident's name, date of removal, time of removal, and a signature. She said the nurse would then fax the completed Emergency Kit Exchange Form to the pharmacy to receive a replacement containing all the listed emergency medications. Nurse #2 said this process was not followed and was not sure if the IV e-kit was supposed to be sealed at all. During an interview on 8/25/22 at 11:00 A.M., the Director of Nursing (DON) said all emergency kits should be sealed unless opened and, if opened, staff were required to document per policy and fax the exchange form right after to receive a replacement kit to ensure the availability of an emergency supply of medications. She said the replacement kits should have been received by the pharmacy within 24 to 72 hours of faxing the request but there was no indication replacement kits had been requested. The DON said the pharmacy had just been there two weeks ago but did not address Insulin e-kit #1 that had a known open date of 7/26/22 approximately two weeks prior.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34145 Based on record review, policy review, and staff interviews, the facility failed to ensure that for nine Residents (#1, #13, #28, #35, #49, #65, #93, #103, and #301), out of a total sample of 22 residents, that each Resident's drug regimen was free of unnecessary drugs. Specifically, the facility failed to ensure that an appropriate diagnosis was identified, targeted behaviors/signs and symptoms were monitored to evaluate the effectiveness of psychotropic medication, and/or potential side effects were identified and monitored to promote or maintain the Residents' highest practicable mental, physical, and psychosocial well-being, per the facility policy. Findings include: Review of the facility's policy titled Psychotropic Medications, dated as revised 7/2019, indicated Physicians and mid-level providers will use psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation, and monitoring. It further indicated but was not limited to the following: - the facility will make every effort to comply with state and federal regulations regarding regular review for continued need, appropriate dosage, side effects, risks, and/or benefits - the facility supports the appropriate usage of psychopharmacological medications that are therapeutic and enabling for residents suffering from mental illness - efforts to reduce dosage or discontinue psychopharmacological medications will be ongoing as appropriate - psychotropic medications include: anti-anxiety, hypnotic, antipsychotic, and antidepressant classes of drugs Review of the facility's policy titled Behavior Management, dated as revised 5/2020, indicated but was not limited to the following: - residents with a history of behavior problems shall be properly monitored by staff and the necessity of psychoactive drug usage evaluated regularly - residents should be monitored for potential side effects of psychotropic medications, these are listed on the reverse side of the behavior monthly flow record 1. Resident #1 was admitted to the facility in May 2022 with diagnoses including frontotemporal dementia, major depressive disorder, restlessness and agitation, violent behavior, and psychotic disorder. Review of the Physician's Orders indicated the following psychotropic medications: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Olanzapine (antipsychotic) 10 milligrams (mg), give 0.5 tablet one time a day for major depressive disorder (7/20/22) -Sertraline(antidepressant) 25 mg one time a day related to major depressive disorder (5/10/22) -Trazodone 100 mg, give one tablet at bedtime for insomnia (5/9/22) -Trazodone 50 mg, give 25 mg one time a day for major depressive disorder (5/10/22) -Antipsychotic medication, monitor resident behaviors for agitation every shift and record number of episodes (8/16/22) -Monitor side effects for antipsychotic use (8/16/22) -Monitor side effects with antidepressant use (8/16/22) The Physician's Order failed to include monitoring of targeted behaviors, signs/symptoms for the use of the antidepressant medication as required. Further review of the medical record failed to indicate that staff monitored targeted behaviors for the use of antidepressant medication as required. 2. Resident #13 was admitted to the facility in May 2022 diagnoses including altered mental status, depression, Alzheimer's disease, and dementia with behavioral disturbance. Review of the medical record indicated the Physician's Orders for the following psychotropic medications: -Divalproex Sodium (used to treat depression) 125 milligrams (mg), give four tablets at bedtime for depression (5/19/22). -Divalproex Sodium 250 mg, give one tablet one time a day for depression (5/19/22). -Sertraline HCl 25 mg, give one tablet one time a day for mood (5/19/22) -Trazodone HCl 150 mg, give 225 mg at bedtime for mood (5/19/22) -Monitor for side effects with antidepressant use (6/14/22) The Physician's order failed to include monitoring of targeted behaviors, signs/symptoms for the use of the antidepressant medication as required. Further review of the medical record failed to indicate that staff monitored targeted behaviors for the use of antidepressant medication as required. 3. Resident #28 was admitted to the facility in February 2020 with diagnoses including dementia with behavioral disturbance, anxiety disorder, depressive disorder, and psychosis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record indicated Physician's Orders for the following psychotropic medications: -Lexapro (antianxiety) 10 mg one time a day for anxiety (9/22/20) -Remeron (antidepressant) 45 mg, give 0.5 tablet at bedtime for depression (3/6/20) -Trazodone (antidepressant) 50 mg, give 0.5 tablet every 24 hours as needed for insomnia for 14 days (7/28/22) -Monitor side effects of antidepressant use (6/9/22) The Physician's order failed to include monitoring of targeted behaviors, signs/symptoms for the use of the antidepressant medication as required. Further review of the medical record failed to indicate that staff monitored targeted behaviors for the use of antidepressant medication as required. 4. Resident #35 was admitted to the facility in September 2020 with diagnoses including anxiety disorder, psychosis, dementia with behavioral disturbance, and paranoid personality disorder. Review of the Physician's Orders indicated the following psychotropic medications: -Remeron (antidepressant) 30 mg at bedtime for appetite stimulant (6/16/22) -Remeron 7.5 mg at bedtime for appetite stimulant (8/23/22) -Risperdal (antipsychotic) 1 mg, give 0.5 tablet in the evening for psychosis -Risperdal 0.5 mg at bedtime for dementia with behavioral disturbance (6/16/22) The Physician's order failed to include monitoring of targeted behaviors, signs/symptoms for the use of the antidepressant, and antipsychotic medication as required. Further review of the medical record failed to indicate that staff monitored targeted behaviors for the use of antidepressant medication as required. 5. Resident #49 was admitted to the facility in June 2022 with diagnoses including psychosis and dementia with behaviors. Review of the medical record indicated the following Physician's Orders for psychotropic medications: -Trazodone 50 mg, give 12.5 mg every morning for dementia with behaviors (7/1/22 - 8/1/22) -Trazodone 50 mg, give one tablet in the evening for dementia with behaviors (7/1/22 - 8/1/22) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ativan Solution (antianxiety) 2 mg/milliliters, give 0.25 ml sublingually three times a day for anxiety (7/20/22) The Physician's order failed to include monitoring of targeted behaviors, signs/symptoms for the use of the antidepressant and antianxiety medication as required. Further review of the medical record failed to indicate that staff monitored targeted behaviors for the use of antidepressant and antianxiety medication as required. 6. Resident #65 was admitted to the facility in July 2022 with diagnoses including depression and anxiety disorder. Review of the medical record indicated the following Physician's Orders for psychotropic medications: -Trazodone 50 mg at bedtime for anxiety/insomnia (7/1/22) -Citalopram Hydrobromide (antianxiety) 30 mg one time a day for depression (7/14/22) The Physician's order failed to include monitoring of targeted behaviors, signs/symptoms for the use of the antidepressant and antianxiety medication as required. Further review of the medical record failed to indicate that staff monitored targeted behaviors for the use of antidepressant and antianxiety medication as required. 7. Resident #93 was admitted to the facility in May 2022 with diagnoses including delusional disorder, Alzheimer's disease, dementia with behavioral disturbance, and both suicidal and homicidal ideations. Review of the medical record indicated the following Physician's Orders for psychotropic medications: -Haloperidol (antipsychotic) 0.5 mg, give 3 half tablets one time a day for schizophrenia (6/16/22) -Zyprexa (antipsychotic) 5 mg in the evening for schizophrenia (5/2/22) -Antipsychotic medication Haldol, monitor resident behaviors every shift and record the number of episodes (7/1/22) The Physician's order failed to include monitoring and documentation of targeted behaviors, signs/symptoms for the use of the antipsychotic medications as required. Further review of the medical record failed to indicate that staff monitored targeted behaviors for the use of Haldol as required. 8. Resident #103 was admitted to the facility in June 2022 with diagnoses including depression. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record indicated the following Physician's Orders for psychotropic medications: -Venlafaxine (antidepressant) 150 mg one time daily for depression (6/3/22) -Venlafaxine 75 mg one time daily for depression (6/3/22) The Physician's order failed to include monitoring of targeted behaviors, signs/symptoms for the use of the antidepressant medication as required. Further review of the medical record failed to indicate that staff monitored targeted behaviors for the use of antidepressant and antianxiety medication as required. 9. Resident #301 was admitted to the facility in August 2022 with diagnoses including dementia with behavioral disturbance. Review of the medical record indicated the following Physician's Orders for psychotropic medications: -Lorazepam (antianxiety) 1 mg every six hours as needed for psychosis (8/11/22, discontinued 8/29/22) -Risperidone (antipsychotic) 1 mg two times a day for anxiety/agitation (8/11/22) -Seroquel (antipsychotic) 25 mg at bedtime for anxiety (8/11/22) -Trazodone 50 mg, give 0.5 tablet every 12 hours as needed for 14 days for anxiety/agitation (8/18/22) -Trazodone 50 mg, give 0.5 tablet two times a day for anxiety/agitation (8/11/22) -Antipsychotic medication monitor resident behavior for agitation every shift and record the number of episodes (8/11/22) The Physician's order failed to include monitoring of targeted behaviors, signs/symptoms for the use of the antidepressant medication as required. Further review of the medical record failed to indicate that staff monitored targeted behaviors for the use of antidepressant medication and failed to record the number of behavior episodes observed for the use of antipsychotic medication as required. During an interview on 8/24/22 at 9:40 A.M., Nurse #9 said that staff do not monitor for behaviors for the use of psychotropic medications, they only monitor for side effects.

