

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 11/20/2024
NAME OF PROVIDER OR SUPPLIER Hunt Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37342</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had a history of falls, was assessed by nursing as being at risk for falls and whose comprehensive plan of care included an intervention of a fall mat on the floor beside his/her bed when in bed, the Facility failed to ensure staff consistently implemented and followed the plan of care, when on 10/21/24, Resident #1 was found on the floor after a fall out of bed, and there was no fall mat in place beside his/her bed.</p> <p>Findings include:</p> <p>The Facility Policy, titled Care Planning, dated 10/28/22, indicated the Facility would develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment.</p> <p>Resident #1 was admitted to the Facility in June 2024, diagnoses included dementia and history of falls.</p> <p>Review of Resident #1's Falls Risk Assessment, dated 09/25/24, indicated he/she was assessed as being at risk for falls.</p> <p>Review of Resident #1's Medical Record indicated he/she had a Physician's Order, dated 10/03/24 for the use of a fall mat at his/her bedside on the right side of his/her bed.</p> <p>Review of Resident #1's Falls Care Plan indicated he/she had an intervention, dated 10/03/24 for fall mat on the floor while in bed.</p> <p>Review of Resident #1's Nurse Progress Note, dated 10/21/24, indicated he/she was found lying on the floor in his/her room.</p> <p>Review of the Facility's Corrective Measures Narrative, dated 10/25/24, indicated the Facility identified that the fall mat was not in place when Resident #1 fell on [DATE].</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 11/20/24 at 08:40 A.M., the Director of Nurses (DON) said that on 10/21/24 at 07:00 A.M., he observed Resident #1 sleeping in his/her bed, but could not recall if he saw the floor mat in place at that time. The DON said that at 07:30 A.M., he was alerted by staff that Resident #1 was found on the floor in his/her room, and said that he (DON) observed that the floor mat was not in place next to Resident #1's bed, or in his/her room at all, but should have been in place per his/her plan of care.</p> <p>On 11/20/24, 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:</p> <p>A. 10/21/24, The Morning Meeting Resident At Risk Minutes indicated Resident #1's fall was reviewed by the Interdisciplinary Team.</p> <p>B. 10/21/24, The Ad-Hoc Quality Assurance Performance Improvement (QAPI) Plan indicated the Facility Leadership developed a plan to correct the deficient practice and ensure that residents were provided with fall devices as indicated in the plan of care.</p> <p>C. 10/21/24, an Audit Tool was initiated and completed by Unit Managers and the Facility's Regional Nurse, who conducted rounds on all units to ensure residents with falls devices identified in the plan of care, had the devices in place.</p> <p>D. Audit Tool indicated Unit Managers and the Facility's Regional Nurse will continue to conduct rounds to ensure residents with falls devices were in place daily, until substantial compliance is met.</p> <p>E. 11/13/24, The October Monthly QAPI Meeting Minutes indicated the Interdisciplinary Team reviewed compliance with falls device placement and staff education.</p> <p>F. 11/15/24, Staff Development Coordinator provided education to nursing staff to ensure any devices identified in the residents' care plans to prevent falls are in place, and with nursing staff required to sign and participate in the educational inservice.</p> <p>G. The DON/designee will continue audits to ensure placement of falls devices weekly through the end of November 2024, then monthly ongoing.</p> <p>H. The Facility will continue to monitor compliance at the monthly and quarterly QAPI meetings.</p> <p>I. The Director of Nurses and/or designee are responsible for overall compliance.</p>		