

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER Ayer Valley Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Groton Road Ayer, MA 01432	

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 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>37086</p> <p>Based on observation, interviews and records reviewed, for one of three sampled residents (Resident #3) who's comprehensive care plan indicated he/she required the use of a Hoyer lift (mechanical mobility aid that supports a person's body weight to allow movement from one surface to another) with assistance of two staff members for all transfers, the Facility failed to ensure staff consistently implemented and followed interventions in his/her care plan, when on 06/05/24, Certified Nurse Aide (CNA) #3 transferred Resident #3 from his/her bed into the wheelchair with a Hoyer lift, without another staff member present to provide assistance.</p> <p>Findings include:</p> <p>Review of the Facility's policy titled Comprehensive Care Plan, with a revision date of 06/25/20, indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.</p> <p>Resident #3 was admitted to the Facility in January 2024, diagnoses included paraplegia (inability to voluntarily move the lower parts of the body).</p> <p>Review of Resident #3's Quarterly Minimum Data Set (MDS) Assessment, dated 04/02/24, indicated he/she scored a 15 out of 15 on his/her Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). The MDS also indicated he/she was dependent for all transfers.</p> <p>Review of Resident #3's Activities of Daily Living (ADL) Care Plan, dated 04/23/24, indicated he/she required a Hoyer lift and assistance of two staff members for all transfers.</p> <p>Review of Resident #3's Care Kardex (used by CNAs to determine individual care needs), indicated he/she required a Hoyer lift and assistance of two staff members for all transfers.</p> <p>On 06/05/24 at 12:58 P.M., while touring the unit, as this surveyor walked past Resident #3's room, the surveyor observed CNA #3, who was in the process of transferring Resident #3 (who was seated in the Hoyer lift sling and suspended in the air above the seat of his/her wheelchair at that time) lowering him/her into the wheelchair with the Hoyer lift, however there was no additional staff member in the room providing assistance to CNA #3 at that time.</p> <p>(continued on next page)</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/05/24 at 1:04 P.M. Certified Nurse Aide (CNA) #3 said Resident #3 required a Hoyer lift and assistance of two staff members for transfers. CNA #3 said the other staff on the unit were too busy and there are not a lot of us (staff) to help, so he transferred Resident #3 by himself.</p> <p>During an interview on 06/05/24 at 1:10 P.M., Resident #3 said that sometimes the nursing staff used one staff member and not two, during his/her Hoyer lift transfers.</p> <p>During an interview on 06/05/24 at 3:41 P.M., the Director of Nurses (DON) said she had never heard of a Hoyer lift being used with less than two staff members. The DON said that staff members were expected to follow the resident care plans and to use two staff members for all Hoyer lift transfers.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>37086</p> <p>Based on observations, interviews and records reviewed, for one of three nursing units (North 2), the Facility failed to ensure they provided and maintained a sufficient number of Certified Nurse Aides (CNAs) so that 1) that each resident's individual care needs were provided in a timely manner and as needed, and 2) so that each resident received their meal while food items were still palatable.</p> <p>Findings include:</p> <p>Review of the Facility Assessment, dated 02/26/24, indicated the Facility was licensed for 123 beds and there were 41 beds on the North 2 Unit. The Assessment indicated the Facility required the following for Full Time Employees (FTE):</p> <ul style="list-style-type: none"> -Certified Nurse Aides (CNA)- 29 -Licensed Practical Nurse (LPN)- 19 -Registered Nurse (RN)- 8 <p>Review of the Nursing Staff List indicated the Facility employed 11 FTE CNAs (18 less than the Facility Assessment indicated) and four FTE RNs (4 less than the Facility Assessment indicated).</p> <p>During an interview on 06/05/24 at 2:26 P.M., the Schedule Coordinator said the staffing goals on the secured North 2 Unit were as follows:</p> <ul style="list-style-type: none"> -7:00 A.M. through 3:00 P.M. (day) shift - four CNAs and one Nurse -3:00 P.M. through 11:00 P.M. (evening) shift- four CNAs and one Nurse -11:00 P.M. through 7:00 A.M. (night) shift- two CNAs and one Nurse -8:00 A.M. through 8:00 P.M. shift- one additional Nurse <p>The Schedule Coordinator said she did not consider a unit to be short staffed unless there was only one CNA on duty.