STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225318	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37342 Based on observations, records reviewed and interviews, for two of three sampled residents (Resident #2 and Resident #3), the Facility failed to ensure they developed and implemented an individualized comprehensive plans of care that included interventions, treatment goals, and measurable outcomes, when 1) for Resident #2, his/her Plan of Care did not include his/her transfer status for the need of two staff member assistance with a mechanical Lift, and did not include interventions for him/her to be transferred out of bed daily, and 2) for Resident #3, his/her plan of care did not include his/her preference to be barefoot. Findings include: The Facility Policy, titled Resident Assessment, dated 09/04/24, indicated the Facility would develop and maintain an individualized interdisciplinary plan of care, treatment, and services with appropriate education and training about each resident's illnesses and care needs, and an individualized plan of care would be established. A Hoyer (mechanical) Lift transfer is performed using a full body sling attached to the boom of a mechanical lift. A Sit to Stand Lift transfer is performed using a mechanical lift in which a person is supported by a sling and brought to a standing position. 1) Resident #2 was admitted to the Facility in March 2024, diagnoses included chronic pain, lymphoma (cancer of the lymphatic system), metabolic encephalopathy (change in how the brain functions due to another underlying condition), lymphedema (swelling of a limb or limbs due to blockage of the lymphatic system), and generalized anxiety disorder. Review of Resident #2's Nursing Progress Note, dated 10/24/24, indicated the interdisciplinary team met with Resident #2 and formulated a plan for Resident #2 to be transferred out of bed to his/her wheelchair daily around 10:30 A.M. and transferred back into bed around 01:00 P.M. daily. Review of Resident #2's Physical Therapy Recert, Progress Report, and Updated Therapy Plan, with a certification date of 11/12/24 through 02/09/25, indicated two trials using the sit to stand lift had been performed, with ongoing adjustments to Resident #2's foot position on the foot plate of the lift and strap placement to secure Resident #2 in the lift. (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: 225318	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER: Mill Town Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 22 Maple Street Amesbury, MA 01913	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/11/25 at 01:36 P.M., the Director of Rehabilitation (DOR) said Therapy had tried trials of use of the sit to stand lift with Resident #2, but it was determined that he/she lacked the upper body strength to use the sit to stand lift safely, and that Hoyer lift transfers were safest for him/her. Further review of Resident #2's Physical Therapy Recert, Progress Report, and Updated Therapy Plan indicated there was no documentation to support that nursing staff were updated regarding the failed trials of transfers with the sit to stand lift, and to utilize the Hoyer lift for all transfers. Review of Resident #2's quarterly Minimum Data Set Assessment, dated 12/19/24, indicated he/she was dependent on staff for transfers. Review of Resident #2's Activities of Living (ADL) Plan of Care, (which did not include a reviewed and/or renewed date), indicated there was no documentation to support interventions, goals, and measurable outcomes related to his/her transfer status. Further review of Resident #2's Comprehensive Plans of Care, indicated there was no documentation to support that his/her plan of care included that nursing staff would use the Hoyer lift and two staff to assist him/her to transfer in and out of his/her bed/wheelchair. Review of Resident #2's Documentation Survey Reports, for January 2025, up through and including February 11 2025, indicated Certified Nurse Aides documented Resident #2 was dependent on two staff for transfers. During an interview on 02/11/25 at 12:20 P.M., Unit Manager #1 said Resident #2 required transfer with the assistance of two staff members using the Hoyer lift. Unit Manager #1 said she was unaware that Resident #2's Comprehensive Plan of Care did not include his/her transfer status, but said it should have been included. During an interview on 02/11/25 at 03:30 P.M., The Director of Nurses (DON) said Resident #2's plan of care did not include his/her transfer status or plan to get him/her out of bed daily, but said it should have. 2) Resident #3 was admitted to the Facility in May 2015, diagnoses included dementia, schizophrenia, failure to thrive, and delusional disorder. During observations on 02/11/25 at 07:30 A.M., and 03:00 P.M., Resident #3 was observed in the unit dining room, seated in his/her reclining wheelchair, and he/she was barefoot. During an interview on 02/11/25 at 03:00 P.M., Certified Nurse Aide (CNA) #1 said Resident #3 did not like wearing socks or shoes, and did not walk anymore. CNA #1 said Resident #3 would take off his/her socks and/or shoes if someone tried to put them on him/her. Review of Resident #3's risk for falls care plan, dated as revised 10/16/24, indicated staff would encourage him/her to wear appropriate footwear when out of bed. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #3's comprehensive plan of care indicated there was no documentation to support interventions, assessments, and goals of care related to Resident #3's preference of not wearing socks, shoes and that he/she preferred to be barefoot, were developed or implemented. During an interview on 02/11/25 at 03:30 P.M., the DON said nursing staff should have developed a plan of care to address Resident #3's preference to not wear shoes and/or socks, but had not.

