STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225404	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Hill Rehabiliation & Healthcare Center	190 North Avenue Haverhill, MA 01830

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 - 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 records reviewed and interviews, for one of three sampled residents (Resident #3), whose comprehensive plan of care and Care Kardex (a summary of the resident's care needs, utilized by Certified Nurse Aides) indicated he/she required staff assistance with ambulation, the Facility failed to ensure staff consistently implemented and followed interventions related to ambulation, per his/her plan of care. On 02/11/25, Certified Nurse Aide (CNA) #2 saw Resident #3 ambulating by him/herself, and although she thought he/she required staff supervision with ambulation, CNA #2 did not provide him/her with supervision or assistance (per the plan of care) with ambulation. Resident #3 ambulated unassisted to his/her room, fell , was found a short time afterward on the floor, and was bleeding from a cut on his/her left eyebrow. Resident #3 was transferred to the Hospital Emergency Department (ED) and required three sutures to close the wound. Findings include: The Facility Policy, titled Comprehensive Person-Centered Care Plans, dated as revised 03/2022, indicated a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs would be developed and implemented for each resident. The Facility Policy, titled Managing Falls and Fall Risk, dated as revised 03/2018, indicated that based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling, and the staff would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk. Resident #3 was admitted to the Facility in February 2023, diagnoses included chronic kidney disease, anemia, depression, anxiety, and insomnia. Review of Resident #3's Annual Minimum Data Set (MDS) Assessment, dated 01/16/25, indicated he/she required partial to moderate assistance from staff with ambulation. Review of Resident #3's Activities of Daily Living Care Plan, reviewed and renewed with his/her January 2025 MDS, indicated interventions included Resident #3 required assistance of one staff member for ambulation. (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: 225404	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER Aspen Hill Rehabiliation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 190 North Avenue Haverhill, MA 01830	

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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 - Actual harm Residents Affected - Few	Review of Resident #3's CNA Kardex Report, dated 02/11/25, indicated he/she required one staff member assistance with ambulation. Review of Resident #3's Nurse Progress Note, dated 02/11/25, indicated that at 02:45 P.M., Resident #3 was found by a physician on the floor in his/her room, he/she was complaining of neck pain, and was bleeding from a cut on the left side of his/her forehead. The Progress Note indicated Resident #3 was transferred to the Hospital ED for evaluation. Review of Resident #3's Hospital ED Discharge Summary, dated 02/11/25, indicated Resident #3 was diagnosed with a left eyebrow laceration as a result of a fall at the Facility, and required three sutures to close the wound. During an interview on 03/10/25 at 02:37 P.M., Certified Nurse Aide (CNA) #2 said she was familiar with Resident #3 and had been his/her assigned CNA many times. CNA #2 said the CNAs accessed the residents' Kardex's via the computer, and said she had been trained to do so prior to caring for her assigned residents. CNA #2 said she had never reviewed Resident #3's Kardex. CNA #2 said she thought Resident #3's ambulation status was that he/she was independent with just staff supervision. CNA #2 said she had seen Resident #3 ambulating without assistance in the past, so she had not checked his/her ambulation status on the Kardex. CNA #2 said that on 02/11/25 at 02:40 P.M., she was monitoring the residents in the unit dining room while the Activities Aide was off the unit, when Resident #3 got up and left the dining room. CNA #2 said she asked Resident #3 to wait because she could not leave the other residents unsupervised, but Resident #3 said he/she wanted to go to his/her room, and left. CNA #2 said she called out to a nurse (exact name unknown) who was down the hall working at a medication cart that Resident #3 was ambulating, but the nurse did not respond. CNA #2 said five minutes later she was relieved from monitoring the Dining Room by the Activities Aide, so she went to check on Resident #3, but he/she had already fallen and nursing staff were attending to him/her. During an interview on 03/10/25 at 01:20 P.M., The Unit Manager said that on 02/11/25 at the time Resident #3 fell , she was in her office. During an interview on 03/11/25 at 08:15 A.M., Nurse #1 said she was normally Resident #3's nurse and that on 02/11/25 she was his/her nurse. Nurse #1 said she was not sure what Resident #3's Care Plan indicated his/her ambulation status was, and said he/she usually ambulated by his/herself. Nurse #1 said at the time Resident #3 fell , she was off the unit on her break. During an interview on 03/10/25 at 02:12 P.M., Nurse #5 said that on 02/11/25 between 02:30 P.M., and 02:40 P.M., she was preparing and administering medications to residents on the unit, said she did not see Resident #3 at that time and did not hear CNA #2 say anything about Resident #3 ambulating by him/herself. Nurse #5 said she was not familiar with Resident #3's ambulation status at all, and said she only knew him/her in passing as she had never been his/her assigned nurse. During an interview on 03/10/25 at 03:41 P.M., the Director of Nurses (DON) said Resident #3's Plan of Care and Kardex, indicated he/she required assistance from one staff member for ambulation, and it was expected that staff would follow the Plan of Care, but that on 2/11/25, staff had not done so.