</p> <p>Review of emails from the Regional Nurse Manager, dated 06/06/24 and 06/07/24, indicated that per review of the Point of Care documentation and the most recent Minimum Data Set (MDS) Assessment section GG (Activities of Daily Living) for the 40 residents that resided on the North 2 Unit, their care needs were identified as follows:</p> <ul style="list-style-type: none"> -35 Residents -were incontinent of bowel and bladder -27 Residents- had identified and exhibited behaviors at times <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-14 Residents- were totally dependent for ADL care needs</p> <p>-10 Residents- required mechanical lift transfers (which required two staff members to complete)</p> <p>-19 Residents- required minimum to moderate assistance with care</p> <p>-7 Residents- required supervision and/or set up with care</p> <p>1) Review of the Resident Council Meeting Minutes indicated the following:</p> <p>-On 03/24/24 a Resident Council Meeting was held with 15 residents in attendance. The Minutes indicated that residents said the call lights were not being answered, were taking too long to be answered, or were being shut off by staff who did not return.</p> <p>-On 04/17/24 a Resident Council Meeting was held with 13 residents in attendance. The Minutes indicated that residents said more nursing staff was needed on the units.</p> <p>-On 05/22/24 a Resident Council Meeting was held with 16 residents in attendance. The Minutes indicated that residents said call lights were not being answered in a timely manner.</p> <p>Resident #1, who resided on the North 2 Unit, was admitted to the Facility in November 2022, diagnoses included unspecified dementia and senile degeneration of the brain.</p> <p>Review of Resident #1's Significant Change Minimum Data Set (MDS) Assessment, with a reference look back period from 05/16/24 through 05/22/24, indicated he/she scored a 5 out of 15 on his/her Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact).</p> <p>The MDS also indicated that he/she was dependent for bathing, dressing, hygiene, transfers and incontinent care and he/she was always incontinent of bladder and bowel.</p> <p>Review of Resident #1's Activities of Daily Living Care Plan, reviewed and renewed with the May 2024 Significant Change MDS, indicated he/she was dependent for bathing, dressing, grooming and required 1-2 person staff assistance for bed mobility.</p> <p>Review of Resident #1's Incontinence Care Plan, reviewed and renewed with the May 2024 Significant Change MDS, indicated staff were to provide incontinence care and check/change him/her hourly.</p> <p>During a telephone interview on 06/04/24 at 11:16 A.M., Resident #1's Family Member, said that on 05/17/24 at 3:53 P.M., she found Resident #1 in bed with a top sheet, blanket, and hospital gown that were wet from urine and soiled from diarrhea, so she rang the call light for assistance.</p> <p>The Family Member said that at 3:58 P.M. a nurse (later identified as Nurse #2) came and in turned off the call light, and said there was only one Certified Nurse Aide (CNA) on the floor and they would be in soon to take care of him/her. The Family Member said the nurse and a CNA (later identified as CNA #4) did not come back until 4:35 P.M. (37 minutes later) to provide care.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Facility Daily Census for North 2 Unit, dated 05/17/24, indicated the census was 40 residents.</p> <p>Review of the Nursing Schedule for the North 2 Unit, dated 05/17/24, indicated there were three CNAs and two nurses scheduled to work on the evening shift.</p> <p>Review of the CNA time cards on 05/17/24 indicated one of the scheduled CNAs punched in at 5:16 P.M. (over two hours after the scheduled start of the shift).</p> <p>During an interview on 06/05/24 at 3:22 P.M., Certified Nurse Aide (CNA) #4 said that she was on duty on 05/17/24 for the evening shift and took care of Resident #1. CNA #4 said Resident #1's Family Member was in and requested care for him/her. CNA #4 said she told (Resident #1's) Family Member that she would be back to provide care as soon as she was able.</p> <p>CNA #4 said that they were supposed to have four CNAs on the evening shift, but said that it was unusual to have four. CNA #4 said when they only have two CNAs it was very difficult to provide care to all the residents. CNA #4 said I can only take care of one person at a time.</p> <p>During a telephone interview on 06/11/24 at 10:28 A.M., Nurse #2 said she was on duty on the evening shift on 05/17/24. Nurse #2 said that Resident #1's Family Member requested care for him/her early in the shift (exact time unknown). Nurse #2 said two out of the three scheduled CNAs for that shift came in late.</p> <p>Nurse #2 said that she and CNA #4 provided care to Resident #1 but that it took some time because they had other residents who had also requested care who were attended to first. Nurse #2 said they were supposed to have four CNAs but lately they have had only three and sometimes only two CNAs on duty for the evening shift. Nurse #2 said staffing was bad, especially for CNAs. Nurse #2 said North 2 Unit had a lot of residents that required two staff members for assistance with all of their care needs.</p> <p>Resident #1's Family Member said that on 05/19/24 at 1:24 P.M., she found Resident #1 in bed with a top sheet, blanket and hospital gown again, that were wet from urine, that his/her brief that was full of diarrhea and she turned the call light on. The Family Member said the call light was not answered right away and at 1:35 P.M. (ten minutes later) a nurse (later identified as Nurse #1) came into Resident #1's room and told her that there were only two CNAs on the floor for 40 residents and they would get to him/her. The Family Member said the nurse (Nurse #1) came back to Resident #1's room at 1:40 P.M. to provide care.