MA DPH/Division of Health Care Facility Licensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225772	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR ISLAND HOME	EAST CREEK ROAD NANTUCKET, MA 02554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R000	Initial Comments During the recertification survey on 3/2-3/5/20 the following state licensure deficiencies were cited:	R000		
R290	150.002 Administration - Reporting (G) The administrator shall be responsible for ensuring all required records, reports and other materials are complete, accurate, current and available within the facility and the following requirements are met: (1) Each facility shall immediately report to the Department any of the following events occuring on premises covered by its license: (a) A death that is unanticipated, not related to the natural course of the resident's illness or underlying condition, or is the result of an error or other incident as specified in the Department's guidelines; (b) Full or partial evacuation of the facility; (c) Fire; (d) Suicide; (e) Serious criminal act; (f) Pending or actual strike action by its employees, and contingency plans for operation of the facility; (g) Reportable conditions and illness as defined in 105 CMR 300.020: Report of a Disease when such illness is: 1. Believed to be part of a suspected or confirmed cluster or outbreak; 2. Believed to be unusual as defined in 105 CMR 300.020: Unusual Illness; or 3. Related to food consumption or believed to be transmissible through food; or (h) Other serious incidents or accidents as specified in the Department's guidelines. (2) Each facility shall immediately report to the	R290	The Plan of Correction is the centers credible allegation of compliance. Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan is solely executed because it is required by the provision of federal and state laws. R-290 Resident #10 has had a report filed with the Virtual Gateway Resident #19 has had a report filed with the Virtual Gateway. Resident #33s bruise was determined to be caused by hitting the side rail. The side rail has been padded. Residents have been interviewed by the Administrator/designee to ensure no allegations of abuse are unreported. The DON and Social worker have received individual education by the Administrator, on the abuse policy, including reporting of unknown origin. Staff have been educated on the abuse policy. The Administrator/designee will conduct weekly interviews of 10% of the residents to ensure there are no unreported allegations. The Administrator/designee is responsible for monitoring and the results will be reported to the monthly QAPI committee to ensure ongoing compliance for a period of three months.	4/15/20

MA Division of Health Care Facility Licensure and Certification	TITLE	(X6) DATE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Electronically Signed	03/26/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225772	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR ISLAND HOME	**EAST CREEK ROAD NANTUCKET, MA 02554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R290	Continued From page 1 Department any suspected instance(s) of resident abuse, neglect, mistreatment or misappropriation of a resident's personal property, as defined in 105 CMR 155.000: Patient and Resident Abuse Prevention, Reporting, Investigation, Penalties and Registry. (3) Within seven days of the date of occurrence of the event, each facility shall report to the Department any other incident or accident occurring on premises covered by the facility's license that seriously affects the health or safety of a resident(s) or causes serious physical injury to a resident(s). This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that: a. two allegations of abuse (Residents #10 and #19) and, b. one bruise of unknown origin (Resident #33) were reported to the Department of Public Health (DPH) as required. Findings include: a. Review of 1/30/20 Resident Council Meeting Minutes indicated the following: -One resident (#10) expressed that he/she has vocalized,several times, concerns about one CNA (certified nursing assistant), who he/she feels is "rough", stating "it feels like she is throwing me around". Another resident (#19) added, "I'm tired of hearing people talk down to the elderly" and reported that she has heard one CNA state, "You're old, you're going to die anyway...get in bed and stay there".	R290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225772	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR ISLAND HOME	EAST CREEK ROAD NANTUCKET, MA 02554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R290	Continued From page 2 Review of the Health Care Facility Reporting System on 3/4/20 at 2:30 P.M., failed to indicate that Residents #19 and #10's allegations of abuse were reported to DPH within seven days as required. b. Resident #33 was admitted to the facility in 11/2019 with diagnoses including dementia without behavioral disturbance and legal blindness. Review of the most recent Quarterly Minimum Data Set, with a reference date of 2/13/20, indicated that Resident #33 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 10 out of 15, required extensive assistance/dependent of staff for bed mobility, transfers, and all other activities of daily living. Review of the medical record indicated an incident note dated 1/23/20. The note indicated that a CNA noted bruising to the resident's right eye. The resident was unable to recall what happened, the area was tender to the touch, and the Director of Nursing (DON) was aware. Review of the Health Care Facility Reporting System on 3/4/20 at 2:30 P.M. failed to indicate that Resident #33's bruise of unknown origin was reported to DPH as required. During interview with the DON on 3/4/20 at 3:20 P.M., she said that she received and read the Resident Council minutes via email on 1/30/20, but did not report the two allegations of abuse that were documented in the minutes, and Resident #33's bruise of unknown origin was not reported to DPH but should have been.	