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NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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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. 36542 Based on interviews and record review, the facility failed to ensure one Resident (#302) remained free of significant medication errors, in a total sample of 14 residents. Specifically, Resident #302 was administered a COVID-19 bivalent booster dose without having received a primary monovalent series of the COVID-19 vaccine. Findings include: Review of the Centers for Disease Control and Preventions (CDC): Interim Clinical Considerations for Use of COVID-19 Vaccines indicated the Primary Series Vaccination for Pfizer-BioNTech was a monovalent composition and the Booster Vaccine was a bivalent composition. For primary series vaccination, three monovalent COVID-19 vaccines (listed in alphabetical order by manufacturer), are recommended: Moderna, Novavax, and Pfizer-BioNTech. Bivalent mRNA vaccines are not authorized or approved at this time for primary series doses. Review of the CDC Interim Clinical Considerations for Use of COVID-19 Vaccines: Appendix D indicated the following: -A vaccine administration error is any preventable event that may cause or lead to inappropriate use of vaccine or patient harm -Recommendations: For Bivalent vaccine incorrectly administered for the primary series; Bivalent Pfizer-BioNTech vaccine: Do not repeat dose. -Inform the recipient of the vaccine administration error -Consult with the state immunization program and/or immunization information system (IIS) to determine how the dose should be entered into the IIS, both as an administered dose and to account for inventory. -Report the error to the Vaccine Adverse Event Reporting System (VAERS), unless otherwise indicated in the table. Providers are required to report all COVID-19 vaccine administration errors-even those not associated with an adverse event-to VAERS. -Determine how the error occurred and implement strategies to prevent it from happening again. Review of the list of Residents' Vaccine Status, provided by the facility, indicated Resident #302 did not receive a primary series vaccination for COVID-19, but received a Bivalent COVID-19 vaccine booster on 10/7/22. Review of the nursing progress notes for Resident #302 included a note, dated 10/7/22, indicating the Resident received the COVID-19 booster on this day. During an interview on 10/27/22 at 9:00 A.M., the Director of Nurses said she was not aware Resident #302 had not had a COVID-19 primary series vaccine and would confirm the records. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/27/22 at 9:50 A.M., the Director of Nurses said Resident #302 had never received the COVID-19 primary series vaccine and confirmed the Resident received the COVID-19 Pfizer Bivalent booster on 10/7/22. The Director of Nurses said she was unsure if the Bivalent booster was to be administered without receiving the primary series and would follow up with the Department of Public Health (DPH) Epidemiologist. During an interview on 10/27/22 at 12:10 P.M., the Director of Nurses said the DPH Epidemiologist responded to follow the CDC Interim Clinical Considerations for Use of COVID-19 Vaccines, Appendix D for Vaccine Administration Errors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
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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. 42742 Based on observation, interview, document review, and policy review, the facility failed to ensure all medications used in the facility were safely and securely stored and labeled in accordance with currently accepted professional principles. Specifically, the facility failed to: 1. Properly label all medications stored in 3 out of 6 medication carts; 2. Maintain consistent documentation of medication refrigerator temperatures for 1 out of 3 unit medication refrigerators and report temperatures out of range; 3. Ensure staff locked 2 out of 6 medication carts when unattended; and 4. Ensure safe and locked storage of 2 out of 3 unit treatment carts when unattended. Findings include: Review of the facility's policy titled Medication-Storage, revised January 2019, indicated but was not limited to the following: -With the exception of Emergency Drug Kits, all medications will be stored in a locked cabinet, cart, or medication room that is accessible only to authorized personnel, as defined by facility policy. -Medications requiring refrigeration will be stored in a refrigerator that is maintained between 2 to 8 degrees Celsius (36-46 degrees Fahrenheit (F)). -Temperatures will be checked daily to ensure it is within the specified range. If temperature is out of range, the refrigerator thermostat will be adjusted. Review of the facility's policy titled Labeling of Medication Containers, revised April 2019, indicated but was not limited to the following: - All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations. Review of the facility's policy titled Administration of Medication Oral, Ophthalmic, or Suppository, dated August 2016, indicated but was not limited to the following: -Medication cart is always visible to the nurse or locked. -Medication keys are retained by the nurse at all times. Ophthalmic drops/ointment (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-New container will be dated and initialed when opened -Solutions and ointments must be used in 30 days, otherwise discard Review of a facility document titled Common Expiration Dates After Opening and Dating both Package and Unit, undated, indicated but was not limited to the following: -Eye medications - 28 days -Advair Diskus (bronchodilator to prevent symptoms of asthma and chronic obstructive pulmonary disease)- 30 days -Flonase (nasal spray to relieve allergic and non-allergic nasal symptoms) - 60 days -Humalog/Novolog (types of insulin to treat diabetes) - 28 days (vial and pen) -Lantus (type of insulin to treat diabetes)- 28 days (vial and pen) 1a. On 8/22/22 at 8:47 A.M., the surveyor reviewed the Unit C, high side, medication cart with Nurse #13 and observed the following: -One opened bottle of over the counter (OTC) Refresh tears inside the packaging box, not labeled with the date when opened, not labeled with the expiration date, labeled only with a resident's name -One opened bottle of OTC Artificial tears inside the packaging box, not labeled with the date when opened, not labeled with the expiration date, labeled only with a resident's name -Advair Diskus 100 micrograms (mcg)/50 mcg, not labeled when opened, not labeled with the expiration date, labeled only with a resident's name During an interview on 8/22/22 at 8:48 A.M., Nurse #13 said the bottle of Refresh tears, Artificial tears, and the Advair Diskus should have been labeled when opened, but were not. She said she thought they were only good for 30 days once opened and could not determine the date of expiration if they were not labeled when opened. Nurse #13 said she would have to dispose the medications. b. On 8/22/22 at 9:19 A.M., the surveyor reviewed the Unit C, low side, medication cart with Nurse #9 and observed the following: -One opened bottle of OTC Artificial tears inside the packaging box, not labeled with the date when opened, not labeled with the expiration date, labeled only with a resident's name -One opened tube of Erythromycin Ophthalmic Ointment 0.5% inside the packaging, not labeled with the date when opened, not labeled with the expiration date, labeled only with a resident's name -One opened bottle of Fluticasone Propionate (Flonase) 50 mcg nasal spray inside the packaging, not labeled with the date when opened, not labeled with the expiration date, labeled only with a resident's name (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One opened tube of Erythromycin Ointment 5 milligrams (mg)/gram inside the packaging, not labeled with the date when opened, not labeled with the expiration date, labeled only with a resident's name During an interview on 8/22/22 at 9:20 A.M., Nurse #9 said the medications had all been used and should have been labeled with an open date and expiration date but were not. Nurse #9 said the Artificial tears were only good for 30 days after opening but was not sure about the others. She said the Erythromycin Ophthalmic Ointment should have been removed from the medication cart as the resident was no longer at the facility. c. On 8/22/22 at 9:50 A.M., the surveyor reviewed the Unit A, medication cart A, with Nurse #11 and observed the following: -One opened bottle of OTC Artificial tears inside the packaging box, not labeled with the date when opened, not labeled with the expiration date, labeled only with a resident's name -One used vial of Insulin Glargine (type of insulin to treat diabetes), labeled with an open date of 5/03, labeled with an expiration date of 5/24, manufacture's expiration date of 8/2023 -One used vial of Lispro, not labeled with the date when opened, not labeled with an expiration date -One used Advair Diskus 500 mcg/50mcg inhaler inside the packaging box, not labeled when opened, not labeled with the expiration date, only labeled with a resident's name During an interview on 8/22/22 at 9:51 A.M., Nurse #11 said all the medications had been used and the Artificial tears were good for one year after opening but was not sure if it needed to be labeled. She said the Insulin Glargine had a labeled open date of 5/3/22 with an expiration date of 5/2024, two years later and beyond the manufacturer's expiration, and did not have a short expiration date once opened. Nurse #11 said the Lispro should have been labeled when it was opened and with an expiration date, but it was not and did not know how long it would be good for once opened. Nurse #11 said the Advair Diskus should have been labeled once opened but was not and did not know if it had a shortened expiration date once opened. During an interview on 8/25/22 at 11:00 A.M., the Director of Nursing (DON) said the medications and packaging containers should have both been labeled with the date when opened and the new expiration dates. She said the eye medications were only good for 28 days, the Advair Diskus for 30 days, and the Flonase for 60 days upon opening. She said the insulins were only good for 28 days after opening and should have been properly labeled but were not. 2. On 8/23/22 at 8:27 A.M., the surveyor reviewed the Unit C medication storage room with Nurse #13 and observed the current refrigerator temperature registered at 18 degrees Fahrenheit (F) on a free-standing thermometer on the inside top rack. Nurse #13 said the current temperature was 18 degrees F. Injectable Vitamin B12 (to raise blood levels of B12), a box of Tuberculin (used in the diagnosis of tuberculosis), Kwik Pens (insulin), and Potassium Chloride (to treat low potassium levels) were stored inside. Review of the May, June, July, and August 2022 refrigerator temperature logs with Nurse #13 indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Refrigerator needs to be at 36 degrees F to 46 degrees F (2 degrees Celsius (C) to 8 degrees C) -May 2022 - 7 out of 31 days without temperatures documented -June 2022 - 10 days below range (32-34 degrees F), 1 out of 30 days without temperatures documented -July 2022 - 11 days below range (29-34 degrees F), one day above range (60 degrees F), 3 out of 31 days without temperatures documented -August 2022 - 11 days below range (24-34 degrees F) During an interview on 8/23/22 at 8:28 A.M., Nurse #13 said the normal refrigerator temperatures should be between 36-46 degrees F, but there were multiple days where temperatures were out of range and temperatures were not consistently documented. Nurse #13 said to correct the current refrigerator temperature reading she would unplug the medication refrigerator then plug it back in and said, Maybe I should call maintenance. She said the 11:00 P.M.-7:00 A.M. shift nurse is responsible for checking and documenting the refrigerator and freezer temperatures once daily. During an interview on 8/25/22 at 11:00 A.M., the DON said the 11:00 P.M.-7:00 A.M. nurse is responsible for checking the medication refrigerator temperatures once daily, but all nurses are responsible for ensuring that it is done consistently, and temperatures are within range. She said agency staff had not been doing it. The DON said staff should have notified maintenance right away for temperatures out of range as the medications stored inside required proper temperatures to preserve their integrity. During an interview on 8/30/22 at 2:41 P.M., the Maintenance Director said he was not notified by staff that the Unit C medication refrigerator temperatures had been out of range. He said staff should have notified him right away via a text or phone call on his cellular device but they did not. 3a. On 9/1/22 at 8:12 A.M., the surveyor observed the Unit B, low side, medication cart in front of the nurses' station unlocked and unattended. During an interview on 9/2/22 at 8:16 A.M., Nurse #2 said she was assigned to the medication cart that day and it should have been locked when unattended. Nurse #2 then locked the cart, four minutes after the initial observation. During an interview on 9/1/22 at 8:45 A.M., the DON said the medication cart should have been locked when unattended. 34145 3b. On 8/19/22 at 2:08 P.M., the surveyor observed an unattended, unlocked medication cart outside of the nursing station on the C Unit (secured unit for residents with dementia). There was no nursing staff in the vicinity of the unlocked medication cart and no staff at all in any of the three unit hallways. A resident seated in a wheelchair was positioned directly across the hallway from the unlocked medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/19/22 from 2:08 P.M. to 2:42 P.M., the surveyor observed the following residents and staff walk by the unlocked medication cart: -Wandering residents on 11 occasions, -Nursing staff on six occasions, -The Director of Nursing on one occasion, -Certified Nursing Assistants on five occasions, -Activity staff on two occasions, and -Housekeeping staff on one occasion. During an interview on 8/19/22 at 2:42 P.M., the surveyor alerted Nurse #17 that the medication cart had been unlocked for nearly 20 minutes, and she said that it wasn't her cart, it was Nurse #9's. Nurse #17 did not lock the cart and walked away. The surveyor requested that the Nurse secure the cart so wandering residents and others do not have access to it. On 8/19/22 at 2:50 P.M., the surveyor observed Nurse #9 in a resident's room at the end of the Unit C hallway, approximately 50 feet from the position of the unlocked medication cart observation. Nurse #9 said that he forgot to lock the medication cart. 27189 4. On 8/31/22 at 10:02 A.M., the surveyors walked by the Unit B treatment cart and observed the cart to be unlocked. The treatment cart remained unsupervised and unlocked until 10:10 A.M., when Nurse #2 exited the resident's room. The treatment cart remained open and unattended for 8 minutes. The following prescription ointments, wound dressing supplies, sharps, etc. were observed to be stored in the treatment cart: -1-Nystatin topical powder-antifungal powder -Hydrogel wound dressing-provides a moist environment to aid in wound healing -1 Ketoconazole Cream 2%-anti fungal cream -2 tubes of Acyclovir ointment 5%-anti viral cream -1 Nystatin Ointment 100,000 Units per gram-antifungal cream -1 tube of Clobetasol Propionate Cream 0.05%-corticosteroid used to treat skin conditions such as eczema -2 Bottles of Normal Saline (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Alcohol prep pads -A box of DermaCol collagen dressing-used for wound care -A box of individual packets of Hydrocortisone Cream 1%-used to help relieve redness itching swelling or other discomfort caused by skin conditions. -A bottle containing Iodoform packing strip-Iodine impregnated gauze -Individual packets of Bacitracin Zinc Ointment-first aid ointment -A tube of lubricating jelly -A bottle of hand Sanitizer -A tube of Iodosorb (Iodine gel) -A container of Hydrogel -14 packages of Calcium Alginate (use to treat wounds) -1 Triamcinolone Acetonide Cream 0.1%-steroid cream used to treat skin disorders including eczema -A tube of Santyl ointment (prescription medicine debriding agent) -A tube of Diclofenac Sodium cream 1%-nonsteroidal anti-inflammatory used to relieve joint pain from arthritis -A box of Xeroform Petrolatum Dressing-Petroleum impregnated gauze use for wound care -A container of antibacterial wipes -2 packets of skin prep-Skin protectant During an interview on 8/31/22 at 10:10 A.M., Nurse #2 told the surveyors she knows that it is supposed to be locked. She further stated that if she locked the cart, she did not have a key to unlock it, so it is left open. During an interview on 8/31/22 at 10:12 A.M., Unit Manager #1 said we don't have a key and that is why the treatment cart remains unlocked. He further stated that the cart should have been locked. Unit Manager #1 said that Unit Manager #2 would know if and where there is a spare key, but he is on vacation and not here. He said the Director of Nursing (DON) was just informed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/31/22 at 10:16 A.M., the DON said the treatment cart should be locked when unattended and that the nurses should have a key. She said Unit Manager #2, who is on vacation, has the master set of keys. The DON was able to locate the treatment cart key and said that she will ensure the nurses have a key.