</p> <p>Review of the Facility Census for the North 2 Unit, dated 05/19/24, indicated and the census was 40 residents.</p> <p>Review of the Nursing Schedule for the North 2 Unit, dated 05/19/24, indicated there were two CNAs and two nurses scheduled to work on the day shift.</p> <p>During an interview on 06/05/24 at 12:47 P.M. and 2:56 P.M., Certified Nurse Aide (CNA) #1 said she was on duty on the North 2 Unit on 05/19/24 during the day shift and that there was one other CNA with her during that shift.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/05/24 at 9:05 A.M., Unit Manager #1 said the scrambled eggs and cream of wheat were both cold. Unit Manager #1 said that staff should have offered to reheat the resident's breakfast trays because they had been out too long.</p> <p>During an interview on 06/05/24 at 9:26 A.M., [NAME] #1 said that North 2 Unit had two meal trucks. [NAME] #1 said that all residents got the same entree and hot cereal that morning. [NAME] #1 said it was her understanding that nothing under 145 degrees for hot food should have been served.</p> <p>Review of the Truck Delivery Log, dated 06/05/24, indicated the first meal truck on North 2 Unit was delivered at 7:59 A.M. and the second one was delivered at 8:08 A.M.</p> <p>Review of the Service Line Checklist, dated 06/05/24, indicated the following temperatures obtained in the kitchen, prior to meal service:</p> <p>Main entree (scrambled eggs) - 190 degrees F</p> <p>Hot cereal (cream of wheat) - 180 degrees F</p> <p>During an interview on 06/05/24 at 12:47 P.M., Certified Nurse Aide (CNA) #1 said that there were supposed to be four CNAs during the day shift but that day they had three and that meant that each CNA had 13 residents and one had 14 residents to care for. CNA #1 said that because it was a secured unit, a lot of the residents had behaviors and many of them required assistance of two staff members for care.</p> <p>CNA #1 said she meant what she said earlier (what was she supposed to, do 10 things at once), because that's how she felt. CNA #1 said it was difficult to get residents up, pass the breakfast trays, and feed the residents who needed to be fed, all at once. CNA #1 said when they had four CNAs she could provide the right kind of care and not feel rushed.</p> <p>During an interview on 06/05/24 at 1:27 P.M. Certified Nurse Aide (CNA) #2 said there were supposed to be four CNAs on the day shift but usually there are only three. CNA #2 said they were supposed to stop giving resident care at 8:00 A.M. so they can start the breakfast tray pass but that does not always happen. CNA #2 said they were usually done passing breakfast trays by 9:00 A.M. (which is one hour after the meal trucks scheduled time of arrival).</p> <p>During an interview on 06/05/24 at 3:41 P.M. the Director of Nurses (DON) said it was her expectation that a meal pass should not take more than 10-15 minutes to complete. The DON said that if the pass took longer than that, the food would need to be reheated before it was served to a resident.</p> <p>Review of the Nursing Staffing Schedules for North 2 Unit from 05/05/24 through 06/05/24 indicated the following:</p> <p>On the following dates, the Facility did not have four CNAs scheduled to work on the day shift:</p> <ul style="list-style-type: none"> - 05/05/24 through 05/08/24, - 5/10/24 through 05/14/24, <p>(continued on next page)</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>37086</p> <p>Based on records reviewed and interviews, the Facility failed to ensure they implemented their Quality Assurance Performance Improvement (QAPI) plan of action to monitor, assess, and document the data related to staffing to identify if improvements were made.</p> <p>Findings include:</p> <p>Review of the Facility's policy, Quality Assurance Plan, with a revision date of 11/05/19, indicated the Facility would develop, implement and maintain an ongoing program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality care, and to resolve identified problems.</p> <p>Review of the Statement of Deficiencies, dated 03/05/24, indicated the Department of Public Health cited the Facility for F725 during the survey completed on 03/05/24, and the Facility's Plan of Correction, with an alleged compliance date of 03/25/24, indicated the following:</p> <ul style="list-style-type: none"> -The Director of Nurses (DON) educated staff that meal tray service must be performed upon receipt of the meal carts from the kitchen to ensure food remained at the appropriate temperature. -The DON would audit staff to resident staffing ratios weekly for four weeks then monthly for three months to ensure nursing care was provided to all residents in accordance with their care plans. -The results of the audits would be presented to the Quality Assurance Performance Improvement (QAPI) committee until substantial compliance had been achieved. <p>During a telephone interview on 06/04/24 at 11:16 A.M., Resident #1's Family Member said that on 05/17/24 at 3:53 P.M. and 5/19/24 at 1:24 P.M., she found Resident #1 in bed with a top sheet, blanket, and hospital gown that were wet from urine and diarrhea. The Family Member said that Resident #1 had to wait for care by staff on both days because she was told by nursing they were short staffed.