

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Neville Center at Fresh Pond for Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 640 Concord Avenue Cambridge, MA 02138	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>36797</p> <p>Based on observation and interview, the facility failed to provide residents with a dignified dining experience on one of three units.</p> <p>Findings include:</p> <p>On 7/22/24 at 8:41 A.M., the surveyors observed residents on the 3rd floor unit being served on institutional trays in the dining room during the breakfast meal.</p> <p>On 7/23/24 at 8:32 A.M., the surveyors observed residents on the 3rd floor unit being served on institutional trays in the dining room during the breakfast meal.</p> <p>On 7/23/24 at 12:34 A.M., the surveyors observed residents on the 3rd floor unit being served on institutional trays in the dining room during the lunch meal.</p> <p>During an interview on 7/23/24 at 12:41 P.M., Unit Manager #1 said that all the meals are served on trays in the dining rooms.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016</p> <p>Based on record review and interview, the facility failed for one Resident (#81) of 25 sampled residents, to develop a baseline care plan to address his/her risk for falls.</p> <p>Findings include:</p> <p>The facility policy Accident and Incidents Guideline dated 2/8/2018, indicated:</p> <p>- The interdisciplinary team (IDT), based upon the identified potential risk factors develops and implements an individualized plan of care.</p> <p>Resident #81 was admitted to the facility in July 2024, and had diagnoses which included difficulty in walking, ataxia (loss of coordination of voluntary muscle movements), repeated falls, Parkinson's disease, syncope (fainting) and collapse, and orthostatic hypotension (low blood pressure that happens when standing after sitting or lying down and can cause dizziness or lightheadedness and possibly fainting).</p> <p>Review of Resident #81's Fall Risk assessment dated [DATE], indicated he/she was at a moderate risk for falls. The assessment indicated a falls care plan was to be developed and it included specific goals and interventions.</p> <p>Review of Resident #81's Fall Incident Assessment, dated 7/8/24, indicated he/she fell at approximately 2:30 A.M. and staff found the Resident on the floor next to the bed. The assessment indicated Resident #81 did not sustain any injuries. The assessment indicated there was no fall care plan, or goals and interventions to manage this risk.</p> <p>On 7/22/24 at approximately 1:00 P.M., the surveyor reviewed Resident #81's care plan in the electronic medical record and noted there was no baseline care plan to address his/her risk for falls, as identified in the fall assessments. The surveyor re-reviewed the record and determined a baseline or comprehensive fall-risk care plan had not been developed.</p> <p>Review of Resident #81's physician orders dated July 2024, indicated there were no orders for interventions to manage his/her risk for falls.</p> <p>On 7/23/24 at approximately 8:20 A.M., the surveyor requested a hard copy of Resident #81's baseline care plans from staff. The care plans provided included a falls care plan, developed by Unit Manager #3. Review of Resident #81's falls care plan indicated it was initiated on 7/7/24 (date of admission) but created on 7/23/24. The falls care plan also had a revision date of 7/23/24. Further review of the falls care plan with a creation date of 7/23/24, indicated the focus: Fall Risk - Resident is at risk for fall and/or injury. Has a change in mobility. Has a change in transfer ability. Newly admitted to different environment.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the MDS (minimum data set) Director on 7/23/24 at approximately 10:00 A.M., she opened Resident #81's electronic medical record. The MDS Director and surveyor observed that a baseline falls care plan was present. The baseline falls care plan had a documented initiation date of 7/7/24, a creation date of 7/23/24, and a revision date of 7/23/24. The MDS Director said she did not understand how the care plan could be initiated on 7/7/24 yet created on 7/23/24.</p> <p>During an interview with Unit Manager #3 on 7/23/24 at approximately 1:00 P.M., she said she completed Resident #81's Fall Risk Assessment on 7/7/24. She said Resident #81's Fall Risk Assessment would have triggered the creation of a baseline falls care plan, and included in it would be the focus, goals, and interventions auto populated from the assessment. Unit Manager #3 said that on 7/23/24 she noticed the goals section of the assessment did not auto populate to the care plan so she entered this revised information into the falls care plan on this date. Unit Manager #3 said she was unable to explain why the creation date for the falls care plan was 7/23/24.