STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225740	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunt Nursing & Rehab Center	90 Lindall Street Danvers, MA 01923

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 #1), whose comprehensive plan of care indicated he/she was at risk for falls due to impulsivity and decreased strength, required assistance from two staff members for toileting and transfers, with a staff member remaining outside the bathroom door while he/she was on the toilet, the Facility failed to ensure staff implemented and followed interventions identified in his/her care plan, when on 02/26/24, Resident #1 told the Director of Rehabilitation (DOR) that he/she had to use the bathroom, The DOR left him/her in his/her room to take him/herself to the bathroom, and did not tell any other staff that he/she was going to use the bathroom. Resident #1 transferred him/herself into the bathroom and as a result, fell . The next day, Resident #1 complained of left elbow pain and was diagnosed with a fractured elbow. Findings include: The Facility Policy, titled Care Planning, indicated the Facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and psychological needs that are identified in the comprehensive assessment. Resident #1 was admitted to the Facility in January 2024, diagnoses included spinal stenosis, left sided hemiplegia, left foot drop, history of falls, and anxiety. Review of Resident #1's Falls Care Plan, dated as revised on 01/31/24, indicated he/she was at risk for falls, was impulsive, and had multiple falls while at the Facility. The Care Plan indicated staff would remind Resident #1 to use the call bell to ask for assistance and when assisting him/her to the bathroom, staff were to stand outside the door (later clarified by the Director of Nurses to mean that once Resident #1 was on the toilet, a staff member would stay outside of and next to the bathroom door to allow for privacy and provide supervision). Review of Resident #1's Activities of Daily Living (ADL) care plan, dated 01/19/24, indicated he/she required assistance by two staff members for toileting and transfers. Review of Resident #1's Physical Therapy Evaluation, for certification period 02/06/24 through 03/06/24, indicated Resident #1 required standby assistance and close supervision for safety for toilet transfers. (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: 225740	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Hunt Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 90 Lindall Street Danvers, MA 01923	

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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 Occupational Therapy Evaluation, for certification period 02/07/24 through 03/07/24 indicated Resident #1 required contact guard level of assistance for toilet transfers. Review of the Nurse Progress Note, dated 02/26/24, indicated that at 01:45 P.M., Resident #1 fell while attempting to transfer him/herself into the bathroom, and as a result had a new skin tear on his/her elbow. Review of the Nurse Progress Note, dated 02/27/24, indicated Resident #1 complained of increased pain in his/her left elbow, and a Physician's order for an X-ray of his/her elbow was obtained. Review of the Radiology Report, dated 02/28/24, indicated Resident #1 had an acute proximal ulna (lower arm bone) nondisplaced fracture and moderate joint effusion (fluid buildup) of his/her left elbow. Review of the Facility's Investigation Report, dated 02/28/24, indicated Resident #1 was known to be impulsive, had poor safety awareness, required assistance with all transfers, and staff were to stay outside his/her bathroom door when he/she was on the toilet. The Report indicated that on 02/26/24, Resident #1 told the Director of Rehabilitation (DOR) that he/she needed to use the bathroom, and the DOR asked him/her if he/she could do it on his/her own, Resident #1 said yes, and the DOR left him/her to toilet his/herself. The Report indicated Resident #1 then attempted to transfer his/herself to the bathroom, fell , the next day complained of pain in his/her elbow, and was diagnosed with a left elbow fracture. During an interview on 04/16/24 at 9:54 A.M., the Director of Rehabilitation said he was familiar with Resident #1 since he had worked with him/her for a few weeks. The DOR said that he knew Resident #1 was known to be impulsive, had a history of falls, and that he/she required standby assistance by rehabilitation staff for transfers. The DOR said that on 02/26/24 he went to Resident #1's room to bring him/her to therapy, he/she was seated in his/her wheelchair next to the bed, and Resident #1 said he/she needed to use the bathroom. The DOR said he asked him/her if he/she could go to the bathroom by him/herself to which Resident #1 said yes, so he then left Resident #1's room, and did not assist Resident #1 to the bathroom. The DOR said he did not tell anyone else that Resident #1 said he/she needed to use the bathroom. The DOR said he should have stayed with Resident #1 or told another staff member that he/she had to use the bathroom, but did not. The Director of Rehabilitation said when he returned to get Resident #1 a little while later, he was told he/she had fallen while taking him/herself to the bathroom. During a telephone interview on 04/16/24 at 11:48 A.M., the Director of Nurses (DON) said the Rehabilitation Department staff had helped develop Resident #1's Care Plan and said the DOR should have helped Resident #1 or asked another staff member to help him/her to the bathroom but did not. On 04/16/24, the Facility was found to be in Past Non-Compliance and provided the Surveyor with a plan of correction which addressed the area of concern as evidenced by: A. 02/26/24, Resident #1's Care Plan was revised to include staff are to remind him/her with each encounter to call for assistance, and when rehabilitation staff work with him/her they are to assist him/her with toileting. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Hunt Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 90 Lindall Street Danvers, MA 01923	

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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	B. 02/26/24, The Audit Sheet, completed by the Director of Rehabilitation, indicated all residents who were receiving rehabilitation services were audited to ensure the nursing and rehabilitation plans of care were up to date. C. 02/28/24, The Hospital Visit Summary indicated Resident #1 was assessed and treated at the Emergency Department for a closed fracture of the left ulna, and a follow up appointment was scheduled. D. 02/2024, The Education Sign in Sheet indicated nursing staff were educated by the Staff Development Coordinator (SDC) that all residents identified as being at risk for falls have a care plan in place and staff are to implement the interventions as per the resident's care plan and kardex. E. 03/01/24, The Education Sign in Sheet indicated rehabilitation staff were educated by the SDC that rehabilitation staff are responsible for checking with nursing staff prior to resident treatment sessions to determine the required level of assistance with toileting. F. 03/08/24, The Weekly Risk Meeting Fall Review minutes indicated the interdisciplinary team reviewed Resident #1's fall that occurred on 02/26/24, and other falls that occurred that week. G. 03/20/24, The Quality Assessment Performance Improvement (QAPI) Plan indicated Facility leadership developed a plan to correct the deficient practice and ensure that residents were provided with the appropriate level of supervision and assistance as determined by assessments and identified in their plans of care. H. The Facility will continue to review all falls at Weekly Risk Meetings. I. The Director of Nurses and/or designee are responsible for overall compliance.

