STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225481	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Bedford Jewish Convalescent Home, Inc	200 Hawthorn Street New Bedford, MA 02740

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 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. 37183 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was assessed by nursing as being at risk for falls and required the use of a chair alarm in an effort to prevent falls, the Facility failed to ensure his/her assistive devices were functioning properly to prevent incidents and/or accidents resulting in an injury. On 4/07/24 after Resident #1 was found on the floor in the hallway after a fall, it was determined that his/her chair alarm was found to be in the off position and therefore had not sounded to alert staff that he/she was in motion. Resident #1 sustained a laceration to the left side of his/her head, was transferred to the Hospital Emergency Department for evaluation, required staples to close the laceration, was diagnosed with multiple fractures as a result of the fall and was admitted for treatment. Findings include: Review of the Facility's Policy titled, Fall Policy, dated 10/2022 indicated the following: -it is the policy of the facility to ensure that residents who are fall risks are assessed accurately with interventions in place to prevent further falling; -in the event of a fall, the team leader will do a full body assessment, assess for injury and arrange for medical treatment as needed; -an incident report and an investigation of fall will be completed by the licensed nurse; -employee statements are obtained, and written on witness statement sheet; -Unit Manager/Supervisor/Designee will ensure completeness of forms, initiate or add components of the care plan and forward to the Director of Nurses(DON); -upon determination of the cause of injury, the corrective action will be initiated; -the DON will meet with the Staff Development Coordinator to plan educational session in response to any identified area of concern and ensure follow-up if needed. Review of the Facility's Policy titled, Falls Prevention, dated 5/2018 indicated the following: (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	-it is the policy of the facility to assess all residents for fall risk and upon determination, implement interventions in accordance with regulation; -upon determination that a resident is at risk for falls, a Red Falling Star symbol is placed on each identified resident's door name plate, wheelchair (if applicable) or name bracelet (as a last resort); -the resident's name is placed on the Falls Prevention Plan list and a copy is forwarded to Nurse Managers and all department heads; -the Falls Prevention Team decides which additional interventions are required. Review of the Facility Policy titled, Chair/Bed Alarm System, dated 7/2012 indicated the following: -the facility shall use a chair/bed alarm system to monitor the wheelchair/bed activity of the resident who stands, attempts to stand or attempts to get out of bed without asking for assistance and who's ambulatory and/or transfer status is not at an independent/safe level; -the licensed nurse will determine if an alarm is needed and the Falls Prevention Committee will be notified of alarm use; -if an alarm is used it will be documented on the care plan and electronic Certified Nurse Aide (CNA) flow sheet; -if an alarm is needed on a chair the alarm will be permanently placed on the rear of the wheelchair/chair utilizing a strap and the alarm cord will be attached to the back of the residents clothing with a prime snap; -alarm is to be checked daily to assure it is in working order. Resident #1 was admitted to the Facility in October 2023, diagnoses included acute on chronic congestive heart failure, fracture of the left third and fourth metacarpal bones, type 2 diabetes mellitus, non-ST elevation myocardial infarction, history of falls, atrial fibrillation, Parkinson's and dementia. Review of Resident #1's Fall Risk Assessment, dated 01/30/24, indicated he/she was assessed as being at risk for falls. Review of Resident #1's CNA Resident Care Instructions, (used as a reference guide by CNA's), dated 10/27/23, indicated that he/she was on fall precautions and that he/she utilized bed and chair alarms for safety. Review of Resident #1's Care Plan related to Falls, dated 10/29/23, indicated he/she was at high risk for falls, and interventions included: anticipate resident needs with regard to Activities of Daily Living (ADL's), use appropriate assistive device and level of assistance, star outside door, and chair/bed alarms. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 01/30/24, indicated he/she required supervision or touch assistance with transfers and had moderate cognitive impairment Review of the Facility's Internal Investigation Report, dated 04/07/24, indicated that between 10:30 A.M. and 11:45 A.M., Resident #1 had set off his/her chair alarm twice, was attempting to stand up and noted to be trying to turn off his/her chair alarm. The Report indicated that at approximately 11:45 A.M., a family member of another resident informed a nurse that Resident #1 was on the floor in the hallway. The Report indicated that the nurse responded immediately and noted blood and a laceration on the left side of Resident #1's head. The Report indicated that Resident #1's chair alarm was noted to be on the seat of the wheelchair and not behind his/her wheelchair where it had been mounted. The Report indicated that Resident #1 was transferred to the Hospital Emergency Department (ED) for further evaluation