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797</p> <p>Based on observation, record review and interview the facility failed to develop a dental care plan for one Resident (#87) out of 25 sampled residents.</p> <p>Findings include:</p> <p>Resident #87 was admitted to the facility in February 2024 with diagnoses including malnutrition, kidney disease and depression.</p> <p>On 7/22/24, at 8:50 A.M. the surveyor observed Resident #87 to have only two top teeth, both of which were carious.</p> <p>During an interview on 7/22/24 at 8:50 A.M. Resident #87 said that he/she wants to see a dentist. Resident #87 then said that he/she thinks that his/her partial plates were lost in the move to the facility.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE], indicated that Resident #87 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating intact cognition.</p> <p>Review of the facility document titled NUT-Nutrition/Hydration Assessment V3-V4 dated 5/8/24, section V. Oral Status/Swallowing indicated that Resident #87 had missing or broken teeth and had a partial lower denture as well as mild dysphagia (difficulty swallowing) due to lack of dentition, per Speech Language Therapy (SLP).</p> <p>Review of the facility documents titled SLP Evaluation and Plan of Treatment, dated 5/22/24, indicated the following:</p> <p>Patient with no lower denture found in mouth or anywhere in the room, not safe for upgrade (in diet texture) due to no denture.</p> <p>Review of the facility document titled Speech Therapy Treatment Encounter Note(s), dated 5/22/24, indicated the following:</p> <p>Patient with signs/symptoms dysphagia including impaired mastication (chewing) due to poor dentition/missing partials.</p> <p>Review of the care plan dated initiated on 2/9/24 failed to indicate a plan of care for dental care.</p> <p>During an interview on 7/23/24 at 9:44 A.M., Unit Manager #1 said that she would expect that a care plan would be in place for Resident #87's dental concerns.</p> <p>(continued on next page)</p>		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/23/24 at 12:15 P.M., MDS Nurse #1 said that he gets the information to document the admission MDS from the Admission Nursing Assessment. MDS Nurse #1 then said that the Admission Nursing Assessment is incorrect.		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807</p> <p>Based on observations, interviews and record review, the facility failed to ensure the environment was free from hazards that could cause accidents for one Resident (#79) out of a sample of 25 Residents. Specifically, the facility failed to pad the Resident's side rails as ordered.</p> <p>Findings include:</p> <p>A review of the facility's policy titled 'Accident & Incidents Guideline' with a revision date of February 2018 indicated the following:</p> <p>-It is the center's policy to provide an environment that is free from hazards over which the center has control. The intent of this policy is that the center identifies each resident at risk for accidents, and adequately plans care and implements procedures to prevent accidents.</p> <p>Resident #79 was admitted to the facility in December 2022 with diagnoses including localization related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus.</p> <p>A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 indicating intact cognition. Further review of the MDS indicated that the Resident has a diagnosis of seizure disorder or epilepsy.</p> <p>On 7/22/24 at 8:15 A.M., the surveyor observed the Resident in bed with two quarter side rails up on the right and left side of the bed. The two quarter side rails were not padded.</p> <p>On 7/23/24 at 8:09 A.M., the surveyor observed the Resident in bed with two quarter side rails up on the right and left side of the bed. The two quarter side rails were not padded.</p> <p>A review of the July 2024 physician's orders indicated the following:</p> <p>-Use 1/4 siderails on right and left side of the bed.</p> <p>-Monitor for seizures every shift.</p> <p>-Padded side rails when in bed every shift.</p> <p>A review of the care plan initiated 12/22/22 indicated the following:</p> <p>-Focus: Seizure Disorder-Resident is at risk for injury related to seizure disorder.</p> <p>-Intervention: Pad side rails on the bed.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 7/23/24 at 11:02 A.M., Certified Nurses Assistants (CNAs) #1 and #2 and surveyor observed the Resident in bed, the two quarter side rails on the left and right side of the bed were up and not padded. They said the Resident recently moved from a different room. They said they have not seen his/her side rails padded since he/she moved to this room, they both looked around the room and could not locate any side rails pads. The CNAs said they were not aware that the Resident's side rails should be padded. The CNAs said the Unit Manager, or the Nurse has not informed them that the Resident should have padded side rails while in bed.