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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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37342 Based on records reviewed and interviews, for one of three sampled residents (Resident #3), who was assessed by nursing as being at risk for falls, the Facility failed to ensure he/she was provided with the necessary level of staff assistance to prevent an incident resulting in an injury. On 02/11/25, Certified Nurse Aide #2, who was familiar with and had provided care to Resident #3, observed him/her ambulating alone, but did not provide or get another staff member to assist or supervise him/her. Resident #3 was found a short time later on the floor in his/her room, was bleeding from a cut on his/her left eyebrow, was transferred to the Hospital Emergency Department (ED) and required three sutures to close the head wound. Findings include: The Facility Policy, titled Managing Falls and Fall Risk, dated as revised 03/2018, indicated that based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling, and the staff would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk. Resident #3 was admitted to the Facility in February 2023, diagnoses included chronic kidney disease, anemia, depression, anxiety, and insomnia. Review of Resident #3's Fall Risk Evaluation, dated 10/11/24, indicated he/she was at risk for falls due to deconditioning and weakness. Review of Resident #3's Annual Minimum Data Set Assessment, dated 01/16/25, indicated he/she required partial to moderate assistance from staff with ambulation. Review of Resident #3's Activities of Daily Living Care Plan, reviewed and renewed with the January 2025 MDS, indicated interventions included Resident #3 required assistance of one staff member for ambulation. Review of Resident #3's Kardex Report (a summary of the resident's care needs, utilized by Certified Nurse Aides), dated 02/11/25, indicated he/she required one staff member assistance with ambulation. Review of Resident #3's Nurse Progress Note, dated 02/11/25, indicated that at 02:45 P.M., Resident #3 was found by a physician on the floor in his/her room, he/she was complaining of neck pain, and was bleeding from a cut on the left side of his/her forehead. The Progress Note indicated Resident #3 was transferred to the Hospital ED for evaluation. Review of Resident #3's Hospital ED Discharge Summary, dated 02/11/25, indicated Resident #3 was diagnosed with a left eyebrow laceration as a result of a fall at the Facility, and required three sutures to close the wound. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/10/25 at 02:37 P.M., Certified Nurse Aide (CNA) #2 said she was familiar with Resident #3 and had been his/her assigned CNA many times. CNA #2 said she thought Resident #3's ambulation status was for staff to supervise him/her. CNA #2 said she had seen him/her ambulating without assistance in the past. CNA #2 said that on 02/11/25 at 02:40 P.M., she was monitoring the residents in the unit dining room while the Activities Aide was off the unit, when Resident #3 got up and left the dining room. CNA #2 said she asked Resident #3 to wait because she could not leave the other residents unsupervised, but Resident #3 said he/she wanted to go to his/her room, and left. CNA #2 said she called out to a nurse (exact name unknown) who was down the hall working at a medication cart that Resident #3 was ambulating, but the nurse did not respond. CNA #2 said five minutes later she was relieved from monitoring the Dining Room by the Activities Aide, so she went to check on Resident #3, but he/she had already fallen and nursing staff were attending to him/her. During an interview on 03/10/25 at 01:20 P.M., The Unit Manager said that on 02/11/25 at the time Resident #3 fell , she was in her office. During an interview on 03/11/25 at 08:15 A.M., Nurse #1 said she was normally Resident #3's nurse and that on 02/11/25 she was his/her nurse. Nurse #1 said at the time Resident #3 fell , she was off the unit on her break. During an interview on 03/10/25 at 02:12 P.M., Nurse #5 said that on 02/11/25 between 02:30 P.M., and 02:40 P.M., she was preparing and administering medications to residents on the unit, and said she did not see Resident #3 at that time and did not hear CNA #2 say anything about Resident #3 ambulating by him/herself. During an interview on 03/10/25 at 03:41 P.M., the Director of Nurses (DON) said Resident #3 required assistance from one staff member for ambulation, and it was expected that staff would provide the necessary level of care and assistance to each resident.