R290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225772	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR ISLAND HOME	EAST CREEK ROAD NANTUCKET, MA 02554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R1110 R1110	Continued From page 3 150.008 Pharmaceutical Services - Self Administration (a) All medication to be self-administered shall be kept in the resident's room in a locked cabinet or in a locked drawer. (b) In the case of a resident with a history of mental illness, a self-administration order must be supported by a written finding by the primary care provider that the resident has the ability to manage the medication on this basis. (c) Every self-administration order shall be reconsidered as part of the periodic review of medications under 105 CMR 150.0008(B)(2). This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, and resident and staff interviews, the facility failed to ensure for one Resident (#189), out of a total sample of 12 residents, that medication to be self administered was kept in a locked cabinet or in a locked drawer as required. Findings include: Resident #189 was admitted to the facility in 2/2020 with diagnoses including metastatic pancreatic cancer. On 03/02/20 at 1:50 PM, Resident #189 was observed lying upright in bed. A prescription bottle of Zenpep (a prescription medicine for people who need digestive enzymes to help break down and digest fats, starch, and proteins) was observed on a bed side table alongside Resident #189's bed. The Resident said that he/she takes the	R1110 R1110	R-1110 Resident #189 has been discharged An in-house audit has been completed, and there are no residents who wish to self administer medications. Licensed nursing staff have been educated on the Self Administration of Medication policy, and are aware to complete an assessment of the resident to ensure the policy is followed. The DON/designee will conduct random weekly audits, at least twice weekly, to ensure medications are not left at the bedside. The DON/designee is responsible for monitoring and the results will be reported to the monthly QAPI committee to ensure ongoing compliance for a period of three months.	4/15/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225772	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR ISLAND HOME	EAST CREEK ROAD NANTUCKET, MA 02554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R1110	Continued From page 4 medicine with meals. The Resident said that no one had told him/her that the medications had to be stored out of reach of other residents. On 3/3/20 at 9:15 A.M., Resident #189 was again observed lying upright in bed, with the prescription bottle of Zenpep on the bedside table. During interview with Nurse #3 on 3/3/20 at 11:13 A.M., she said that she was not aware that the medication had to be stored out of reach of other residents.	R1110		
R1120	150.008 Pharmaceutical Services - Administration (4) All medications shall be accurately recorded and accounted for at all times, and each dose of medication administered shall be properly recorded in the clinical record with a signature of the administering nurse or responsible person. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that a nurse who administered medication to a resident, recorded the medication administration in the clinical record. Findings Include: Review of the 3/3/20 nursing schedule indicated that Nurse #4 was the medication nurse on duty for the day shift (7:00 A.M.-3:00 P.M.). On 3/3/20 at 8:04 A.M., the surveyor observed Nurse #1 entering a resident's room on the East	R1120	R-1120 No residents were adversely affected by this practice Nurse #1 and Nurse #4 have received education on Medication Administration and documentation. Licensed nursing staff have received education on Medication Administration and documentation. The DON/designee will conduct random weekly audits of the medication administration pass, at least twice weekly to ensure compliance with facility practice. The DON/designee is responsible for monitoring and the results will be reported to the monthly QAPI committee to ensure ongoing compliance for a period of three months.	4/15/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225772	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR ISLAND HOME	EAST CREEK ROAD NANTUCKET, MA 02554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R1120	Continued From page 5 unit with medication cups in her hand which contained multiple medications. Nurse #1 was then observed to leave the room a few minutes later with the empty medication cups. During interview with Nurse #1 at 8:11 A.M. she said that she administered medications to the Resident. Nurse #1 said that she did not prepare the medications, and did not sign off in the clinical record that the medications were administered. She said that Nurse #4 was responsible for the medication cart and administering medications. Nurse #4 was interviewed at 8:53 A.M., she said she signed off in the clinical record that she administered the medications even though she did not administer them. She said that she should have administered the medications herself.	R1120		
R1180	150.008 Pharmaceutical Services - Expiration (10) Medications having a specific expiration date shall be removed from usage and destroyed at expiration. All medications no longer in use shall be disposed of or destroyed at as directed by the Department. This REQUIREMENT is not met as evidenced by: Based on observation , the facility failed to ensure that expired medication was removed from usage and destroyed at expiration. Findings Include: On 3/2/20 at 2:59 P.M., during review of the medication cart and medication storage room , six bottles of 81 milligram (mg) enteric coated	R1180	R-1180 No residents were adversely affected by this practice The medication storage room, the medication room, and the medication cart have been audited to ensure there are no expired medications. Staff have been educated on discarding medication prior to the expiration date. The supply clerk has been educated to monitor for expiration dates and to rotate stock as it arrives in the facility. The Charge Nurse/designee will conduct weekly audits of the medication cart, medication room, and medication storage to ensure medications are within date ranges. The DON/designee is responsible for monitoring and the results will be reported to the monthly QAPI committee to ensure	4/15/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225772	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR ISLAND HOME	EAST CREEK ROAD NANTUCKET, MA 02554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R1180	Continued From page 6 Aspirin tablets, one bottle of 500 mg Acetaminophen tablets and one bottle of Senna 8.6 mg tablets, all with an expiration date of 2/2020, were observed stored in the medication cart and medication storage cabinet. The medications were not removed from usage and destroyed at date of expiration as required.	R1180	ongoing compliance for a period of three months.	