</p> <p>During an interview and observation on 7/23/24 at 9:16 A.M., the surveyor and Nurse #2 observed the Resident in bed with two quarter side rails up on the left and right side of the bed. The two quarter side rails were not padded. Nurse #2 said that both side rails should be padded if the physician's orders indicated so.</p> <p>A review of a social services progress note dated 7/8/24 indicated the following:</p> <p>-Due to roommate incompatibility, the Resident will be moved from 205 B to 212 A. Roommate change form completed and filed.</p> <p>During a telephone interview on 7/25/24 at 10:09 A.M., Social Worker #1 said Resident # 79 changed rooms on 7/8/24.</p> <p>During an interview and observation on 7/23/24 at 9:35 A.M., Unit Manager #2 and surveyor observed the Resident in bed, the quarter side rails on the left and right side of the bed were up and not padded, she said physician's orders should be followed as indicated.</p> <p>During an interview on 7/23/24 at 11:58 P.M., the Director of Nurses and Assistant Director of Nurses said Resident #79 has a history of seizures and his/her right and left side rails should be padded while he/she is in bed. They said he/she recently changed rooms and staff did not move his/her side rail pads to his/her new bed. They both said physician's orders should be followed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016</p> <p>Based on interviews, policy review and observations, the facility failed to secure medication on one of three units (second floor).</p> <p>Findings include:</p> <p>Review of the facility policy Storage of Medications dated [DATE], indicated:</p> <p>- Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity control.</p> <p>On [DATE] at 8:42 A.M., on the second floor unit, the surveyor observed Nurse #1 remove an expired bottle of liquid Trazodone, 5 milligrams per milliliter, from the refrigerator located in the unit's locked medication room. Nurse #1 gave the medication to Unit Manager #2, who then placed it on the nursing station desk, which was located approximately two feet from the common area hallway.</p> <p>Trazodone is a prescription medication used for the treatment of depression.</p> <p>On [DATE] at 9:33 A.M., the surveyor returned to the second floor unit and observed the same bottle of liquid Trazodone on the nursing station desk. No staff were at the desk or the nursing station, and none within view. The surveyor observed a resident walking in the hallway with a rehabilitation therapist, passing the nursing station desk.</p> <p>On [DATE] at 9:41 A.M., Unit Manager #2 entered the nursing station and sat down next to the medication. Unit Manager #2 said she was looking into whether the physician wanted to reorder or discontinue the Trazodone. The surveyor told Unit Manager #2 he had observed the Trazodone on the desk unsecured and unattended for almost 10 minutes. Unit Manager #2 said the Trazodone should have been either secured or attended to by nursing staff.</p> <p>On [DATE] at 9:47 A.M., Unit Manager #2 stood up and left the nursing station. The Trazodone remained on the desk, unsecured, and no other nursing staff were in the area.</p> <p>On [DATE] at 9:51 A.M., Unit Manager #2 returned to the nursing station and entered the medication room. Unit Manager #2 then left the medication room and sat at the nursing station desk, in front of the Trazodone. Unit Manager #2 said she was still looking into whether the physician wanted to reorder or discontinue the Trazodone. The surveyor told Unit Manager #2 the Trazodone had, again, been left on the desk, unsecured and unattended by staff. Unit Manager #2 said the Trazodone should not have been left unsecured and unattended on the desk.</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797</p> <p>Based on records reviewed and interviews for two Residents (#87 and #89) out of a total sample of 25, the facility failed to provide dental care. Specifically:</p> <ol style="list-style-type: none"> 1. For Resident #87, who had broken/carious teeth and lost his/her lower dentures, the facility failed to ensure he/she had a timely dental consultation. 2. For Resident #89, the facility failed to follow up on the recommendation for the fabrication of the upper dentures, three months after originally recommended. <p>Findings Include:</p> <p>Review of the facility policy titled Dental Care guideline dated 5/23/18, indicated the following:</p> <p>The facility will if necessary or requested, assist the resident with making appointments or arrange dental services.</p> <p>A dentist will be made available for each resident through a contractual agreement by an approved dental provider that services the center or from the community.</p> <ol style="list-style-type: none"> 1. Resident #87 was admitted to the facility in February 2024 with diagnoses including malnutrition, kidney disease and depression. <p>On 7/22/24 at 8:50 A.M. the surveyor observed Resident #87 to have only two top teeth, both of which were carious.