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NAME OF PROVIDER OR SUPPLIER: Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 305 Walpole Street Norwood, MA 02062	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 27189 Based on observation, staff interview, and record review, the facility failed to ensure the main kitchen and 3 of 3 kitchenettes were clean and sanitary to ensure safe food storage and service and to prevent the potential spread of foodborne illness to residents who are at high risk. Findings include: On 8/18/22 at 8:20 A.M., the surveyors made the following observations in the main kitchen: -There were mouse droppings on the windowsills. -The walls had food splatter and were dirty. -The tile floors, especially at the coving base, had a buildup of a thick black, substance on and between the tiles. -The double doors as you enter the main kitchen were gouged and the paint was chipping. -The janitor's closet had debris and mops on the floor (serve as a breeding ground for pests). -Meal trays were badly scratched and cracked. Because the trays did not have a smooth, cleanable surface they posed an infection control concern. -The Food Service Director (FSD)'s office, which also served as the dry storage room, had debris on the floor. -Cutting boards and dishware were scratched. Because the items did not have a smooth, cleanable surface they posed an infection control concern. During an interview on 8/18/22 at 8:30 A.M., the FSD said he was aware of the unsanitary condition of the kitchen, and he has been working hard to get the kitchen clean. Review of the daily cleaning schedule failed to indicate a cleaning schedule for the floors or the walls. On 8/23/22 from 11:45 A.M. to 12:30 P.M., the following observations were made by the surveyors: Nutrition Kitchenette A: -The floor adjacent to the wall coving was encrusted with a thick, black substance. The coving was not firmly affixed to the wall and was pulling away. In all four corners of the floor, scattered mouse droppings were noted. -The sink was leaking into the below cabinet where a toaster was stored. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The trash was uncovered and exposed which could potentially attract pests. -The microwave was dirty. Under the glass plate was a dried brown substance and there was scattered food debris inside the microwave. Nutrition Kitchenette B: -The floor adjacent to the wall coving was encrusted with a thick, black substance and scattered mouse droppings were noted along the perimeter of the coving throughout the area. -There were food crumbs scattered throughout the area. -There was a large hole in the wall. -The refrigerator was dirty and rusted on both sides. Nutrition Kitchenette C: -Floor adjacent to the wall was encrusted with a thick black substance and scattered mouse droppings were noted along the entire perimeter of the coving. -The second drawer of the cabinet was noted to be stained with old food/liquid and numerous mouse droppings were present in the drawer. -All surfaces inside the microwave were dirty, with a very dark brown substance under the glass plate. -The face of the cabinets had splattered food stains. During an interview on 8/23/33 at 12:45 P.M., the FSD, Administrator, and Maintenance Director toured the kitchenettes and said the kitchenettes were dirty and verified there was evidence of mice droppings present. Refer to F908 and F925

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observation, interview, and record review, the Administration failed to 1. Initiate an appropriate response to an outbreak of COVID-19 when a staff member tested positive for COVID-19 on [DATE]; and 2. Implement the facility's infection prevention and control program, including testing of staff and residents, and cohorting and quarantine measures to protect vulnerable residents during a COVID-19 outbreak. The facility's COVID-19 outbreak began on [DATE]. As of [DATE], the facility identified 5 staff members and 18 residents had tested positive for COVID-19. Five of the positive residents were sent to the hospital and one unvaccinated resident died at the facility after being exposed to their COVID-19 positive roommate. It was determined the Immediate Jeopardy began on [DATE] and was identified on [DATE]. The Department of Public Health sent a Notice of Determination of Immediate Jeopardy and the Immediate Jeopardy templates to the Facility Administrator on [DATE]. On [DATE], the Department of Public Health determined the Immediate Jeopardy was removed effective [DATE]. Findings include: 1. Review of the staff COVID-19 positive list indicated a Receptionist tested positive on [DATE] and had chills as a symptom; there was no indication of the date of symptom onset. During an interview on [DATE] at 10:28 A.M., the Infection Preventionist said she had been notified of the Receptionist testing positive for COVID-19 at an appointment, outside of the facility. The Infection Preventionist said she had been in communication with the Administrator on [DATE] and had instructed the Administrator to initiate contact tracing to see which residents and staff had contact with the Receptionist while infectious. During an interview on [DATE] at 2:55 P.M., the Administrator said she had not initiated any response (contact tracing, testing, additional monitoring of residents) when the Receptionist tested positive on [DATE]. Review of the staff testing log indicated staff testing was not initiated until [DATE], nine days after the outbreak began. 2A. Review of the facility's COVID-19 Testing Logs and Line Listings indicated the facility did not respond to the outbreak through broad-based or close contact testing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the positive residents indicated 4 residents tested positive on [DATE] (3 on the B Unit and 1 on the A Unit). The facility initiated unit based testing of the B Unit and contact tracing for the roommate (#23) of the resident on the A Unit. The facility administration did not initiate staff outbreak testing until [DATE], which identified two nurses who worked on the B Unit, tested positive for COVID-19. During an interview on [DATE] at 9:17 A.M., Resident #23 said he/she had tested negative for COVID-19, despite his/her roommate being positive and had continued to attend activities. Resident #23 tested positive for COVID-19 the evening of [DATE]. During an interview on [DATE] at 10:15 A.M., the Director of Nurses said Resident #23, who resided on the A Unit had tested positive on [DATE] and had attended activities on the A Unit prior to the positive test result. She said they had not conducted any contact tracing or unit-based testing based on this COVID-19 positive result on the A Unit. During an interview on [DATE] at 8:00 A.M., the Administrator said the Director of Rehabilitation had tested positive for COVID-19 on [DATE]. When asked what the facility response was to the positive result, the Administrator said she had not initiated any additional testing (contact tracing, broad-based) as the staff member had not worked in the previous 48 hours (since [DATE]). When the surveyor inquired about the symptoms of the staff member the Administrator said the Director of Rehabilitation had congestion which had started either [DATE] or [DATE], she was not sure. She said she did not know that a person was infectious for 48 hours prior to symptoms and not 48 hours from test date. 2B. Review of 5 sampled staff members during outbreak testing from [DATE] through [DATE] indicated the following: -Dietary Assistant was not tested during the outbreak and had worked on ,d+[DATE], ,d+[DATE], ,d+[DATE] and [DATE]. -Physical Therapy Assistant was not tested during the outbreak until [DATE] and had worked on ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], [DATE] and [DATE]. -Activity Assistant #1 was not tested during the outbreak and had worked ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], and [DATE]. Certified Nursing Assistant (CNA) #3 was not tested during the outbreak and had worked on ,d+[DATE], , d+[DATE] and [DATE]. Nurse #4 was not tested during the outbreak and had worked on ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE] and [DATE]. During an interview on [DATE] at 10:30 A.M., the Director of Nurses and the Infection Preventionist said all staff were to be tested every three days during the outbreak and they were not checking to ensure staff were being tested and had no log to demonstrate that all staff had been tested . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2C. Review of exposed residents who were unvaccinated or not up to date with the COVID-19 vaccine indicated four out of four were not isolated from their COVID-19 positive roommate following a COVID-19 negative test result on [DATE]. Review of the list of COVID-19 positive residents indicated the roommate of Resident #67 tested positive for COVID-19 on [DATE]. Review of the medical record for Resident #67 indicated the Resident was not vaccinated against COVID-19. Review of a Physician's Progress note, dated [DATE], indicated Resident #67 was exposed to COVID-19, lived with significant comorbidities, and would be considered high risk. On [DATE] at 12:02 P.M. a family member of Resident #67 was observed to walk up to the nurses' station and request to Nursing Supervisor #1 that Resident #67 be tested for COVID-19. Review of the Physician's Progress note, dated [DATE], indicated Resident #67 tested positive for COVID-19 and had cough and congestion for the past few days. On [DATE] at 12:58 P.M., the surveyor observed four Emergency Medical Technicians (EMT) arrive at the facility and go to the room of Resident #67, where CPR was in progress. At 1:19 P.M. Resident #67 was pronounced dead. Review of the list of COVID-19 positive residents indicated the roommate of Resident #302 tested positive for COVID-19 on [DATE]. Review of the medical record for Resident #302 indicated the Resident was not vaccinated against COVID-19. Resident #302 tested positive for COVID-19 on [DATE]. Review of the list of COVID-19 positive residents indicated the roommate of Resident #95 tested positive for COVID-19 on [DATE]. Review of the medical record for Resident #95 indicated the Resident was not up to date with the COVID-19 vaccine, as they did not have any booster shots. Resident #95 tested positive for COVID-19 on [DATE]. Review of the list of COVID-19 positive residents indicated the roommate of Resident #102 tested positive for COVID-19 on [DATE]. Review of the medical record for Resident #102 indicated the Resident was not up to date with the COVID-19 vaccine, as they had not received the second recommended booster for their age group. Resident #102 tested positive for COVID-19 on [DATE]. During an interview on [DATE] at 2:55 P.M., the Administrator said she had made the decision to not move roommates who were residing with residents who had tested positive for COVID-19 because there were only 9 open beds in the facility. She said the vaccination status of the exposed residents did not play a role in her decision and had not been considered. She said she had checked with the Infection Preventionist on [DATE] and at the start of the outbreak the facility did not have any residents who were recovered from COVID-19 within the last 90 days. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the medical records for 22 sampled residents indicated 1 out of 22 sampled residents was recovered from COVID-19 in the previous 90 days. The medical record for Resident #60 indicated Resident #60 had tested positive for COVID-19 during a hospital stay on [DATE] (77 days before the outbreak). Refer to F880 and F886