</p> <p>During a telephone interview on 06/11/24 at 10:28 A.M., Nurse #2 said they were supposed to have four CNAs on the evening shift, but lately they had only three and sometimes only two CNAs on duty for the evening shift. Nurse #2 said staffing was bad, especially for CNAs.</p> <p>During an interview on 06/05/24 at 12:47 P.M. and 2:56 P.M., Certified Nurse Aide (CNA) #1 said they were supposed to have four CNAs on the day shift, and when they had two CNAs they could not provide incontinent care to each resident every two hours, and that even when there were three CNAs it can be difficult to get to each resident.</p> <p>During a telephone interview on 06/07/24 at 12:02 P.M., Nurse #1 said it was a real struggle when they had two CNAs, by the time the CNAs got through their first rounds on each resident, stopped care during mealtimes, it was late in the day when they started their second rounds. Nurse #1 said the CNAs are drowning when there are only two of them.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/05/24, from 8:25 A.M. through 9:03 A.M., the surveyor observed the breakfast meal pass on North 2 Unit which took over 45 minutes to complete.</p> <p>During an interview on 06/05/24 at 12:47 P.M., Certified Nurse Aide (CNA) #1 said that there were supposed to be four CNAs but that day they had three and that meant that each CNA had 13 residents and one had 14 residents to care for. CNA #1 said that because it was a secured unit, a lot of the residents had behaviors and many of them required assistance of two staff members for care. CNA #1 said it was difficult to get residents up, pass the breakfast trays, and feed the residents who needed to be fed, all at once.</p> <p>During an interview on 06/05/24 at 1:27 P.M. Certified Nurse Aide (CNA) #2 said there were supposed to be four CNAs on but usually they only had three. CNA #2 said they were supposed to stop giving resident care at 8:00 A.M. so they can start the breakfast pass but that did not always happen. CNA #2 said they were usually done passing breakfast trays by 9:00 A.M. (approximately one hour after the meal trucks scheduled time of arrival).</p> <p>During an interview on 06/05/24 at 3:41 P.M. the Director of Nurses (DON) said it was her expectation that a meal pass should not take more than 10-15 minutes to complete.</p> <p>Review of the Facility Assessment, dated 02/26/24, indicated the Facility was licensed for 123 beds and there were 41 beds on the North 2 Unit. The Assessment indicated the Facility required the following for Full Time Employees (FTE):</p> <ul style="list-style-type: none"> -Certified Nurse Aides (CNA)- 29 -Licensed Practical Nurse (LPN)- 19 -Registered Nurse (RN)- 8 <p>Review of the Nursing Staff List indicated the Facility employed 11 FTE CNAs (18 less than the Facility Assessment indicated) and four FTE RNs (4 less than the Facility Assessment indicated).</p> <p>During an interview on 06/05/24 at 2:26 P.M., the Schedule Coordinator said the staffing goals on the secured North 2 Unit were as follows:</p> <ul style="list-style-type: none"> -7:00 A.M. through 3:00 P.M. (day) shift - four CNAs and one Nurse -3:00 P.M. through 11:00 P.M. (evening) shift- four CNAs and one Nurse -11:00 P.M. through 7:00 A.M. (night) shift- two CNAs and one Nurse -8:00 A.M. through 8:00 P.M. shift- one additional Nurse <p>The Schedule Coordinator said she did not consider a unit to be short staffed unless there was only one CNA on duty.</p> <p>Review of the Nursing Staffing Schedules for North 2 Unit from 05/05/24 through 06/05/24 indicated the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER Ayer Valley Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Groton Road Ayer, MA 01432	

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 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On the following dates, the Facility did not have four CNAs scheduled to work on the day shift:</p> <ul style="list-style-type: none"> - 05/05/24 through 05/08/24, - 5/10/24 through 05/14/24, - 05/17/24 through 05/19/24, - 05/24/24, 05/25/24, 05/27/24, 05/28/24, and 05/29/24, - 06/02/24, 06/03/24, 06/05/24 <p>On the following dated, the Facility did not have four CNAs scheduled to work on the evening shift:</p> <ul style="list-style-type: none"> - 05/05/24, 05/06/24, 05/11/24, 05/13/24, 05/17/24, 05/18/24, 05/19/24, - 05/21/24 through 05/26/24, and 05/28/24, - 05/30/24 through 06/05/24. <p>During an interview on 06/05/24 at 3:59 P.M., the Administrator said that staffing had been an ongoing issue and that they supplemented with Agency staff but they were still having a lot of call outs. The Administrator said the meals should be put in front of the residents within five minutes of truck delivery.</p> <p>The Administrator said that none of the staff to resident ratio audits for May 2024 had been done, as indicated in the Facility's Plan of Correction (03/25/24).</p>