

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225768	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2024
NAME OF PROVIDER OR SUPPLIER  New England Homes for the Deaf, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  154 Water 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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15016</p> <p>Based on record review and interview for one Resident (Resident #18) of 30 sampled residents, the facility failed to accurately complete a Medical Orders for Life Sustaining Treatment (MOLST) form.</p> <p>Findings include:</p> <p>Review of the facility's Advanced Directive Policy and Procedure, dated as revised on February 2017, indicated Nurses and other health care staff are educated to initiate CPR [cardiopulmonary resuscitation], as recommended by the American Heart Association (AHA) unless a valid Do Not Resuscitate order is in place.</p> <p>Resident #18 was admitted to the facility in [DATE] and his/her current diagnoses included deafness, blindness, and psychosis.</p> <p>Review of Resident #118's Minimum Data Set assessment dated [DATE], indicated he/she was unable to complete the Brief Interview for Mental Status examination and was represented by a legal guardian.</p> <p>Review of Resident #18's medical record profile indicated he/she elected Do Not Resuscitate status.</p> <p>Review of Resident #18's Medical Orders for Life Sustaining Treatment (MOLST) form dated [DATE], indicated he/she elected Do Not Resuscitate (DNR), Do Not Intubate or Ventilate, and Do Not Hospitalize. The form indicated it required section H to be signed by a provider to verify the information on the MOLST accurately reflected the discussion with the signer (Guardian).</p> <p>Review of Resident #18's MOLST indicated the provider did not sign section H.</p> <p>During an interview with the Unit Manager on [DATE] at 11:11 A.M., the surveyor showed her Resident #18's MOLST. The Unit Manager said Resident #18 had elected to be a DNR status, but that the MOLST was invalid without the provider's signature in section H.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225768	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2024
NAME OF PROVIDER OR SUPPLIER  New England Homes for the Deaf, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  154 Water 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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016</b></p> <p>Based on record review and interview, for one Resident (#1) out of 13 sampled residents, the facility failed to ensure staff implemented policies and procedures related to personal privacy and confidentiality. Specifically, the facility used a personal cell phone to take a picture of the Resident's wound.</p> <p>Findings include:</p> <p>Review of the facility's Clinical Photography Policy, undated, indicated:</p> <p>*Clinical photography of residents may be appropriate for the diagnosis and treatment of medical conditions as well as professional education.</p> <p>*Clinical photography is defined as any photography or videotaping of a resident and includes but not limited to: pictures/videos of pressure ulcers, wounds, skin tears, bruises, abrasions, etc. Pictures/videos of abuse, neglect, assaults, or accidents. Pictures/videos of residents taken for the purpose of identification.</p> <p>*Clinical photography will only be done post completion of the Photography Consent Form as completed by the resident or the residents' guardian/HCP (health care proxy).</p> <p>*Clinical photography is not allowed by clinical staff on their own individually owned devices. All [facility] phones will be overseen by their respective Unit Manager to ensure compliance with this policy.</p> <p>Resident #1 died at the facility in [DATE].</p> <p>Review of Resident #1's clinical record indicated that his/her activated health care proxy had consented to the use of clinical photography while at the facility.</p> <p>Review of the facility Social Worker's written statement to the Human Resource (HR) staff, dated [DATE], indicated: This morning during clinical meeting, we were discussing a resident who had an open wound on his/her backside. Unit Manager #1 pulled out what looked like her personal cell phone and asked the Administrator and DON if they would like to view a photo of it. Unit Manager #1 also commented that her husband always hates when she shows him these photos and laughed. No one present responded to this remark which is a violation of HIPPA and violation of resident's privacy and dignity.</p> <p>During an interview on [DATE] at 8:49 A.M., the Social Worker said that a few weeks ago ([DATE]) while at clinical meeting, Unit Manager #1 had a picture on her personal phone of a pressure ulcer on Resident #1's coccyx area and was showing it to the Director of Nursing (DON). The Social Worker said that Unit Manager #1 then offered to show the photo to the Administrator and when the Administrator declined, she laughed and said, oh my husband hates when I show him these pictures. Social Worker #1 said that it was against company policy for staff to use their personal phones to photograph residents, and she brought her concerns forward to Human Resources (HR) after the meeting.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225768	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2024