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 34145 Based on review of the Facility Assessment and interviews, the facility failed to conduct and document a facility wide assessment that accurately reflected the resources necessary to care for its residents. Specifically, the facility failed to: 1. Complete a Facility Assessment which accurately reflected the average daily census; 2. Identify the utilization of agency/temporary staff; 3. Conduct staff training and competencies of nursing staff; 4. Ensure that the Facility Assessment identified the facility would accept residents with specialized respiratory care, specifically for the care and treatment of a tracheostomy and have competent staff to provide the care; 5. Include contracts, memorandums of understanding, or other agreements with third parties that provide services or equipment to the facility during both normal operations and emergencies; and 6. Include a facility-based and community-based risk assessment, utilizing an all-hazards approach. Findings include: The Facility Assessment should be reviewed and updated whenever there is, or the facility plans for, any change that would require a substantial modification to any part of its assessment. 1. Review of the Facility Assessment, dated 9/15/21, indicated the facility had 124 licensed beds with an average daily census of 53 residents. The resident census on 8/18/22 was 106. 2. The Facility Assessment Tool failed to indicate the facility utilized agency staff in the provision of care for their Residents. During an interview on 8/18/22 at 8:28 A.M., the Administrator said the facility utilizes staff from contracted nurse staffing agencies on a regular basis. 3. The Facility Assessment Tool indicated the facility conducted staff training/education and competencies that are necessary to provide the level and types of support and care needed for the resident population (on hire and annually) including person-centered care, activities of daily living, disaster planning, medication administration, measurements-vitals and intake and output, resident assessment, caring with residents with dementia, Alzheimer's and cognitive impairments, caring for residents with mental and psychosocial disorders, non-pharmacological management of responsive behaviors and clinical competencies. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/25/22 at 11:45 A.M., the Director of Nursing (DON) said they do not have a Staff Development Coordinator (SDC) and she is responsible for education and staff competencies. The DON said she does education and competencies for staff upon hire only, not annually as indicated on the Facility Assessment. 4. The Facility Assessment Tool failed to identify that staff provided respiratory treatments including tracheostomy care. Review of the Matrix for Providers indicated Resident #401 received tracheostomy care at the facility. During interviews on 8/23/22 at 2:35 P.M. and 8/31/22 at 2:52 P.M., the Director of Nursing (DON) said no staff had been trained to care for a resident with a tracheostomy as long as she had been there since January 2022 and the facility failed to provide proper care and treatment for Resident #401's tracheostomy as per professional standards of practice for a tracheostomy. 5. The Facility Assessment Tool failed to include contracts, memorandums of understanding, or other agreements with third parties that identify providers of services or equipment to the facility including, but not limited to pharmacy, laboratory services, behavioral health, podiatry, audiology, dental, optometry, and medical transportation. 6. The Facility Assessment Tool failed to include a facility-based and community-based risk assessment, utilizing an all-hazards approach as required. During interviews on 8/18/22 at 8:28 A.M. and 9/1/22 at 11:58 A.M., the Administrator said the Facility Assessment does not include the required components and does not reflect the status of the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 36542 Based on record review and staff interview, the facility failed to maintain medical records that are complete, accurate, and systemically organized within accepted professional standards of practice for one Resident (#60), out of a total sample of 22 residents. Findings include: Resident #60 was admitted to the facility in July 2022. Review of the medical record indicated on 8/1/22 the physician completed a Documentation of Resident Incapacity Pursuant to Massachusetts Health Care Proxy Act, which indicated Resident #60 was no longer able to make health care decisions and decisions would be made by the designated Health Care Proxy. Review of the paper and electronic medical record failed to include a Health Care Proxy. During an interview on 8/26/22 at 10:05 A.M., Nurse #1 said the brother of Resident #60 was the Health Care Proxy and the Health Care Proxy form was missing from the medical record. In addition, she said she had completed the Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) form with the brother who had requested Resident #60 not be resuscitated. Nurse #1 and the surveyor were unable to locate the signed MOLST form in the medical record. During an interview on 8/26/22 at 11:05 A.M., the Social Worker said he had to contact the hospital to obtain the Health Care Proxy for Resident #60 as it was not in the facility. He said he was not sure what happened to the MOLST form and why it was not in the medical record.

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NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 34145 Based on record review and interview, the facility failed to ensure that services were coordinated with the Hospice provider to implement the resident's plan of care as required in the provider contract agreement for one Resident (#93), out of a total sample of 22 residents. Findings include: Review of the facility and elected Hospice Care Services Agreements, signed April 26, 2022, indicated the Hospice provider shall develop, at the time of admission, a Nursing Facility Plan of Care. The Hospice Plan of Care is a document which will provide a detailed description of the scope and frequency of hospice services, and who will provide those services. The Hospice Interdisciplinary Group (IDG) will document their care and services provided at each visit to the hospice patient. Documentation is placed in the Nursing Facility's patient chart; a copy shall be maintained in the Hospice medical record. Review of the facility's Hospice policy, dated 5/2016, included but was not limited to: -Communicate, establish, and agree upon a coordinated Interdisciplinary Plan of Care (IPOC) -Identify the care and services, which the facility and Hospice will provide, in order to be responsive to the individual needs of the resident -Document in the IPOC the services that Hospice will be responsible for, for coordination of care -The facility retains overall professional management and responsibility for implementation of the IPOC Resident #93 was admitted to the facility in May 2022 with diagnoses including chronic obstructive pulmonary disease and Alzheimer's disease. Review of Resident #93's medical record indicated a Physician's order for Hospice services dated 7/14/22. Review of the Resident's Hospice binder contained an Admission Consent form, a Consent for election of Medicare/Medicaid Hospice benefits, and a Consent to Share Health Information/Confidential Communication Acknowledgement form. The following tabbed sections in the binder were empty: Care Plan, Health Aide, Skilled Nursing, Social Services, Spiritual, Miscellaneous. Review of the medical record indicated an Interdisciplinary Care Plan for Hospice that included but was not limited to: Focus: I have been admitted to the care of Hospice after discussion with my caregivers, physicians and family. (5/3/22) (continued on next page)

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	225208	A. Building B. Wing	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: -All care should be coordinated between my doctors, Hospice, and this nursing home to keep me comfortable (5/3/22) -For certification period beginning 7/31/22: -Skilled Nursing: 1-2 visits a week for 8 weeks; 8 as needed visits for change in condition -Medical Social Services: 1-2 visits a month for 2 months -Aide: 3 visits a week for 8 weeks -Chaplin: 1-2 visits a month for 2 months Further review of the medical record failed to indicate skilled nursing visits, Home Health Aide visits, Social Work visits, and Chaplain visits were conducted as indicated on the Plan of Care. During an interview on 8/23/22 at 9:50 A.M., the surveyor reviewed Resident #93's medical record and Hospice binder with Nurse #9. The Nurse said he did not know where any Hospice documentation was, could not identify the Hospice plan of care, and was unable to locate any evidence that the Hospice provider had implemented Resident #93's Hospice plan of care. He said there was no Hospice schedule on the unit to indicate when Hospice staff (Nursing, Aides, Social Work, Clergy) come into the facility to provide care and services to Resident #93.

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NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 34145 Based on interview and policy review, the facility failed to develop a Quality Assurance and Performance Improvement (QAPI) plan that describes their approach to improving the quality of life, care, and services to residents in the facility. Findings include: A review of the facility's QAPI policy, dated 9/2016, indicated the facility's QAPI plan serves to accomplish the following: -Assure care and services are provided in accordance with standards and regulations; -Identify and solve problems using a team-centered approach that includes input from all departments and stakeholders (resident, families, physicians, staff, Ombudsman and regulatory agencies) involved; -Enhance interdepartmental communication and teamwork by having leaders participate in cross-department Performance Improvement Project activities when analyzing problems, identifying solutions and assessing outcomes; -Continuously improve resident outcomes; -Establish a culture of resident safety; -Establish a culture of continual learning; and -Establish goals that are specific, measurable, attainable, relevant and time-lined. The facility experienced a COVID-19 outbreak on 8/10/22. The Administrator could not produce any QAPI projects, infection control meeting sign in sheets, education, or information regarding a plan to prevent further spread of the virus. During the survey from 8/18/22 to 9/1/22, additional COVID-19 cases were identified. During interviews on 8/23/22 at 12:25 P.M. and 9/1/22 at 11:58 A.M., the Administrator said that when she started at the facility in January 2022, there was no QAPI plan, and they still do not have one. The Administrator failed to indicate that infection control practices including, but not limited to staff and visitor screening, the use of personal protective equipment (PPE), outbreak management, and testing requirements identified during the survey had been addressed and reviewed by the QAPI Committee during the COVID-19 pandemic.

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	225208	A. Building B. Wing	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34145 Based on record review and interviews, the facility failed to define, implement, and maintain a comprehensive quality assurance and performance improvement (QAPI) plan to address the full range of care and services provided by the facility, including infection control practices during the COVID-19 pandemic. Findings include: Review of the facility's policy titled Quality Assurance Performance Improvement, dated September 2016, indicated the facility's QAPI program is a proactive approach to improving the quality of life, care, and services in the nursing home. The Administrator has to implement and maintain an ongoing QAPI Committee designed to monitor and evaluate the quality of resident care/services, pursue methods to improve quality care, and to identify and resolve problems, issues, concerns through: -Designating one or more persons to be accountable for Performance Improvement (Committee Chair) -Ensuring adequate leadership and staff training; and -Establishing policies to sustain the program regardless of personnel changes and staff turnover. During interviews on 8/23/22 at 12:25 P.M. and 9/1/22 at 11:58 A.M., the Administrator said that when she started at the facility in January 2022, no one knew how to develop a QAPI plan and how to identify areas for performance improvement. She said she has been doing a QAPI on QAPI and educating the committee members and there are no current performance improvement projects currently in place. The Administrator failed to indicate that infection control practices including, but not limited to staff and visitor screening, the use of personal protective equipment (PPE), outbreak management, and testing requirements identified during the survey had been addressed and reviewed by the QAPI Committee during the COVID-19 pandemic.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 34145 Based on policy review and interview, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) committee that included the required members at their meetings. Findings include: Review of the facility's policy titled, Quality Assurance and Performance Improvement, dated 9/2016, included, but was not limited to: -The facility's QAPI program is a proactive approach to improving the quality of life, care, and services in nursing home. -The QAPI Committee meets monthly and consists of the following individuals: -Administrator -Medical Director -Director of Nursing -Assistant Director of Nursing -1-2 front line staff (optional) -Dietician -Food Services Manager -Admissions Director -Staff Education/IC/Quality Assurance Nurse -Directors of Social Services, Activities, Rehabilitation, Environmental Services, Maintenance -Consultant Pharmacist (notify prior to meetings) Quarterly QAPI: -A quarterly QAPI will be held with the regional and/or divisional level to review and identify trends within the company. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of QAPI attendance sign-in sheets indicated the following required members were not in attendance: -3/30/22 (monthly): Admissions Director, Staff Education/IC/Quality Assurance Nurse, Director of Social Services, Activities, Environmental Services, consultant Pharmacist. -4/28/22 (quarterly): Dietician, Food Service Manager, Admissions Director, Staff Education/IC/Quality Assurance Nurse, Environmental Services, consultant Pharmacist, no regional and /or divisional staff. -5/25/22 (monthly): Director of Nursing, Dietician, Admissions Director, Staff Education/IC/Quality Assurance Nurse, Director of Social Services, Activities, consultant Pharmacist. -6/30/22 (monthly): Medical Director or designee, Dietician, Food Service Manager, Staff Education/IC/Quality Assurance Nurse, consultant Pharmacist. -7/27/22 (quarterly): Medical Director or designee, Food Service Manager, Admissions Director, Staff Education/IC/Quality Assurance Nurse, Director of Rehab, Environmental Services, Maintenance, consultant Pharmacist, no regional and /or divisional staff During an interview on 9/1/22 at 11:58 A.M., the surveyor and Administrator reviewed the QAPI committee policy and the March 2022 through July 2022 attendance sign-in sheets. She said she needs to work on educating staff and consultants on QAPI and encourage meeting attendance.

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NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections, including COVID-19. Specifically, the facility failed to 1. Identify and respond to an outbreak of COVID-19 on [DATE]; 2. Ensure staff implemented infection prevention and control practices including: a. Cohorting residents during an outbreak, including those who were not up to date with the COVID-19 vaccine, and b. Utilizing the appropriate personal protective equipment (PPE) between the care of COVID-19 positive residents and COVID-19 negative residents, including those residents who were not up to date with the COVID-19 vaccine; and 3. Implement and utilize a system of surveillance for residents and staff positive for COVID-19. The facility COVID-19 outbreak began on [DATE]. As of [DATE], the facility identified 5 staff and 18 residents positive for COVID-19. Five residents were sent to the hospital and one unvaccinated resident died at the facility after being exposed to their COVID-19 positive roommate. It was determined the Immediate Jeopardy began on [DATE] and was identified on [DATE]. The Department of Public Health sent a Notice of Determination of Immediate Jeopardy and the Immediate Jeopardy templates to the Facility Administrator on [DATE]. On [DATE], the Department of Public Health determined the Immediate Jeopardy was removed effective [DATE]. In addition to the residents in Immediate Jeopardy, non-compliance at F880 continued at a lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility also failed to 4. Ensure staff and residents wore appropriate PPE and implemented enhanced PPE precautions for residents not up to date with their COVID-19 vaccine during a current COVID-19 outbreak on all three units; 5. Ensure staff maintained proper hand hygiene and PPE use during the medication pass; 6. For Residents #76, #78 and #92, ensure staff maintained proper infection control during a dressing change; and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER: Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 305 Walpole Street Norwood, MA 02062	

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F 0880

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

7. Ensure proper signage was posted at the front entrance notifying staff and visitors of PPE needed to be worn, and ensure dialysis transportation personnel entering the building performed proper hand hygiene and wore appropriate PPE prior to attending to a Resident.