and treatment. The Report indicated that Resident #1 sustained a left parietal (top and side of skull) laceration that required three staples, a left distal clavicle (collarbone) and left femoral neck (hip) fracture from his/her injuries. Review of Resident #1's Hospital Discharge Summary, dated 04/12/24, indicated that Resident #1 presented to the Hospital ED after an unwitnessed fall at the Nursing Home and complained of left shoulder and left hip pain. The Summary indicated that an x-ray revealed that Resident #1 had a left distal clavicle fracture and a left femoral neck fracture and he/she underwent a left hip hemiarthroplasty (surgical procedure to treat a fractured hip). The Summary indicated that Resident #1 was also noted with a left scalp laceration, and it was repaired with three staples by the emergency room (ER) physician. The Summary indicated that Resident #1 was admitted to the Hospital for treatment of his/her injuries. Review of a Nurse Progress Note, dated 4/07/24, (written by Nurse #2), indicated that at 11:50 A.M., Resident #1 was found on the floor in the hallway by a family member of another resident. The Note indicated that Resident #1 had sustained a laceration on the left side of the head, 911 (Emergency Services) was notified and Resident #1 was transferred to the Hospital ED for evaluation. The Note further indicated that Resident #1 had deactivated the chair alarm, transferred him/herself out of the chair and walked out into the hallway. During a telephone interview on 4/29/24 at 9:47 A.M., Nurse #2 said that Resident #1 was found lying on his/her left side on the floor in the hallway by a family member of another resident. Nurse #2 said she immediately ran down to assess Resident #1 and found him/her bleeding from the left side of the head, said she applied a pressure dressing to his/her head until 911 arrived. Nurse #2 said that Resident #1's chair alarm did not sound, said that {although none of the staff saw him/her do it, they believe} Resident #1 had deactivated and turned the chair alarm switch to the off position, got out of the chair and walked out into the hallway where he/she was found. Nurse #2 said that there have been times when Resident #1 has removed his/her alarm, has deactivated the alarm and turned it off. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/24/24 at 1:20 P.M., (which included review of her written witness statement), CNA #2 said that on 4/07/24 at 10:30 A.M., Resident #1 set off his/her chair alarm and was sitting in the wheelchair with the alarm sounding. CNA #2 said that she reset Resident #1's chair alarm and made sure it was in the on position. CNA #2 said that there have been times when Resident #1 had removed his/her chair alarm and turned it to the off position. CNA #2 said that at 11:30 A.M., prior to going on her lunch break, she checked on Resident #1 and said that his/her chair alarm was in the on position. During an interview on 4/24/24 at 1:36 P.M., (which included review of her written witness statement), CNA #1 said that on 4/07/24 sometime around 11:45 A.M., Resident #1 set off his/her chair alarm, she went in to check on him/her and asked him/her if she needed to go to the bathroom or needed anything else. CNA #1 said that Resident #1 said he/she did not need anything. CNA #1 said she reset Resident#1's chair alarm and made sure it was in the on position. CNA #1 said that she left Resident #1's room to take care of another resident and when she came out of the resident's room, she saw Resident #1 lying on the floor in the hallway with the nurse. CNA #1 said that she did not hear Resident #`1's alarm sound and said that she went to check Resident #1's chair alarm and found it on his/her wheelchair in the off position. CNA #1 said that there have been times when Resident #1 has removed his/her chair alarm and turned it to the off position. Review of a Resident Incident/Accident Report, dated 04/07/24, indicated that Resident #1 was found on the floor in the hallway by a family member of another resident and was noted to have sustained a laceration to his/her left side of the head. The Report indicated that {although he/she was not seen by staff doing so, it was believed} Resident #1 had switched his/her chair alarm to the off position. Per staff interviews, prior to the fall Resident #1 had been left in his/her room, in the wheelchair by the window where he/she liked to be. Resident #1 was therefore able to get up, ambulate across and out of his/her room, before being found on the floor in the hallway. During an in-person interview on 04/24/24 at 2:50 P.M., and a follow up telephone interview on 05/01/24 at 10:20 A.M., the Director of Nurses (DON) said that Resident #1 had set off the chair alarm a couple of times during the morning on 04/07/24 and the CNA's had answered his/her alarm and turned the chair alarm back on. The DON said a few minutes after one of the CNA's left Resident #1's room, Resident #1 was found on the floor in the hallway by another resident's family member. The DON said at that time his/her chair alarm did not sound. The DON said it was her expectation that staff place the chair alarm in a location that the resident cannot reach and said that {although none of the staff saw him/her do it, they believed} Resident #1 removed his/her chair alarm by pulling on the cord and somehow reached the chair alarm and turned off the alarm that morning. The DON said that she was unaware that Resident #1 had tried to remove his/her chair alarm before and had turned off the chair alarm before and said this was the first time she was made aware that Resident #1 had done this before.