</p> <p>During an interview on 7/22/24 at 8:50 A.M. Resident #87 said that he/she wants to see a dentist. Resident #87 then said that he/she thinks that his/her partial plates were lost in the move to the facility and his/her teeth need fixing.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE], indicated that Resident #87 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating intact cognition.</p> <p>Review of the medical record indicated a consent for dental services dated 5/28/24.</p> <p>Review of the facility document titled NUT-Nutrition/Hydration Assessment V3-V4 dated 5/8/24, section V. Oral Status/Swallowing indicated that Resident #87 had missing or broken teeth and had a partial lower denture as well as mild dysphagia (difficulty swallowing) due to lack of dentition, per Speech Language Therapy (SLP).</p> <p>Review of the facility document titled SLP Evaluation and Plan of Treatment, dated 5/22/24, indicated the following:</p> <p>Patient with no lower denture found in mouth or anywhere in the room, not safe for upgrade (in diet texture) due to no denture.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility document titled Speech Therapy Treatment Encounter Note(s), dated 5/22/24, indicated the following:</p> <p>Patient with signs/symptoms dysphagia including impaired mastication (chewing) due to poor dentition/missing partials.</p> <p>During an interview on 07/23/24 at 9:44 A.M., Unit Manager #1 said that she would expect that Resident #87 would have been seen by a dentist.</p> <p>2. Resident #89 was admitted to the facility with diagnoses including cancer, heart disease and anxiety.</p> <p>During an interview on 7/22/24, at 10:43 A.M. Resident #89 said that he/she needs to see a dentist to have dentures redone.</p> <p>Review of the minimum Data Set (MDS) dated [DATE] indicated Resident #89 scored a 13 out of 15 on the Brief Interview for Mental Status exam indicating intact cognition. Further review indicated that Resident #87 has decayed, broken teeth and a loosely fitting full upper denture.</p> <p>Review of the doctor's orders dated July 2024 indicated an order initiated on 3/8/24, may be seen by dentist as needed.</p> <p>Review of the care plan dated 3/11/24 indicated a focus for dental with an intervention to coordinate arrangements for dental care.</p> <p>Review of the medical record indicated a consent for dental services dated 4/10/24.</p> <p>Review of the facility documents titled Risk progress Assessment (LMHS) dated 4/28/24 and 5/20/24, indicated that Resident #89 had been approved for denture fabrication.</p> <p>During an interview on 7/23/24 at 8:23 A.M., Unit Manager #1 said that the dentist's recommendation for new dentures should have been followed up on.</p> <p>During an interview on 7/23/24 at 10:25 A.M., the Director of Nursing said that the dental service had seen the Resident on 4/15/24 and sent a letter to the Resident's financial power of attorney with the expected costs, but the facility had not followed up with the dental service to find out what the status of the refabrication of the denture was, now more than three months later.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797</p> <p>Based on observation, record review and interview, the facility failed to maintain accurate medical records in accordance with professional standards and practices for two Residents (#87 and #79) out of a total sample of 25 residents. Specifically:</p> <ol style="list-style-type: none"> 1. For Resident #87, the facility failed to accurately document the dental status on the nursing admission assessment, 2. For Resident #79, the facility failed to accurately document the presence of side rail pads after Resident #79's room change. <p>Findings include:</p> <p>Review of the facility policy titled Nursing Admission guideline dated as revised on 12/20/22, indicated that the purpose of this guideline is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS (minimum data set). Further review indicated that the nurse conducts an admission assessment including a review of systems to include teeth and gums as well as all active patient problems. Further review indicated that all relevant assessment data obtained is documented in the resident's medical record.</p> <p>1. Resident #87 was admitted to the facility in February 2024 with diagnoses including malnutrition, kidney disease and depression.</p> <p>Review of the MDS dated [DATE], indicated that Resident #87 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Further review indicated that Resident #87 has no broken or carious teeth.</p> <p>On 7/22/24 at 8:50 A.M. the surveyor observed Resident #87 to have only two top teeth, both of which were carious.</p> <p>During an interview on 7/22/24 at 8:50 A.M. Resident #87 said that he/she wants to see a dentist. Resident #87 then said that he/she thinks that his/her partial plates were lost in the move to the facility and his/her teeth need fixing.</p> <p>Review of the facility document titled NUT-Nutrition/Hydration Assessment V3-V4 dated 5/8/24, section V. Oral Status/Swallowing indicated that Resident #87 had missing or broken teeth and had a partial lower denture as well as mild dysphagia (difficulty swallowing) due to lack of dentition, per Speech Language Therapy (SLP).</p> <p>Review of the facility document titled SLP Evaluation and Plan of Treatment, dated 5/22/24, indicated the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Neville Center at Fresh Pond for Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 640 Concord Avenue Cambridge, MA 02138	
