STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225409	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nevins Nursing & Rehabilitation Center	Ten Ingalls Court Methuen, MA 01844

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 observations, records reviewed and interviews, for one of three sampled residents (Resident #1), who was assessed by nursing as being at high risk for falls, and whose comprehensive plan of care indicated he/she required the use of monitoring devices (bed and chair alarms) to alert staff when he/she attempted to stand or transfer alone, the Facility failed to ensure staff consistently implemented and followed interventions identified in his/her plan of care, when on 05/22/24, Nurse #1 left Resident #1 alone, without an alarm in place, seated on the commode in his/her room, Resident #1 fell , later complained of pain, was transferred to the Hospital Emergency Department and was diagnosed with a fractured right hip which required surgical intervention to repair. Findings include: The Facility's Policy, titled Comprehensive Person-Centered Care Plans, dated as revised 03/2022, indicated that a comprehensive, person-centered care plan to meet the resident's needs would be developed and implemented. The Facility's Policy, titled Guidelines for the Use of Position Change Alarms, dated 2021, indicated position change alarms were defined as alerting devices that emitted an audible signal when a resident moved in a certain way and was intended to monitor a resident's movement when a resident who required contact guard or physical assistance was attempting to stand or transfer independently. The Facility's Policy, titled Falls Prevention and Management Program, dated 09/2018, indicated residents would be assessed for risk for falls and interventions would be implemented as appropriate. Resident #1 was admitted to the Facility in December 2022, diagnoses included unsteadiness on feet, and cognitive decline. Review of Resident #1's Morse Fall Scales Assessment, dated 02/23/24 and 05/13/24, indicated he/she was assessed by nursing as being at high risk for falls Review of Resident #1's Minimum Data Set (MDS) assessment, dated 05/17/24, indicated he/she was severely cognitively impaired. (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

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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 #1's Falls Care Plan, reviewed and renewed with his/her May MDS (with a target date of 09/17/24), indicated he/she had an intervention, dated as initiated 12/27/22, for bed and chair alarms, and staff were to ensure the device was in place and functioning properly. Review of Resident #1's Care Kardex Report (utilized by Certified Nurse Aides and provides direct care staff with a brief overview of each resident's needs), dated 05/22/24, indicated he/she required the use of bed and chair alarms. Review of Resident #1's Nurse Progress Note, dated 05/22/24, indicated his/her bed alarm was functioning and sounded when he/she transferred him/herself from bed to the bedside commode. The Note indicated that Nurse #1 responded and left Resident #1 alone in his/her room on the commode, then a few minutes later Nurse #1 heard a bang and found Resident #1 on the floor. The Note indicated Resident #1 later complained of pain, was screaming, and was transferred to the Hospital Emergency Department via 911. Review of Resident #1's Hospital X-ray Report of his/her right hip, dated 05/23/24, indicated he/she had an impacted right femoral neck fracture. Review of Resident #1's Hospital Discharge Summary, dated 05/30/24, indicated he/she was admitted to the Hospital 05/23/24, diagnosed with a right hip fracture and required an Open Reduction Internal Fixation (ORIF) surgical intervention. During a telephone interview on 06/20/24 at 9:32 A.M., Nurse #1 said she knew Resident #1, that he/she was known to be impulsive and to self-transfer. Nurse #1 said that on 05/22/24 at 8:15 P.M., she heard Resident #1's bed alarm sounding and when she got to his/her room, he/she had already self-transferred to his/her bedside commode. Nurse #1 said she turned off the bed alarm, gave Resident #1 his/her call bell, pulled the privacy curtain closed, and left Resident #1's room. Nurse #1 said she was outside Resident #1's bedroom door at her medication cart for about five minutes and heard a loud bang, and said she found Resident #1 lying on the floor on his/her right side. Nurse #1 said at that time Resident #1 did not complain of any pain, and she and another staff member lifted him/her back into bed, then an hour later, Resident #1 started yelling in pain holding his/her right hip, and he/she was transferred to the Hospital Emergency Department via 911. During an interview on 06/18/24 at 11:23 A.M., Unit Manager #1 said Resident #1 was known to be impulsive and had a history of falls. Unit Manager #1 said Resident #1 should not have been left on the commode unsupervised, and without an alarm in place. During an observation on 06/18/24 at 11:38, on Resident #1's unit, accompanied by Unit Manager #1, upon entering the hallway, the Surveyor observed Certified Nurse Aide (CNA) #1 walk out of Resident #1's room and go to a linen cart located at the other end of the hall several yards away from Resident #1's room, observed CNA #1 walk back and enter Resident #1's room. Unit Manager #1 then entered Resident #1's room and said that he/she was in the bathroom, and seated on the toilet. Unit Manager #1 said there were no other staff members besides CNA #1 with Resident #1. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Unit Manager #1 said Resident #1 was seated on the toilet, without an alarm, and there were no other staff present in the bathroom with Resident #1. Unit Manager #1 said CNA #1 should not have left Resident #1 alone without an alarm in place. During an interview on 06/18/24 at 12:11 P.M., Certified Nurse Aide (CNA) #1 said he was familiar with Resident #1 and said he/she is often on his assignment. CNA #1 said Resident #1 was known to be confused, impulsive, had a history of falls, and had bed and chair alarms in place. CNA #1 said when he transferred Resident #1 to the toilet, he had to disarm the chair alarm, and said there was not an alarm in place when he/she was seated on the toilet. CNA #1 said he left Resident #1 alone, without an alarm, on the toilet to get linen, and said he should not have. During an interview on 06/18/24 at 01:18 P.M., The Director of Nurses (DON) said residents whose plan of care indicated they required a bed and chair alarm should not be left unattended while seated on a toilet or commode. The DON said Resident #1 should have been supervised for safety while seated on the commode and on the toilet but was 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 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 #1), who was assessed by nursing as being at high risk for falls, was known to be impulsive and whose fall risk interventions included the use of monitoring devices (bed and chair alarms) to alert staff when he/she rose from a sitting or lying position, the Facility failed to ensure he/she was provided with the necessary level of staff supervision to maintain his/her safety, when on 05/22/24, after disabling his/her alarm, Nurse #1 left Resident #1 unattended on the commode, Resident #1 fell to the floor, complained of pain, and was transferred to the Hospital Emergency Department where he/she was diagnosed with a fractured right hip, which required surgical intervention to repair Findings include: The Facility's Policy, titled Falls Prevention and Management Program, dated 09/2018, indicated residents would be assessed for risk for falls and interventions would be implemented as appropriate. The Facility's Policy, titled Guidelines for the Use of Position Change Alarms, dated 2021, indicated position change alarms were defined as alerting devices that emitted an audible signal when a resident moved in a certain way and was intended to monitor a resident's movement when a resident who required contact guard or physical assistance was attempting to stand or transfer independently. Resident #1 was admitted to the Facility in December 2022, diagnoses included unsteadiness on feet, and cognitive decline. Review of Resident #1's Morse Fall Scales Assessments, dated 02/23/24 and 05/13/24, indicated he/she was assessed by nursing as being at high risk for falls. Review of Resident #1's Minimum Data Set (MDS) assessment, dated 05/17/24, indicated he/she was severely cognitively impaired. Review of Resident #1's Falls Care Plan, reviewed and renewed with his/her May MDS, with a target date of 09/17/24, indicated he/she had an intervention (dated as initiated on 12/27/22) for bed and chair alarms, and staff were to ensure the device was in place and functioning properly. Review of Resident #1's Care Kardex Report (utilized by Certified Nurse Aides and provides direct care staff with a brief overview of each resident's needs), indicated he/she required the use of bed and chair alarms. Review of Resident #1's Nurse Progress Note, dated 05/22/24, indicated his/her bed alarm was functioning and sounded when he/she transferred him/herself from bed to the bedside commode. The Note indicated that Nurse #1 responded and left Resident #1 alone in his/her room on the commode, then a few minutes later Nurse #1 heard a bang and found Resident #1 on the floor. The Note indicated Resident #1 later complained of pain, was screaming, and was transferred to the Hospital Emergency Department via 911. (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	Review of Resident #1's Hospital X-ray Report of his/her right hip, dated 05/23/24, indicated he/she had an impacted right femoral neck fracture. Review of Resident #1's Hospital Discharge Summary, dated 05/30/24, indicated he/she was admitted to the Hospital 05/23/24, diagnosed with a right hip fracture and required an Open Reduction Internal Fixation (ORIF) surgical intervention. During a telephone interview on 06/20/24 at 9:32 A.M., Nurse #1 said she knew Resident #1, that he/she was known to be impulsive and to self-transfer. Nurse #1 said that on 05/22/24 at 8:15 P.M., she heard Resident #1's bed alarm sounding and when she got to his/her room, he/she had already self-transferred to his/her bedside commode. Nurse #1 said she turned off the bed alarm, gave Resident #1 his/her call bell, pulled the privacy curtain closed, and left Resident #1's room. Nurse #1 said she should not have left Resident #1 alone without an alarm in place. Nurse #1 said she was outside Resident #1's bedroom door at her medication cart for about five minutes, heard a loud bang, and said she found Resident #1 lying on the floor on his/her right side. Nurse #1 said at that time Resident #1 did not complain of any pain, and she and another staff member lifted him/her back into bed, then an hour later, Resident #1 started yelling in pain holding his/her right hip, and he/she was transferred to the Hospital Emergency Department via 911. During an interview on 06/18/24 at 11:23 A.M., Unit Manager #1 said Resident #1 was known to be impulsive and had a history of falls. Unit Manager #1 said Resident #1 should not have been left on the commode unsupervised, and without an alarm in place. During an interview on 06/18/24 at 01:18 P.M., The Director of Nurses (DON) said residents whose plan of care indicated they require a bed and chair alarm should not be left unattended while seated on a toilet or commode. The DON said Resident #1 should have been supervised for safety while seated on the commode but was not.