NAME OF PROVIDER OR SUPPLIER  New England Homes for the Deaf, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  154 Water 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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:38 A.M., the HR Staff Person said that a few weeks ago, the Social Worker brought her a concern reporting that Unit Manager #1 had taken an inappropriate photo of Resident #1. She said that she did not recall being told that Unit Manager #1 had shown her spouse any photos and was not sure whether the photo was taken on a personal phone or facility phone. The surveyor and the HR Staff Person then reviewed the written statement on the sticky note written by the Social Worker indicting it was a personal cedll phone, and said she must have missed that. The HR Staff Person said she brought the concerns to the Administrator and the Director of Nursing (DON).</p> <p>During interviews on [DATE] at 11:56 A.M., and [DATE] at 8:29 A.M., the DON said that the facility's photo policy includes ensuring a consent form is completed before photos are taken of wounds. The DON said that a few weeks ago at clinical meeting Unit Manager #1 was showing the DON a photo of Resident #1's pressure ulcer to discuss staging. She said that Unit Manager #1 made a joke asking, anyone else want to see it? after the Administrator had asked a question about staging. The DON said that she believed that the photo was taken on the unit cell phone and not Unit Manager #1's personal phone but couldn't recall. The DON said that after the meeting, HR had come to her and said that a concern was brought forward that Unit Manager #1 had taken an inappropriate photo. The DON and the surveyor reviewed the photos on the unit cell phone, including deleted photos, and were unable to locate any photos of pressure ulcers taken in the last 30 days.</p> <p>During an interview on [DATE] at 1:10 P.M., the Rehab Director said that during a clinical meeting a couple weeks ago, Unit Manager #1 showed the DON a picture of a resident's wound and then held up the phone joking and asked if anyone else wanted to see the photo. The Rehab Director said that Unit Manager #1 said I horrify my husband every time he looks through my phone. The Rehab Director said she believed the photo of the resident was on her personal phone as the phone was white (the facility phone is black). The Rehab Director said she believed that the Social Worker brought the concern forward to HR.</p> <p>During an interview on [DATE] at 7:04 A.M., Unit Manager #1 said that she has never taken a photo of a resident on her personal phone and was joking with staff during the clinical meeting about how her husband doesn't like to see pictures like that as she has some personal medical photos on her personal phone. Unit Manager #1 and the surveyor then looked through the photos on the unit cell phone of the past 30 days and could not locate a picture of a pressure ulcer. The surveyor and Unit Manager#1 were unable to locate a photo of the pressure ulcer.</p> <p>During an interview on [DATE] at 8:29 A.M., with the Administrator and the DON, the Administrator said that he had been at the clinical meeting and vaguely remembers Unit Manager #1 making a joke about her husband not liking seeing pictures of wounds. The Administrator said he had assumed the photo was taken on the unit cell phone and not Unit Manager #1's personal phone. The Administrator said that he had spoken to HR after the Social Worker brought a concern forward regarding the photo of a Resident. The Administrator said that the Social Worker wrote a statement on a sticky note and not a formal grievance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225768	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2024
NAME OF PROVIDER OR SUPPLIER  New England Homes for the Deaf, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  154 Water 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15016</p> <p>Based on observations, record review and interviews, the facility failed to develop and implement the plan of care for two Residents (#81 and #3) out of a total sample of 13 residents. Specifically, the facility failed to:</p> <ol style="list-style-type: none"> <li>1. For Resident #81, the facility failed to develop a plan of care for the diagnosis of post-traumatic stress disorder.</li> <li>2. For Resident #3, the facility failed to implement the falls care plan for the use of fall mats while in bed.</li> </ol> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Resident #81 was admitted to the facility in May 2021 and had diagnoses which included post-traumatic stress disorder (PTSD).</li> </ol> <p>PTSD is a mental health condition that is triggered by a terrifying event, either by experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event.</p> <p>Review of Resident #81's Minimum Data Set (MDS) assessment dated [DATE], indicated he/she had an active diagnosis PTSD.</p> <p>Review of Resident #81's current care plan indicated a diagnosis of PTSD. However, a care plan for the diagnosis was not developed.</p> <p>During an interview with Unit Manager #1 on 3/20/24 at 8:50 A.M., she said Resident #1 has an active diagnosis of PTSD and that a written care plan for the diagnoses should have been developed.</p> <p>45984</p> <ol style="list-style-type: none"> <li>2. Review of the facility policy titled Fall Prevention Measures dated 6/14/16, indicated the following: <ul style="list-style-type: none"> <li>*Provide fall preventative devices and ensure that they are in working order as needed:</li> <li>*Floor mattress</li> <li>*Develop an individualized care plan to meet patient needs and implement the plan of consistently</li> </ul> </li> </ol> <p>Resident #3 was admitted to the facility in December 2005 with diagnoses including traumatic brain injury with loss of consciousness and aphasia (loss of ability to understand or express speech, caused by brain damage).</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225768	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2024
NAME OF PROVIDER OR SUPPLIER  New England Homes for the Deaf, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  154 Water 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>Review of Resident #3's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 0 out of a possible 15 indicating that the Resident has severe cognitive impairment. Further review of the MDS indicated that Resident #3 is dependent on staff for all activities of daily living (ADLs).</p> <p>The surveyor made the following observations:</p> <p>*On 3/19/24 at 8:14 A.M., the surveyor did not observe fall mats in Resident #3's room.</p> <p>*On 3/19/24 at 1:55 P.M., Resident #3 was observed sleeping in his/her bed, there were no fall mats observed on either side of the bed.</p> <p>*On 3/20/24 at 7:15 A.M., Resident #3 was observed sleeping in his/her bed, there were no fall mats observed on either side of the bed.