Findings include:

1. Review of the Centers for Medicare & Medicaid Services (CMS) Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, revised [DATE] indicated the following:

-A new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident triggers an outbreak investigation. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission.

-Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g., facility-wide) testing.

Review of the staff COVID-19 positive list indicated a Receptionist tested positive on [DATE] and had chills as a symptom, there was no indication of the date of symptom onset.

Review of the Timecard Report for the Receptionist indicated she had worked on [DATE] and [DATE]. Therefore, the Receptionist was infectious 48 hours prior to testing positive or symptom onset (whichever was first).

During an interview on [DATE] at 10:28 A.M., the Infection Preventionist said she had been notified of the Receptionist testing positive for COVID-19 at an appointment, outside of the facility. She said she had been in communication with the Administrator on [DATE] and had instructed the Administrator to initiate contact tracing to see which residents and staff had contact with the receptionist while infectious.

During an interview on [DATE] at 10:30 A.M. with the Director of Nurses and the Infection Preventionist, the Director of Nurses said she had been on vacation on [DATE]. The Infection Preventionist said she worked off-site and was available to all staff to coordinate infection control. The DON and the Infection Preventionist said the Administrator would have been responsible for implementing and facilitating any response to the outbreak.

During the interview, the Infection Preventionist said the facility had conducted contact tracing when Resident #71 tested positive for COVID-19 on [DATE]. The facility determined the close contacts of Resident #71 were the other residents who congregated with Resident #71 in the Solarium, a sitting area off of the reception area. The Infection Preventionist and the Director of Nurses said they had not taken into consideration that the residents who congregated in the Solarium were close contacts with the receptionist who had tested positive on [DATE].

During an interview on [DATE] at 2:55 P.M., the Administrator said she had not initiated any response (contact tracing, testing, additional monitoring of residents) when the Receptionist tested positive on [DATE].