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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Patient with no lower denture found in mouth or anywhere in the room, not safe for upgrade (in diet texture) due to no denture.</p> <p>Review of the facility document titled Speech Therapy Treatment Encounter Note(s), dated 5/22/24, indicated the following:</p> <p>Patient with signs/symptoms dysphagia including impaired mastication (chewing) due to poor dentition/missing partials.</p> <p>Review of the initial nursing assessment titled NSG-Admission/Readmission Evaluation-V4, dated 2/9/24, section G Oral and Nutrition #1, indicated the Resident has no oral, dental, or swallowing issues evident at this time.</p> <p>During an interview on 7/23/24, at 12:15 P.M., MDS Nurse #1 said that he gets the information to complete the admission MDS from the NSG-Admission/Readmission Evaluation-V4. MDS Nurse #1 then said that the admission nursing assessment is incorrect, which is also the reason the MDS is inaccurate.</p> <p>43807</p> <p>2. Resident #79 was admitted to the facility in December 2022 with diagnoses including symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus.</p> <p>A review of Resident #79's most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 indicating intact cognition. Further review of the MDS indicated that the Resident has a diagnosis of seizure disorder or epilepsy.</p> <p>On 7/22/24 at 8:15 A.M., the surveyor observed the Resident in bed, the left and right quarter side rails were up. The two quarter side rails were not padded.</p> <p>On 7/23/24 at 8:09 A.M., the surveyor observed the Resident in bed, the left and right quarter side rails were up. The two quarter side rails were not padded.</p> <p>A review of the July 2024 physician's orders indicated the following:</p> <ul style="list-style-type: none"> -Use 1/4 siderails on right and left side of the bed. -Monitor seizures every shift. -Padded side rails when in bed every shift. <p>A review of the care plan initiated 12/22/22 indicated the following:</p> <p>Focus: Seizure Disorder - Resident is at risk for injury related to seizure disorder.</p> <p>Intervention: Pad side rails on the bed.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 7/23/24 at 11:02 A.M., Certified Nurses Assistants (CNAs) #1 and #2 and the surveyor observed the Resident in bed. The right and left quarter side rails were up and not padded. The CNAs said the Resident recently moved from a different room. They said they have not seen his/her side rails padded since he/she moved to this room. Both CNAs looked around the room and could not locate any side rails pads. The CNAs said they were not aware that the Resident's side rails should be padded. The CNAs said the Unit Manager or the Nurse had not informed them that the Resident should have padded side rails while in bed.</p> <p>A review of a social services progress note dated 7/8/24 indicated the following:</p> <ul style="list-style-type: none"> - Due to roommate incompatibility, the Resident will be moved from 205 B to 212 A. Roommate change form completed and filed. <p>During a telephone interview on 7/25/24 at 10:09 A.M., Social Worker #1 said Resident #79 changed rooms on 7/8/24.</p> <p>A review of the July 2024 Treatment Administration Record (TAR) indicated staff had checked off that Resident #79's side rails were padded when the Resident was in bed on all three shifts dated 7/9/24, 7/10/24, 7/11/24, 7/12/24, 7/13/24, 7/14/24, 7/15/24, 7/16/24, 7/17/24, 7/18/24, 7/19/24, 7/20/24, 7/21/24 and 7/22/24.</p> <p>During an interview on 7/23/24 at 12:28 P.M., the Director of Nurses and Assistant Director of Nurses said Resident #79 has a history of seizures and his/her left and right side rails should be padded while he/she is in bed. They said he/she recently changed rooms and staff did not move his/her side rail pads from his/her old bed to his/her new bed. They both said staff are expected to check for equipment before documenting in the medical record. They said Resident #79's medical record was not accurately documented because he/she did not have side rail pads on his/her new bed after the room change on 7/8/24.</p>		