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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 known to be impulsive, required two staff member assistance for toilet transfers, with one staff member remaining outside the bathroom door while he/she was on the toilet to provide standby assistance, the Facility failed to ensure he/she was provided with the necessary level of staff assistance to maintain his/her safety, when on 02/26/24, Resident #1 told the Director of Rehabilitation (DOR) that he/she had to use the bathroom, the DOR left him/her in his/her room to take him/herself to the bathroom, and did not inform any other staff that he/she was going to use the bathroom. Resident #1 attempted to transfer him/herself in the bathroom, fell , sustained a skin tear to his/her left arm, and the next day he/she complained of left elbow pain and was diagnosed with a fractured elbow. Findings include: The Facility Policy, titled Falls Risk Reduction, dated 11/02/23, indicated residents determined to have risk factors for falls would receive individualized interventions based on the risk factors in order to reduce risk for and minimize falls, and that each resident would receive adequate supervision and assistance devices to prevent accidents. The Facility Policy, titled Care Planning, indicated the Facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and psychological needs that are identified in the comprehensive assessment. Review of the Facility's Investigation Report, dated 02/28/24, indicated Resident #1 was known to be impulsive, had poor safety awareness, required assistance with all transfers, and staff were to stay outside his/her bathroom door when he/she was on the toilet. The Report indicated that on 02/26/24, Resident #1 told the Director of Rehabilitation (DOR) that he/she needed to use the bathroom, and the DOR asked him/her if he/she could do it on his/her own, Resident #1 said yes, and the DOR left him/her to toilet him/herself. The Report indicated Resident #1 then attempted to transfer him/herself to the bathroom, fell , the next day complained of pain in his/her elbow, and was diagnosed with a left elbow fracture. Resident #1 was admitted to the Facility in January 2024, diagnoses included spinal stenosis, left sided hemiplegia, left foot drop, history of falls, and anxiety. Review of Resident #1's Falls Care Plan, dated as revised on 01/31/24, indicated he/she was at risk for falls, was impulsive, and had multiple falls while at the Facility. The Care Plan indicated staff would remind Resident #1 to use the call bell to ask for assistance and when assisting him/her in the bathroom, staff were to stand outside the door (later clarified by the Director of Nurses to mean that once Resident #1 was in the toilet, staff would stay outside of and next to the bathroom door, to provide supervision and privacy). Review of Resident #1's Activities of Daily Living (ADL) care plan, dated 01/19/24, indicated he/she required assistance by two staff members for toileting and transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Facility's Incident Reports indicated Resident #1 fell while attempting to toilet him/herself on the following dates: -01/26/24 -02/04/24 -02/11/24 Review of Resident #1's Physical Therapy Evaluation, for certification period 02/06/24 through 03/06/24, indicated Resident #1 required standby assistance and close supervision for safety for toilet transfers. Review of Resident #1's Occupational Therapy Evaluation, for certification period 02/07/24 through 03/07/24 indicated Resident #1 required contact guard level of assistance for toilet transfers. Review of the Nurse Progress Note, dated 02/26/24, indicated that at 01:45 P.M., Resident #1 fell while attempting to transfer him/herself in the bathroom, and as a result had a new skin tear on his/her elbow. Review of the Nurse Progress Note, dated 02/27/24, indicated Resident #1 complained of increased pain in his/her left elbow, and a Physician's order for an X-ray of his/her elbow was obtained. Review of the Radiology Report, dated 02/28/24, indicated Resident #1 had an acute proximal ulna (lower arm bone) nondisplaced fracture and moderate joint effusion (fluid buildup) of his/her left elbow. During an interview on 04/16/24 at 9:54 A.M., the Director of Rehabilitation said he was familiar with Resident #1 since he had worked with him/her for a few weeks. The DOR said that he knew Resident #1 was known to be impulsive, had a history of falls, and that he/she required standby assistance by rehabilitation staff for transfers. The DOR said that on 02/26/24 he went to Resident #1's room to bring him/her to therapy, he/she was seated in his/her wheelchair next to the bed, and Resident #1 said he/she needed to use the bathroom. The DOR said he asked him/her if he/she could go to the bathroom by him/herself to which Resident #1 said yes, so he then left Resident #1's room, and did not assist Resident #1 to the bathroom. The DOR said he did not tell anyone else that Resident #1 said he/she needed to use the bathroom. The DOR said he should have stayed with Resident #1 or told another staff member that he/she had to use the bathroom, but did not. The Director of Rehabilitation said when he returned to get Resident #1 a little while later, he was told he/she had fallen while attempting to take him/herself to the bathroom. The DOR said the next day Resident #1 complained of increased pain in his/her left elbow, and was found to have a left elbow fracture. During a telephone interview on 04/16/24 at 11:48 A.M., the Director of Nurses (DON) said the Rehabilitation Department staff had helped develop Resident #1's Care Plan and said the DOR should have helped Resident #1 or asked another staff member to help him/her to the bathroom but did not. (continued on next page)

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