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 10:29 A.M., the Director of Nurses (DON) said a COVID-19 outbreak had initiated when a resident tested positive on [DATE]. 2. Review of the Centers for Disease Control and Prevention Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, updated February 2, 2022, indicated: -Residents who are not up to date with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator). Review of the facility's policy titled Isolation- Room Placement, dated as revised [DATE], indicated the facility would care for residents in accordance with guidelines as defined by the Centers for Disease Control and Prevention (CDC) and Federal and State Health Care Regulations. In addition, the policy indicated: -Exposed residents who are not recovered and/or are not up to date should be quarantined for 10 days and placed in a private room. If a private room is not available, they can cohort with another exposed resident with no active symptoms if exposure is within 3 days of each other. During an interview on [DATE] at 3:30 P.M., the Administrator said the facility followed guidance from the Massachusetts Department of Public Health but had been unable to update specifics to their facility's policies due to a change in ownership and provided the surveyor with the guidance from [DATE]. Review of the Massachusetts Department of Public Health memorandum Update to Caring for Long-Term Care Residents during the COVID-19 Response, including Visitation Conditions, Communal Dining, and Congregate Activities, dated [DATE] indicated: -Residents who are a close contact of a case of COVID-19 and are not recovered from COVID-19 in the last 90 days or up to date with COVID-19 vaccine, should be placed in quarantine in a private room or, if unavailable, in a room with another resident who is recovered from COVID-19 in the last 90 days or up to date with COVID-19 vaccine. -Residents who are symptomatic should be placed in isolation in a private room or, if unavailable, in a room with another resident who is recovered from COVID-19 in the last 90 days or up to date with COVID-19 vaccine. The long-term care facility should follow up with the resident's provider for next steps. A1. Resident #67 was admitted to the facility in [DATE] with diagnoses including a pleural effusion, pancreatitis, and congestive heart failure. Review of the list of COVID-19 positive residents indicated the roommate of Resident #67 tested positive for COVID-19 on [DATE]. Review of the medical record for Resident #67 indicated the Resident was not vaccinated against COVID-19. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of a Physician's Progress note, dated [DATE], indicated Resident #67 was exposed to COVID-19, lived with significant comorbidities, and would be considered high risk. On [DATE] at 12:02 P.M., the surveyor observed a family member of Resident #67 walk up to the nurses' station and request to Nursing Supervisor #1 that Resident #67 be tested for COVID-19. Review of the Physician's Progress note, dated [DATE], indicated Resident #67 tested positive for COVID-19 and had cough and congestion for the past few days. Review of the paper and electronic medical record indicated the first monitoring for signs or symptoms of COVID-19 was initiated on [DATE] (4 days after their roommate tested positive for COVID-19) with an order to monitor for runny nose, chest congestion, increased shortness of breath, confusion, sore throat, muscle pain, nausea, vomiting, loose stool, headache, loss of taste or smell, or fever. The order is checked off for the night shift on [DATE] as monitored by the nurse, with no indication of whether any of the symptoms were present. On [DATE] at 12:58 P.M., the surveyor observed four Emergency Medical Technicians (EMT) arrive at the facility and go to the room of Resident #67, where CPR was in progress. At 1:19 P.M. Resident #67 was pronounced dead. A2. Resident #302 was admitted to the facility in [DATE]. Review of the list of COVID-19 positive residents indicated the roommate of Resident #302 tested positive for COVID-19 on [DATE]. Review of the medical record for Resident #302 indicated the Resident was not vaccinated against COVID-19. Review of the paper and electronic medical record indicated the first monitoring for signs or symptoms of COVID-19 was initiated on [DATE] (9 days after the roommate tested positive) with an order to monitor for runny nose, chest congestion, increased shortness of breath, confusion, sore throat, muscle pain, nausea, vomiting, loose stool, headache, loss of taste or smell, or fever. Resident #302 tested positive for COVID-19 on [DATE]. A3. Resident #95 was admitted to the facility in [DATE]. Review of the list of COVID-19 positive residents indicated the roommate of Resident #95 tested positive for COVID-19 on [DATE]. Review of the medical record for Resident #95 indicated the Resident was not up to date with the COVID-19 vaccine, as they had not received any booster shots. Review of the paper and electronic medical record indicated the first monitoring for signs or symptoms of COVID-19 was initiated on [DATE] (3 days after the roommate tested positive) with an order to monitor for runny nose, chest congestion, increased shortness of breath, confusion, sore throat, muscle pain, nausea, vomiting, loose stool, headache, loss of taste or smell, or fever. Resident #95 tested positive for COVID-19 on [DATE]. A4. Resident #102 was admitted to the facility in [DATE]. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the list of COVID-19 positive residents indicated the roommate of Resident #102 tested positive for COVID-19 on [DATE]. Review of the medical record for Resident #102 indicated the Resident was not up to date with the COVID-19 vaccine, as he/she had not received the second recommended booster for their age group. Resident #102 tested positive for COVID-19 on [DATE]. During an interview on [DATE] at 2:55 P.M., the Administrator said she had made the decision to not move roommates who were residing with residents who had tested positive for COVID-19 because there were only nine open beds in the facility. She said the vaccination status of the exposed residents did not play a role in her decision and had not been considered. She said she had checked with the Infection Preventionist on [DATE] and at the start of the outbreak the facility did not have any residents who were recovered from COVID-19 within the last 90 days. Review of the medical records for 22 sampled residents indicated 1 out of 22 sampled residents was recovered from COVID-19 in the previous 90 days. The medical record for Resident #60 indicated Resident #60 had tested positive for COVID-19 during a hospital stay on [DATE] (77 days before the outbreak). B. Review of the Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, revised on February 2, 2022, indicated: -HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Review of the facility policy titled: PPE-COVID, updated [DATE], indicated for confirmed, suspected, or exposed residents: - eliminate the practice of re-use of N95 respirators. N95 respirators should be discarded after doffing, such as when leaving a patient room - if reusable goggles or face shields are used ensure the appropriate cleaning and disinfection between uses Review of the facility policy titled: COVID-19 Outbreak Management, updated [DATE], indicated to avoid floating staff between units, to cohort residents with COVID-19 with dedicated Health Care Personnel (HCP) and other direct care providers. Review of the Isolation/droplet precautions sign indicated all staff entering these rooms were to don an N95 respirator, eye protection, gown, and gloves. During an interview on [DATE] at 11:00 A.M., the Director of Nurses said that as of [DATE] the CNA assignments on Unit B were changed. She said CNAs would not have a mix of COVID-19 negative and COVID-19 positive residents on their assignments to provide dedicated staff to care for the residents with known COVID-19 and the staff were no longer floating between units. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 11:54 A.M., the surveyor observed CNA #9 and CNA #4 boosting Resident #302 (who was exposed to COVID-19 and on transmission-based precautions) and adjusting his/her bed linens. CNA #9 was not wearing a gown or eye protection and was wearing a surgical mask, not an N95 face mask. CNA #4 was not wearing a gown or eye protection. An isolation sign was posted outside the room indicating full PPE was required prior to entering the room consisting of eye protection (goggles or face shield), N95 mask, gown, and gloves. During an interview on [DATE] at 11:57 A.M., CNA #9 said she should have worn a gown and eye protection prior to entering the room. She said she wore a surgical mask instead of an N95 face mask because the N95s did not fit her. CNA #4 said he should have worn a gown and eye protection prior to entering the room. On [DATE] at 12:31 P.M., the surveyor observed CNA #1 enter the room and approach Resident #47, who tested positive for COVID-19 on [DATE]. The CNA was observed to only be wearing an N95 mask and eye protection. When exiting the room, the CNA was asked if she knew Resident #47 was COVID-19 positive, she said she did, but thought she did not have to put on a gown or gloves unless she was providing care to the Resident. CNA #1 said she was assigned to care for Resident #47 as well as other residents on the unit who were COVID-19 negative. A later review of staff COVID-19 positive cases indicated CNA #1 tested positive for COVID-19 on [DATE]. On [DATE] at 4:32 P.M., the surveyor observed Nurse #3 in the room with Resident #29, who tested positive for COVID-19 on [DATE]. There was a droplet precaution sign observed on the doorway to this room. Nurse #3 was observed to be wearing an N95 mask and eye protection but was not wearing a gown or gloves. Nurse #3 was observed to exit the room, without performing hand hygiene or doffing the N95 or eye protection, walk down the hallway and take the vital machine caddy to the room of Resident #76, who was negative for COVID-19. Nurse #3 was observed to put on gloves, still had not performed hand hygiene, and use the vital machine to take the blood pressure and oxygen level of Resident #76, while wearing the same eye protection and mask from the encounter with a COVID-19 positive resident (#29). During an interview on [DATE] at 4:45 P.M., Resident #29 said Nurse #3 had been administering medications to him/her during the previous observation. The Resident said he/she was still testing positive for COVID-19 and that was why they were still on isolation precautions. On [DATE] at 4:49 P.M., the surveyor observed Certified Nursing Assistant (CNA)# 3 and CNA #6 exiting the room of Resident #302. Resident #302 tested positive for COVID-19 on [DATE] and a droplet precaution sign was observed on the door of the room. CNA #3 was observed to remove a gown and gloves, did not perform hand hygiene, walk down the hall, push the linen cart towards the room, and then perform hand hygiene. During an interview on [DATE] at 4:50 P.M. CNA #3 said she and CNA #6 had been providing care to Resident #302. Then, upon exiting the room of Resident #302, the surveyor observed CNA #3 and CNA #6 not doff (remove) their N95 mask or eye protection and go to the next resident to provide care. CNA #3 and CNA #6 were then observed to assist Resident #30, who was COVID-19 negative, to the bathroom. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 7:45 A.M., the surveyor observed CNA #6 in the room with Resident #40, who tested positive for COVID-19 on [DATE]. An isolation sign was posted outside the room indicating full PPE was required prior to entering the room consisting of eye protection (goggles or face shield), N95 mask, gown, and gloves. CNA #6 was observed to be wearing an N95 mask, a gown, and gloves and was not wearing eye protection. During an interview on [DATE] at 7:46 A.M. CNA #6 said he had been washing the resident and was not aware it was an isolation room because he had been on vacation. CNA #6 said he had not gotten report yet that day of what residents were positive for COVID-19 on the unit and did not see the isolation sign indicating the required PPE. He said he should have worn eye protection but did not. On [DATE] at 6:55 A.M., the surveyor observed CNA #8 and CNA #7 with Resident #402, who was exposed to COVID-19 and was on transmission-based precautions. CNA #8 was wearing personal eyeglasses without a face shield or goggles. CNA #7 doffed his PPE when exiting the room without performing hand hygiene afterwards. CNA #7 then walked down the hall, put on gloves without performing hand hygiene and entered the room of Resident #37, who tested positive for COVID-19 on [DATE], without donning (putting on) a gown. During an interview with CNA #7 and CNA #8 on [DATE] at 7:10 A.M., CNA #8 said she should have been wearing eye protection, but did not, and personal eyeglasses were not a form of PPE. CNA #7 said he should have worn full PPE to enter an isolation room including a gown but did not wear one because he needed to help CNA #8 boost a resident. He said he should have performed hand hygiene after doffing his PPE and prior to entering another resident's room. On [DATE] at 3:20 P.M., the surveyor observed Nurse #5 enter the room of Resident #94 and Resident #302, which had a droplet precaution sign, indicating to wear a gown, gloves, eye protection and N95, on the door. Nurse #5 was observed to be wearing an N95 mask and eye protection. She did not don a gown or gloves prior to entering the room. When she was exiting the room, she said both residents were positive for COVID-19 and because she did not provide care to them, she did not put on a gown or gloves. She said her nursing assignment for the evening shift consisted of COVID-19 positive and COVID-19 negative residents. During an interview on [DATE] at 10:58 A.M., the Infection Preventionist said staff entering the room of a COVID-19 positive or an exposed resident were to wear an N95, eye protection, gown and gloves. Upon exiting the room, the staff should discard everything, except the eye protection which can be disinfected and put on a new N95 to wear with the disinfected eye protection on the unit. She said the facility was not in crisis capacity and was not re-using N95 masks after an encounter with a COVID-19 positive or exposed resident. Review of the facility's policy titled: COVID-19 Outbreak Management, updated [DATE], indicated to avoid floating staff between units, to cohort residents with COVID-19 with dedicated Health Care Personnel (HCP) and other direct care providers. Review of the facility schedule indicated CNA#4 worked on Unit B, which as of [DATE] had 16 COVID-19 positive residents on [DATE] and [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation with interview on [DATE] at 11:00 A.M., the surveyor observed CNA #4 working on Unit C, which had no COVID-19 positive cases at that time. CNA#4 said he had started working/ orienting at the facility the previous week and had been assigned to work on the C unit on [DATE]. During an interview on [DATE] at 3:30 P.M., the scheduler said CNA #4 was new and did not have an assigned unit, so had not thought about which units he had or had not worked on or considered if he had worked with COVID-19 positive residents. 3. Review of the facility policy titled: COVID-19 Outbreak Management, revised [DATE], indicated pertinent information regarding each resident and employee case should be entered into the surveillance log and updated daily. Once an outbreak has been identified, cases should be placed on a line list. Review of the facility policy titled: COVID-19 Resident Testing, revised [DATE], indicated documentation of testing included the date and times of identification of signs or symptoms. During the entrance conference on [DATE] at 9:30 A.M., the surveyors requested a list of resident cases of confirmed COVID-19 over the last four weeks to include if the resident was hospitalized or died . The line list was provided on [DATE] at 9:00 A.M. A. Review of the COVID-19 positive Resident Line Listing failed to include Resident #71 (tested positive [DATE]) and failed to include Resident #67, who tested positive for COVID-19 on [DATE], experienced respiratory failure, and expired on [DATE]. The line list did not indicate hospitalization s or deaths. The line list category for symptoms only indicated symptoms or no symptoms and did not indicate what the symptoms were or when they started. During an interview on [DATE] at 12:15 P.M., the Director of Nurses said she did not know Resident #67 had tested positive for COVID-19 and she was not sure why Resident #71 was not on the line listing. An updated line listing was provided to the surveyor on [DATE] at 2:10 P.M. and included 18 COVID-19 positive residents. A review of the line listing indicated the following: -Resident #71 tested positive for COVID-19 on [DATE] and had no symptoms. Review of the medical record for Resident #71 and the hospital discharge summary indicated Resident #71 was sent to the hospital with shortness of breath and oxygen saturation at 80%. -Resident #94 tested positive for COVID-19 on [DATE] and had symptoms. Review of the medical record indicated an order for symptom monitoring was not initiated until [DATE], 9 days after the COVID-19 positive test result. -Resident #29 tested positive for COVID-19 on [DATE] (review of the medical record indicated this date was incorrect and the resident tested positive on [DATE]) and had no symptoms. Review of the medical record indicated Resident #29 went to the hospital on [DATE] with hypoxia (low oxygen levels) and change in condition. Resident #29 was treated at the hospital with an antiviral treatment for COVID-19. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-Resident #101 tested positive for COVID-19 on [DATE] and had no symptoms. Review of the medical record indicated Resident #101 went to the hospital on [DATE] following a fall related to weakness. Review of the hospital discharge summary indicated the family was with Resident on [DATE] and the Resident had a cough. Review of a Nursing Progress note, dated [DATE], indicated the resident continued with a moist, non-productive cough. -Resident #92 tested positive for COVID-19 on [DATE] and had no symptoms. Review of the medical record indicated Resident #92 had a cough on [DATE] and was experiencing symptoms on [DATE]. -Resident #87 tested positive for COVID-19 on [DATE] and had no symptoms. Review of the medical record indicated Resident #87 had an occasional cough on ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE]. An order was initiated on [DATE] for cough medicine and for an antiviral therapy for five days. -Resident #5 tested positive for COVID-19 on [DATE] and had no symptoms. Review of the medical record indicated Resident #5 had a cough on [DATE] and a change in mental status on [DATE]. -Resident #32 tested positive for COVID-19 on [DATE] and had no symptoms. Review of the medical record indicated Resident #32 had a cough on [DATE]. An order for symptom monitoring was not initiated until [DATE], 8 days after the COVID-19 positive test result. -Resident #7 tested positive for COVID-19 on [DATE] and had no symptoms. Review of the medical record indicated Resident #7 had a cough on [DATE] and [DATE]. An order for symptom monitoring was not initiated until [DATE], 8 days after the COVID-19 positive test result. -Resident #37 tested positive for COVID-19 on [DATE] and had no symptoms. Review of the medical record indicated Resident #37 was tested on [DATE] related to a sore throat. During an interview on [DATE] at 9:19 A.M., the Infection Preventionist said she works off-site and is at the facility about once per month. She said in order to update the resident line listing she reads the nursing progress notes to determine if a resident has symptoms. She said she does not monitor symptom start date or type of symptoms on the line list. B. Review of the CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, updated [DATE], indicated: -Determining the time period when the patient, visitor, or HCP with confirmed SARS-CoV-2 infection could have been infectious: For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 2 days before symptom onset through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions. For individuals with confirmed SARS-CoV-2 infection who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with SARS-CoV-2 infection may have been exposed could help inform the period when they were infectious. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 10:15 A.M. the surveyor received a list of three staff (two nurses and one CNA) who had tested positive for COVID-19 with no symptoms listed. At this time, the surveyor requested the Staff COVID-19 Line Listing for the past four weeks to include positive test dates, positions, and symptoms. On [DATE] at 10:15 A.M., the Director of Nurses provided the surveyor with a list of five staff who had tested positive for COVID-19. The line listing indicated the following: -Receptionist tested positive for COVID-19 on [DATE] with symptoms of chills. No indication of when symptoms started. -CNA #2 tested positive for COVID-19 on [DATE], no symptoms listed. -Nurse #3 tested positive for COVID-19 on [DATE] with a cough. No indication of when symptoms started. -Nurse #7 tested positive for COVID-19 on [DATE] with a cough. No indication of when symptoms started. -CNA #1 tested positive for COVID-19 on [DATE], no symptoms listed. During an interview on [DATE] at 10:15 A.M., the Director of Nurses said she had been on vacation when the Receptionist, CNA #2, and Nurse #3 tested positive so she could not be sure when the symptoms started. At this time, the Infection Preventionist said she was only told when the staff members tested positive and was responsible for determining when they could test again but had not been keeping a list of staff symptom monitoring. On [DATE], the Department of Public Health determined the Immediate Jeopardy was removed effective [DATE]. Refer to F886 27189 4a. Observations on Unit B- On [DATE] at 8:20 A.M., the surveyor observed Nurse #12 without eye protection (goggles or face shield). Upon further observation it was noted that Nurse #12 had goggles that had the appearance of eyeglasses. The sides provided the correct protection, however there was a large gap at the top of the goggles which does not provide full coverage/complete protection. During an interview on [DATE] at 8:22 A.M., Nurse #12 said that she works at another facility and these types of goggles were provided. When the surveyor indicated the concern of the goggles not providing full eye coverage/protection, she agreed with the surveyor and said that she would obtain a face shield. Observations on Unit C- (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 8:28 A.M., the surveyor observed CNA #12 with the N95 mask around her neck. She observed the surveyor, went into the bathroom in a resident's room and then exited the room. The surveyor approached CNA #12 who indicated that she was observed with the mask around her neck. The CNA said that she was in the process of changing the mask and that is why it was positioned around her neck, and she indicated that the mask that she had donned is a new/clean mask. The surveyor observed that although the mask was clean according to the CNA, while in the Resident's room, the mask should remain in place at all times. The current mask that CNA #12 had donned, also was not donned correctly. It was not providing a proper seal around her nose and mouth and was slipping down. The metal bar inside the mask at the top of the mask had not been pinched to provide a better seal. The mask kept sliding down. Review of the Employee Education Attendance Record, dated [DATE], which addressed proper donning and doffing of Personal Protective Equipment indicated that CNA #12 did not attend the required inservice. On [DATE] at 7:49 A.M., review of documentation for residents in the facility not Up To Date (UTD) with COVID-19 vaccination/boosters indicated the following: Unit A: Resident #352 (not UTD) Unit B: Resident #1A (not UTD) Resident #72 (not UTD) Resident #401 (not UTD) On [DATE] at 8:38 A.M. the following observations were made: Unit A For Resident #352, outside of their room there was no enhanced precautions sign posted and no covid immunizations were documented in the Electronic Medical Record (EMR). Unit B For Resident #1A, Resident #72 and Resident #401, outside of their room there was no enhanced precautions sign posted and no covid immunizations were documented in the Electronic Medical Record (EMR). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 9:16 A.M., the DON said none of these residents are UTD on recommended vaccines and that the facility follows Department of Public Health, Center for Disease Control and the Center for Medicare and Medicaid Services guidance and tries to stay up to date on changes. The DON said that the enhanced precautions should remain in place on the affected units for the 14 days with no new cases, and that there should have been signs posted to indicate the Residents are on enhanced precautions. 34145 4b. Unit C observations: On [DATE] at 7:13 A.M., the surveyor observed Resident #81, who was unmasked, seated in a chair across from the nursing station on Unit C (COVID positive cases on the unit) with six other residents seated in the hallway close to Resident #81. Three of the six residents in the hallway were wearing masks. On [DATE] at 7:14 A.M., the surveyor observed Laundry Aide #1 pushing a laundry [TRUNCATED]