R2640	150.024 DSCU - Staff Qualifications and Training (A) The training requirements listed in 105 CMR 150.024 shall supplement training requirements set forth in 105 CMR 150.000 and must be completed in addition to those training requirements. (B) Each facility must maintain written documentation that all relevant staff members have met the required training standards set forth in 105 CMR 150.025. (1) Prior to being released from the orientation process (providing care without the supervision of a preceptor), all relevant staff members shall receive a minimum of eight hours of initial training. After initial training is completed and documented, a staff member does not have to receive initial training if he or she changes jobs or begins working in another long-term care facility unless the individual has a lapse in employment in long term care for 24 consecutive months or more. (2) All relevant staff members providing care in a facility, whether or not care is provided to residents in a DSCU, shall receive a minimum of four hours of ongoing training each calendar year. (3) A relevant staff member does not need to receive ongoing training in the same calendar	R2640	R-2640 No residents were adversely affected by this practice The DON has received individual education by the Administrator, on the dementia regulation requirements. An audit of employee files has been completed to determine compliance with 8 hour dementia training. New hires will receive 8 hours of dementia education during their orientation and prior to being released from the orientation process. Dementia training schedules have been set up to ensure current staff receive 8 hour dementia training. A tracking sheet has been set up to ensure completion of 4 hour training in the next calendar year, and ongoing thereafter. The DON/designee is responsible for monitoring new hire dementia education and the results will be reported to the monthly QAPI committee to ensure ongoing compliance for a period of three months.	4/15/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225772	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR ISLAND HOME	EAST CREEK ROAD NANTUCKET, MA 02554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R2640	Continued From page 7 year he or she receives eight hours of initial training as required by 105 CMR 150.025. (4) Each facility shall appropriately train its volunteers for the tasks they will be performing. (C) The DSCU and the facility shall maintain documentation of staff training, which shall be available for the Department's review. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure that all relevant staff received a minimum of eight hours of initial training prior to being released from the orientation process. Findings include: During interview with the Director of Nursing on 3/4/20 at 11:27 A.M., she said that she does not provide relevant staff with the required eight hours of initial training, and did not have evidence that any staff had received the required eight hour training at prior facilities prior to being released from the orientation process.	R2640		
R9999	Final Observations Based on record review and staff interview, the facility failed to ensure that signed, informed consent was obtained and documented utilizing a form authorized by the Department of Public Health (DPH) for two Residents (#1 and #189) out of a total sample of 12 residents. Findings include: On 2/1/16, and updated on 2/1/17, DPH issued a Circular Letter regarding the informed written	R9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225772	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR ISLAND HOME	EAST CREEK ROAD NANTUCKET, MA 02554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R9999	Continued From page 8 consent for the use of psychotropic medications in long-term care facilities. The Circular letter outlines the requirements for the documentation of informed consent, and provision of a schedule of medications for which these procedures must be completed. The facilities are required to use the Department of Public Health written consent form, with all areas completed. The form is required to be completed each time a new or renewed prescription falls outside the dosage to which the resident or the resident's legal representative previously consented, or once a year, whichever is shorter. 1. For Resident #1, the facility failed to complete all areas of the DPH written informed consent form as required. Resident #1 was admitted to the facility in 1/2019 with diagnoses including major depression. Review of the medical record indicated physician's orders for Lexapro (antidepressant) 10 mg (milligrams) at bedtime. Review of the signed informed consent form indicated that the following areas of the form were blank: -Name of Resident -Date/Time of Discussion with Prescriber -Prescriber Name -Facility Representative Name/Title 2. For Resident #189, the Facility failed to complete all areas of the DPH written informed consent form as required. Resident #189 was admitted to the facility in 2/2020 with diagnoses including anxiety and	R9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225772	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR ISLAND HOME	**EAST CREEK ROAD NANTUCKET, MA 02554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R9999	Continued From page 9 depression. Review of the medical record indicated physician's orders for the following psychotropic medications: -Ativan (antianxiety) 1 mg three times daily -Wellbutrin (antidepressant) 150 mg every 24 hours -Trazodone (antidepressant) 50 mg at bedtime as needed Review of the signed, informed consent form indicated that the following areas of the form were blank: -Prescriber Name -Facility Representative Name/Title During interview on 3/5/20 at 12:19 P.M. with the Director of Nursing (DON) and the Administrator, the DON said that the written informed consent forms should be complete as required.	R9999		