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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 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.

37342

Based on records reviewed and interviews, for one of three sampled residents (Resident #2), who had a physician's order for nursing to document every shift on his/her transfers in and out of bed, the Facility failed to ensure they maintained a complete and accurate medical record, when nursing documentation was inconsistent, with many days not even one progress note was written by nursing.

Findings include:

The Facility policy, titled Charting and Documentation, dated 06/2022, indicated all observations, services performed, assessments, how the resident tolerated the procedure/treatment, and whether the resident refused the procedure/treatment would be documented in the resident's medical record.

1) Resident #2 was admitted to the Facility in March 2024, diagnoses included chronic pain, lymphoma (cancer of the lymphatic system), metabolic encephalopathy (change in how the brain functions due to another underlying condition), lymphedema (swelling of a limb or limbs due to blockage of the lymphatic system), and generalized anxiety disorder.

Review of Resident #2's Nursing Progress Note, dated 10/24/24, indicated the interdisciplinary team met with Resident #2 and formulated a plan for Resident #2 to be transferred out of bed to his/her wheelchair daily around 10:30 A.M., back into bed around 01:00 P.M. daily, and that the times would be flexible to meet his/her needs.

Review of Resident #2's Physician's Order, dated 12/11/24, indicated: Nursing note to be written every shift noting whether he/she was assisted out of bed to his/her wheelchair. Please note time he/she was assisted to the wheelchair and time assisted back to bed. If Resident refuses, please note reasons and number of attempts.

Review of Resident #2's Nurse Progress Notes, for the month of January 2025 through February 10, 2025, indicated there was insufficient, inconsistent, and/or no progress note written at all to support the time he/she was transferred out of bed to his/her wheelchair and/or back into bed, refusals to get out of bed, and number of attempts on the following dates:

-01/01/25 through 01/05/25, no nurse progress note on any shifts.

-01/06/25, timed 06:35 P.M., a nurse progress note indicated Resident #2 made no attempts to transfer him/herself to his/her wheelchair.

Further review of the progress note indicated there was no documentation to support whether staff attempted to assist Resident #2 to transfer to his/her wheelchair, number of attempts, or refusals.

-01/07/25, timed 09:54 A.M., a nurse progress note indicated Resident #2 stayed in bed because he/she was sleeping.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the progress note indicated there was no documentation to support whether staff attempted to assist Resident #2 to transfer to his/her wheelchair, number of attempts, or refusals. -01/07/25, timed 05:28 P.M., a nurse progress note indicated: No attempts to transfer resident to wheelchair. Further review of the progress note indicated there was no documentation to support whether Resident #2 had refused to transfer to his/her wheelchair, or if he/she provided any reasons to stay in bed. -01/08/25, timed 05:54 P.M., a nurse progress note indicated Resident #2 tolerated being out of bed well, and did not complain of pain. Further review of the progress note indicated there was no documentation to support the amount of time Resident #2 had been out of bed in his/her wheelchair. -01/13/25, timed 02:26 P.M., a nurse progress note provided complete documentation, as ordered by the physician. -01/14/25 through 01/22/25, no nurse progress note on any shift. -01/23/25, timed 10:22 P.M., a nurse progress note provided complete documentation, as ordered by the physician. -01/24/25 through 01/26/25, no nurse progress note on any shift. -01/27/25, timed 10:23 A.M., a nurse progress note indicated Resident #2 was out of bed in the A.M. Further review of the progress note indicated there was no documentation to support the amount of time Resident #2 was in his/her wheelchair or how well he/she tolerated it. -01/28/25, timed 10:11 P.M., a nurse progress note provided complete documentation as ordered by the physician. -01/29/25, no nurse progress note on any shift. -01/30/25, timed 10:24 A.M., a nurse progress note indicated Resident #2 was out of bed in his/her wheelchair. Further review of the progress note indicated there was no documentation to support the amount of time Resident #2 was in his/her wheelchair or how well he/she tolerated it. -02/01/25 through 02/09/25, no nurse progress note on any shift. -02/10/25, timed 09:09 P.M., a nurse progress note indicated Resident #2 requested to stay in bed. Further review of the progress note indicated there was no documentation to support whether staff re-approached Resident #2, or how many attempts were made by staff. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/11/25 at 03:30 P.M., the Director of Nurses (DON) said nurses should have written progress notes regarding Resident #2's transfers, time and tolerance for being in his/her wheelchair, any refusals and staff interventions, and said nurses had not documented on Resident #2's transfers, per his/her physician's orders.