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Report COVID19 data to residents and families. 36542 Based on interviews and record reviews, the facility failed to ensure resident representatives/families were notified of each new COVID-19 positive staff member or resident case by 5:00 P.M. the following day. Findings include: During the entrance conference on 8/18/22 at 9:30 A.M., the Administrator said the facility had been experiencing an outbreak of COVID-19. The Administrator said the Activity Director was responsible for family and resident notifications of COVID-19 cases. Review of the facility cases indicated the following: 8/10/22- 1 staff tested positive for COVID-19 8/14/22- 4 residents tested positive for COVID-19 (total 4 residents and 1 staff) 8/15/22- 8 residents tested positive for COVID-19, one Certified Nursing Assistant (CNA) tested positive (total 12 residents and 2 staff) 8/19/22- 5 residents and 2 nurses tested positive for COVID-19 (total 17 residents and 4 staff) 8/20/22- 1 resident tested positive for COVID-19 (total 18 residents and 4 staff) 8/22/22- 1 CNA tested positive for COVID-19 (total 18 residents and 5 staff) During an interview on 8/19/22 at 1:30 P.M., members of the Resident Council said they were not aware of the cases of COVID-19 in the facility and had not been notified by staff. On 8/24/22 the surveyor was provided with emails from the Activity Director to family members regarding the COVID-19 outbreak. The emails included the following notification to families: 8/15/22 at 2:55 P.M. indicating there were 4 positive residents on unit A and unit B. 8/18/22 at 11:40 A.M. indicating there are 12 positive residents on A and B units. 8/21/22 at 10:33 A.M. indicating there are 16 residents who tested positive. (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 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/25/22 at 2:00 P.M., the Activity Director said she had been told by the Administrator to send out emails to notify families of COVID-19 cases at the facility. She said she pulls emails from the electronic medical record system and if a resident's family had an email listed in the system, then it was sent to them. She said if the resident's family did not have an email address listed, she was not sure who notified them, but assumed someone called those families. She said the three emails provided to the surveyor were the only notifications sent during this outbreak. In addition, she said her activity staff notify the residents who were alert and oriented and she was not sure why some residents were not aware. During an interview on 8/25/22 at 2:50 P.M., the Administrator said the email notifications which were sent, did not provide notification by 5:00 P.M. the following day for each day there were cases. In addition, she said she did not know the Activity Director was not calling the families of residents who were not on the email list.

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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 0886

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

Perform COVID19 testing on residents and staff.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36542

Based on observations, interviews, and record review, the facility failed to conduct COVID-19 testing in accordance to

1. Initiating outbreak testing when a staff member tested positive on [DATE];

2. Initiating testing for Resident #67 who was exposed to COVID-19 and presented with symptoms;

3. Determining if contact tracing or group level testing should be conducted, including following guidelines from the local health authority;

4. Following community transmission levels for routine testing of staff; and

5. Following infection control practices while testing staff.

The facility's COVID-19 outbreak began on [DATE]. As of [DATE], the facility identified 5 staff members and 18 residents had tested positive for COVID-19. Five of the positive residents were sent to the hospital and one unvaccinated resident died at the facility after being exposed to their COVID-19 positive roommate.

It was determined the Immediate Jeopardy began on [DATE] and was identified on [DATE]. The Department of Public Health sent a Notice of Determination of Immediate Jeopardy and the Immediate Jeopardy templates to the Facility Administrator on [DATE].

On [DATE], the Department of Public Health determined the Immediate Jeopardy was removed effective [DATE].

In addition to the residents in Immediate Jeopardy, non-compliance at F886 continued at a lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy, because the facility also failed to

6. Conduct BinaxNOW Rapid Point of Care COVID-19 Testing according to manufacturer's instructions and follow infection control practices while testing staff

Findings include:

1. Review of the Centers for Medicare & Medicaid Services (CMS) Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, revised [DATE] indicated the following:

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- A new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident triggers an outbreak investigation. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g., facility-wide) testing. - Residents who have signs or symptoms of COVID-19, regardless of vaccination status, must be tested immediately. - If the facility has the ability to identify close contacts of the individual with COVID-19, they could choose to conduct focused testing based on known close contacts. If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility). Broader approaches might also be required if the facility is directed to do so by the jurisdiction's public health authority, or in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission. - The facility should test all staff, who are not up to date, at the frequency prescribed in the Routine Testing table based on the level of community transmission reported in the past week. Facilities should monitor their level of community transmission every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing according to the table. Review of the staff COVID-19 positive list indicated a Receptionist tested positive on [DATE] and had chills as a symptom; there was no indication of the date of symptom onset. During an interview on [DATE] at 10:28 A.M., the Infection Preventionist said she had been notified of the Receptionist testing positive for COVID-19 at an appointment, outside of the facility. The Infection Preventionist said she had been in communication with the Administrator on [DATE] and had instructed the Administrator to initiate contact tracing to see which residents and staff had contact with the Receptionist while infectious. During an interview on [DATE] at 10:30 A.M. with the Director of Nurses (DON) and the Infection Preventionist, the DON said she had been on vacation on [DATE]. The Infection Preventionist said she worked off-site and was available to all staff to coordinate infection control. The DON and the Infection Preventionist said the Administrator would have been responsible for implementing and facilitating any response to the outbreak. During the interview, the Infection Preventionist said the facility had conducted contact tracing when Resident #71 tested positive for COVID-19 on [DATE]. The facility determined the close contacts of Resident #71 were the other residents who congregated with Resident #71 in the Solarium, a sitting area off of the reception area. The Infection Preventionist and the DON said they had not taken into consideration that the residents who congregated in the Solarium were close contacts with the Receptionist who had tested positive on [DATE]. During an interview on [DATE] at 2:55 P.M., the Administrator said she had not initiated any testing of staff or residents when the Receptionist tested positive on [DATE]. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2. Resident #67 was admitted to the facility in [DATE] with diagnoses including a pleural effusion, pancreatitis, and congestive heart failure. Review of the list of COVID-19 positive residents indicated the roommate of Resident #67 tested positive for COVID-19 on [DATE]. Review of the medical record for Resident #67 indicated the Resident was not vaccinated against COVID-19. Review of a Physician's Progress note, dated [DATE], indicated Resident #67 was exposed to COVID-19, lived with significant comorbidities and would be considered high risk. On [DATE] at 12:02 P.M., the surveyor observed a family member of Resident #67 walk up to the nurses' station and request to Nursing Supervisor #1 that Resident #67 be tested for COVID-19. Review of the paper and electronic medical record indicated the first monitoring for signs or symptoms of COVID-19 was initiated on [DATE] (4 days after the roommate tested positive) with an order to monitor for runny nose, chest congestion, increased shortness of breath, confusion, sore throat, muscle pain, nausea, vomiting, loose stool, headache, loss of taste or smell, or fever. The order was checked off for the night shift on [DATE] as monitored by the nurse, with no indication of whether any of the symptoms were present. Review of the Physician's Progress note, dated [DATE], indicated Resident #67 tested positive for COVID-19 and had cough and congestion for the past few days. Review of the Resident Testing Log indicated Resident #67 was tested for COVID-19 on [DATE] and was negative. There were no further COVID-19 tests conducted until the daughter requested testing on [DATE]. On [DATE] at 12:58 P.M., the surveyor observed four Emergency Medical Technicians (EMT) arrive at the facility and go to the room of Resident #67, where CPR was in progress. At 1:19 P.M. Resident #67 was pronounced dead. 3. During an interview on [DATE] at 9:00 A.M., the Director of Nurses said the outbreak initiated on [DATE] when a resident tested positive for COVID-19 and there were currently 18 positive residents at the facility and three positive staff members. She said 16 COVID-19 positive residents resided on the B Unit and 2 resided on the A unit. She said the facility was currently only conducting outbreak testing for residents on the B unit (group level) and no testing on the A unit (as both residents were roommates and currently positive). The Director of Nurses said the facility had determined the testing strategy based on guidance from the Department of Public Health (DPH) epidemiology. During an interview on [DATE] at 11:36 A.M., the DPH Epidemiologist said she had spoken with the facility Director of Nurses and Administrator on Friday [DATE] and had recommended unit based resident testing on both units (A and B) that had positive cases. The recommendation was to test all residents on these units, every 3 days until the facility was able to go 7 days without a new positive and if no additional positives to test again on day 14. All staff should be tested every 3 days. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 11:50 A.M., the Director of Nurses said the facility had only tested residents who resided on the B unit and had not tested the residents on the A unit. She said all staff were being tested on Mondays, Wednesdays, and Fridays. She said staff who do not work on these days were responsible for completing and logging their own testing. Review of the resident and staff positive cases and testing indicated the following timeline: [DATE]- Receptionist tested positive for COVID-19. No contact tracing or broad-based testing was initiated at this time. [DATE]- Resident #71 tested positive for COVID-19. The facility initiated contact tracing testing of residents at this time, which did not include testing of the roommate of Resident #71. No staff members were tested . [DATE]- 3 residents (2 from the B unit and 1 from the A unit) who were close contacts with Resident #71 tested positive for COVID-19. [DATE]- the facility initiated unit based testing on the B unit, which identified 7 additional COVID-19 positive residents on the B unit and tested the roommate (Resident #23) of the resident on Unit A, who was negative. No staff members were tested . [DATE]- CNA #2 tested positive at another facility. CNA #2 worked on the B unit on [DATE]. [DATE]- the facility begins testing staff (9 days after the first COVID-19 positive case); Nurse #3 and Nurse #7, who both worked on the B unit, test positive for COVID-19. [DATE]- the facility tested all residents on the B unit- identifying 4 additional COVID-19 positive residents on that unit and tested the roommate from the A unit (Resident #23) who was COVID-19 positive. [DATE]- one additional B unit resident tested positive for COVID-19 [DATE]- CNA #1 tested positive for COVID-19. CNA #1 worked on [DATE] on the A unit. During an interview on [DATE] at 9:17 A.M., Resident #23 said he/she had tested negative for COVID-19, despite his/her roommate being positive and had continued to attend activities. During an interview on [DATE] at 10:15 A.M., the Director of Nurses said Resident #23, who resided on the A Unit had tested positive on [DATE] and had attended activities on the A Unit prior to the positive test result. She said they had not conducted any contact tracing or unit-based testing based on this COVID-19 positive result. (continued on next page)

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F 0886

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

During an interview on [DATE] at 8:00 A.M., the Administrator said the Director of Rehabilitation had tested positive for COVID-19 on [DATE]. When asked what the facility response was to the positive result, the Administrator said she had not initiated any additional testing (contact tracing, broad-based) as the staff member had not worked in the previous 48 hours (since [DATE]). When the surveyor inquired about the symptoms of the staff member, the Administrator said the Director of Rehabilitation had congestion which had started either ,d+[DATE] or [DATE], she was not sure. She said she did not know that a person was infectious for 48 hours prior to symptoms and not 48 hours from test date.

Review of 5 sampled staff members during outbreak testing from [DATE] through [DATE] indicated the following:

-Dietary Assistant was not tested during the outbreak and had worked on ,d+[DATE], ,d+[DATE], ,d+[DATE] and [DATE].

-Physical Therapy Assistant was not tested during the outbreak until [DATE] and had worked on ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], [DATE] and [DATE].

-Activity Assistant #1 was not tested during the outbreak and had worked ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], and [DATE].

Certified Nursing Assistant (CNA) #3 was not tested during the outbreak and had worked on ,d+[DATE], , d+[DATE] and [DATE].

Nurse #4 was not tested during the outbreak and had worked on ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE] and [DATE].

During an interview on [DATE] at 10:30 A.M., the Director of Nurses and the Infection Preventionist said all staff were to be tested every three days during the outbreak and they were not checking to ensure staff were being tested and had no log to demonstrate that all staff had been tested .

4. Review of the Routine Testing Intervals by County COVID-19 Level of Community Transmission indicated staff who were not up to date with the COVID-19 vaccine should be tested as follows:

High (red) level of COVID-19 Community Transmission- twice per week

Substantial (orange) level of COVID-19 Community Transmission - twice per week

The Community Transmission Level for [NAME] County from [DATE] through [DATE] was High.

The Community Transmission Level for [NAME] County starting [DATE] was Substantial.

Activity Assistant #1 was not up to date with the COVID-19 vaccine and was not tested for routine testing during the week of [DATE], the week of [DATE], or the week of [DATE]. Review of the Timecard Report indicated Activity Assistant #1 worked ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE].

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022
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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Nurse #4 was not up to date with the COVID-19 vaccine and was not tested for routine testing during the week of [DATE], the week of [DATE] or the week of [DATE]. Review of the Timecard report indicated the Nurse had worked on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE]. During an interview on [DATE] at 10:30 A.M., the Infection Preventionist said the facility had not been tracking the Community Transmission rate for the facility. During the same interview, the Director of Nurses said she had also not tracked the Community Transmission rate for the facility and did not know that routine testing varied based on the Level of Community Transmission. 5. On [DATE] at 7:10 A.M., the surveyor observed staff testing for COVID-19 at the reception desk. There were three staff lined up next to each other on one side of the desk, not wearing masks and swabbing their noses. Each staff member handed their swab to the Medical Records personnel, who was not wearing gloves and did not hand sanitize between touching each swab. The Medical Records personnel then inserted the swabs into the card, which was placed directly on the reception counter. After discarding the cards, the counter was not observed to be disinfected. At 7:30 A.M., the surveyor observed three additional staff members at the reception desk testing for COVID-19. The staff were observed to be standing shoulder to shoulder with their masks down while swabbing their nostrils. Each staff member handed the receptionist their swab. The receptionist was observed to not be wearing gloves and did not perform hand hygiene between taking swabs. The swabs were placed in the testing cards directly on the reception area counter. 42742 6a. Review of the manufacturer's instructions for use (IFU) titled BinaxNOW COVID-19 Ag Card, dated 2020, indicated but was not limited to the following: Test Procedure -Hold extraction Reagent bottle vertically. Hovering ,d+[DATE] inch above the top hole, slowly add 6 drops to the top hole of the swab well - Read result in the window 15 minutes after closing the card. In order to ensure proper test performance, it is important to read the result promptly at 15 minutes, and not before. -Note: False negative results can occur if test results are read before 15 minutes. Precautions -Wear appropriate PPE and gloves when running each test and handling patient specimens. Patient samples, controls, and test cards should be handled as though they could transmit disease. -Invalid results can occur when an insufficient volume of extraction reagent is added to the test card. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 9:45 A.M., the surveyor observed Consulting Staff #3 in a room behind the front reception desk self-performing a BinaxNOW COVID-19 nasal swab. Consulting Staff #3 placed the COVID-19 Ag Card onto the windowsill surface with the sample swab inserted. She did not place a liner underneath the collection sample and did not disinfect the windowsill when finished. Receptionist #1 told Consulting Staff #3 that she would set a timer for 15 minutes. Receptionist #1 picked up her cellular device then set it down. The surveyor did not observe Receptionist #1 set the timer. During an interview on [DATE] at 9:52 A.M., seven minutes later, Receptionist #1 told Consulting Staff #3 that 15 minutes had passed. Consulting Staff #3 left the reception area and walked down the hallway without documenting her name, the date, or the test results on the Binax Testing Form. When the surveyor pointed out to Receptionist #1 that only seven minutes had passed, not the required 15 minutes, Receptionist #1 was unable to show the surveyor a timer had been set. During an interview on [DATE] at 9:55 A.M., Consulting Staff #3 said her results were negative and she should have documented the results on the Binax Testing Form immediately after but did not. During an interview on [DATE] at 11:10 A.M., the Director of Nurses (DON) said the results should have been promptly read at 15 minutes, not before, and the results should have been documented immediately after. The DON said Consulting Staff #3 did not maintain infection control practices while performing the BinaxNOW COVID-19 testing. 6b. On [DATE] at 11:01 A.M. and 11:06 A.M., the surveyor observed Consulting Staff #1 supervise and assist with BinaxNOW rapid COVID-19 testing for Certified Nursing Assistant (CNA) #11 and Nurse #14 in the basement conference room. Consulting Staff #1 held the extraction reagent bottle above the top hole of the swab well on the testing cards and squeezed the bottle three times for each card. Consulting Staff #1 did not wear gloves at any time while handling the specimens. Both test results were negative, and CNA #11 and Nurse #14 returned to their assigned units. During an interview on [DATE] at 11:44 A.M., Consulting Staff #1 said she added three drops of the reagent, not the required six drops per the manufacturer's IFU, and should have worn gloves to handle the specimens but did not. The DON said because an insufficient amount of the extraction reagent was added to the test cards, she could not validate the results of the two staff members and would have to retest them.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 36542 Based on interviews and record reviews, the facility failed to maintain education documentation regarding the benefits and potential risks associated with the COVID-19 vaccine for four Residents (#32, #74, #352, and #7), out of five sampled unvaccinated residents. Findings include: A review of the facility's policy titled COVID Vaccine, revised 5/11/21, indicated the following: -residents or their representatives are able to accept or decline the vaccine after proper education -facility should offer COVID vaccination to all new admissions and readmission; the opportunity to receive the first dose or required next dose of COVID vaccine -facility to have proper documentation of resident's education and decision on COVID-19 vaccines -when a resident declines the COVID-19 vaccination, a COVID-19 vaccination declination form will be signed and placed in their medical record. During an interview on 8/24/22 at 10:00 A.M., the Infection Preventionist said new admissions were educated on the COVID-19 vaccines and were provided a form to accept vaccines or decline vaccines, which were then placed in their paper medical record. A review of the Revolution Charlwell Vaccination Form indicated the resident or representative could indicate they had been educated on the vaccines and agree to receive them or decline to receive the vaccines. The resident or representative would then sign the bottom of the form to indicate their wishes. 1. Review of the medical record for Resident #32 included the Revolution Charlwell Vaccination Form. The form was not signed by the Resident or the representative. 2. Review of the medical record for Resident #74 included blank informed consent for influenza vaccine and pneumococcal vaccine. There was no form in the medical record regarding education for the COVID-19 vaccine. 3. Review of the medical record for Resident #352 included the Revolution Charlwell Vaccination Form. The form was not signed by the Resident or the representative. 4. Review of the medical record for Resident #7 failed to include any documentation the Resident was educated on the COVID-19 vaccine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/24/22 at 3:50 P.M., the nursing supervisor said if the resident or representative had been educated on the COVID-19 vaccine than the form would be signed in the medical record. The nursing supervisor was unable to locate any additional documentation regarding the COVID-19 vaccine education in the medical records.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 27189 Based on observation and interview, the facility failed to ensure staff implemented a system to ensure that all mechanical and electrical kitchen equipment was maintained in safe operating condition. Findings include: During the initial tour of the kitchen with the Food Service Director (FSD) on 8/18/22 at 8:20 A.M., the surveyor observed the following: - The garbage disposal was not functioning. The FSD said it had been broken since he started in June due to silverware/foreign objects that had inadvertently fallen into it. - The steam table wells were noted to be rusted and, in some areas, corroded with numerous holes in the wells. -The oven hood was last inspected in April 2021. The FSD indicated it was overdue for inspection/cleaning. The FSD said there had been an issue with payment, which resulted in the hood not being cleaned/inspected. During an interview on 8/23/22 at 2:30 P.M., the FSD said that Administration was aware of the above issues.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 27189 Based on observation, document review, and interview, the facility failed to maintain an effective pest control program ensuring that the facility, including the main kitchen and three of three nutrition kitchenettes were free from pests, including mice and roaches. Findings include: During the initial tour of the main kitchen on 8/18/22 at 8:20 A.M., the surveyor observed: -Multiple mouse traps (glue traps and metal traps) located throughout the kitchen, close to the walls encompassing the entire perimeter of the kitchen. -The windowsill behind the food steamer in the main kitchen had numerous mouse droppings. Review of the Pest Control Logs from 6/1/22 to 8/18/22 indicated the facility had mice problems with light activity in the kitchen. On 8/23/22 at 8:56 A.M., during the inspection of the dry storage/emergency food storage room (located within Unit C) with the Food Service Director (FSD), the surveyor observed a glue trap with a dead mouse in the trap. On 8/23/22 from 11:45 A.M. to 12:30 P.M., the surveyor observed evidence of mouse activity in three of three kitchenettes as follows: Nutrition Kitchenette A: -The floor adjacent to the wall coving was encrusted with a thick, black substance and in all four corners of the floor, scattered mouse droppings were noted Nutrition Kitchenette B: -The floor adjacent to the wall coving was encrusted with a thick, black substance and scattered mouse droppings were noted along the perimeter of the coving throughout the area -There were food crumbs scattered throughout the area Nutrition Kitchenette C: -Floor adjacent to the wall, coving, encrusted with a thick black substance and scattered mouse droppings were noted along the entire perimeter of the coving. -The second drawer of the cabinet had numerous mouse droppings present in the drawer. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/23/33 at 12:45 P.M., the surveyor, the FSD, Administrator, and Maintenance Director toured the kitchenettes and verified the surveyor's earlier findings of mice droppings present. During their tour, a live brown 1/2-inch-long insect scurried across the open door of the refrigerator in Kitchenette C. The Administrator, the FSD, and the Maintenance Director all saw the insect and said it was a roach. Further review of the pest control logs failed to indicate that the nutrition kitchenettes were identified as areas of concern for mice and roaches. Further review of the pest control logs indicated pest control logs were not comprehensive. There were no specifics as to what and where the light activity was occurring other than mainly in the Kitchen area, with one report indicating guest rooms (no specific room numbers) and another indicated reception area. The report did not make any recommendations to the facility as to how they could mitigate the pest (mice and roach) activity. During an interview on 8/23/22 at 1:13 P.M., the Maintenance Director said the pest control reports lacked information/ recommendations by the new pest control service to mitigate pest activity.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 34145 Based on interviews, record review, and review of the facility assessment, the facility failed to develop, implement, and permanently maintain an effective training program for newly hired staff, to include training on prevention of abuse, neglect, exploitation, misappropriation of resident property and dementia management. Specifically, a review of employee education records indicated 7 out of 7 employees had not received education related to prohibition of abuse and dementia management. Findings include: Review of the Facility Assessment, dated as last update on 9/15/21, indicated staff were to have the following education upon hire and annually: -care/management for persons with dementia and resident abuse prevention Review of the education and employment files provided indicated the following: 1. Unit Manager #1 was hired in August 2022. Review of the education file for the nurse failed to include training in care/management for persons with dementia and resident abuse prevention. 2. Nurse #8 was hired in July 2022. Review of staff training and the education file for the nurse failed to include training in care/management for persons with dementia and resident abuse prevention. 3. Nurse #14 was hired in June 2022. Review of staff training and the education file for the nurse failed to include training in care/management for persons with dementia and resident abuse prevention. 4. Nurse #15 was hired in May 2022. Review of staff training and the education file for the nurse failed to include training in care/management for persons with dementia and resident abuse prevention. 5. Nurse #16 was hired in June 2022. Review of staff training and the education file for the nurse failed to include training in care/management for persons with dementia and resident abuse prevention. 6. Certified Nursing Assistant (CNA) #3 was hired in May 2022. Review of staff training and the education file for the CNA failed to include training in care/management for persons with dementia and resident abuse prevention. 7. Certified Nursing Assistant #4 was hired in August 2022. Review of staff training and the education file for the CNA failed to include training in care/management for persons with dementia and resident abuse prevention. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/25/22 at 11:45 A.M., the Director of Nursing (DON) said there is no staff development coordinator, and she is responsible for education and competencies for Nursing staff. The DON confirmed that 7 of 7 staff did not have training in prohibition of abuse and dementia management.