</p> <p>Review of Resident #3's Bed Rail assessment dated [DATE] indicated the following:</p> <p>*Summary of findings: Resident #3 has a history of rolling out of bed. Resident #3 has no sense of safety awareness. Floor mats on each side of bed.</p> <p>Review of Resident #3's Kardex (a document summarizing a resident's care needs) indicated the following under the safety section:</p> <p>* Resident #3 has a history of rolling out of bed. Resident #3 has no sense of safety awareness. Floor mats on each side of bed.</p> <p>Review of Resident #3's ADL self-care performance deficit care plan indicated the following intervention dated 3/5/2018:</p> <p>*Floor mats on each side of the bed.</p> <p>Review of Resident #3's most recent Fall Risk assessment dated [DATE] indicated that the Resident was at a moderate risk for falls.</p> <p>During an interview on 3/20/24 at 11:08 A.M., Certified Nursing Assistant #1 said she was not sure if Resident #3 was supposed to have fall mats when in bed.</p> <p>During an interview on 3/20/24 at 11:31 A.M., Unit Manager (UM) #1 said Resident #3 recently moved rooms and his/her fall mats must have been forgotten with the room change. UM #1 continued to say Resident #3 will need to get reassessed and interventions on the Resident's care plan should be followed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225768	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2024
NAME OF PROVIDER OR SUPPLIER  New England Homes for the Deaf, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  154 Water 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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15016</p> <p>Based on record review, interview, and observation for one Resident (#81) of 27 sampled residents, the facility failed to ensure his/her oxygen concentrator filter was free of significant dust.</p> <p>Findings include:</p> <p>Resident #81 was admitted to the facility in May 2021, and had diagnoses which included asthma and congestive heart failure.</p> <p>Review of Resident #81's Minimum Data Set assessment dated [DATE], indicated he/she received intermittent oxygen therapy.</p> <p>Review of Resident #81's respiratory care plan dated 12/9/23, indicated he/she had an altered respiratory status. The goal of care included no complications related to shortness of breath. The care plan did not reference Resident #81's asthma or intermittent use of oxygen therapy.</p> <p>Review of Resident #81's active physician orders dated 3/7/24, indicated Apply oxygen via nasal cannula at 1-2 liters to keep SPO2 (blood oxygen saturation) greater than 88%.</p> <p>Review of Resident #81's nursing progress notes indicated the oxygen concentrator was last used on 3/4/24 for shortness of breath. Review of the Resident's census indicated he/she was hospitalized for shortness of breath on 2/9/24 and 3/22/24.</p> <p>On 3/19/24 at 8:45 A.M. and again on 3/20/24 at 11:00 A.M., the surveyor observed Resident #81's oxygen concentrator filter. At both times, the filter was white and covered in dust.</p> <p>During an interview with Unit Manger (UM) #1 on 3/20/24 at 11:10 A.M., she said she was unaware of Resident #81's dusty oxygen concentrator filter. UM #1 said facility staff do not change or clean these filters, or document when this is done, and that a respiratory equipment vendor comes to the unit once per week to either clean or replace these filters. UM #1 observed said she did not know the last time Resident #81's filter was changed.</p> <p>During an interview with the Administrator and Director of Nursing on 3/20/24 at 11:17 A.M., they said the facility does not have a policy for oxygen concentrator filter maintenance. They said the concentrators are owned by a vendor, and they come to the facility every Thursday to check on the concentrators and filters. They said the facility does not change the filters.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225768	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2024
NAME OF PROVIDER OR SUPPLIER  New England Homes for the Deaf, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  154 Water 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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15016</p> <p>Based on interview and observation for one Resident (#18) of 27 sampled residents, the facility failed to ensure his/her wheelchair was in safe operating condition.</p> <p>Findings include:</p> <p>Resident #18 was admitted to the facility in January 2021 and his/her current diagnoses included deafness, blindness, and psychosis.</p> <p>Review of Resident #118's Minimum Data Set assessment dated [DATE], indicated he/she was unable to complete the Brief Interview for Mental Status examination, used a wheelchair for ambulation and was dependent on staff for wheelchair use.</p> <p>Review of Resident #18's current plan of care for mobility indicated he/she used a wheelchair.</p> <p>On 3/20/24 at 8:37 A.M., the surveyor observed Resident #18 in his/her room and sitting in a wheelchair. The wheelchair was missing the upper left chair handle, and the metal edges were exposed. The right arm rest was broken and loosely attached to the arm. The sling back fabric to the wheelchair was stretched and scratched.</p> <p>During an interview with Resident #18 on 3/20/24 at 8:37 A.M., accompanied by an American Sign Language (ASL) interpreter, he/she said the wheelchair was broken, and two to three months ago he/she reported the condition to nursing staff and the Maintenance Director. Resident #18 said it was painful for his/her back because the back sling was so stretched. Resident #18 said the maintenance staff occasionally repair the wheelchair but that because of its age parts breakdown again.</p> <p>During an interview with the Unit Manager on 3/20/24 at 9:35 A.M., she said she was unaware Resident #18's was in disrepair. She said she did not know the handle was missing, the arm rest was broken or that the back sling was stretched. The Unit Manager said, from the description, it was likely the wheelchair needed to be replaced. The Unit Manager said the Resident may have told rehabilitation staff about the condition of the wheelchair and that they were responsible for requesting repairs from the Maintenance Director and ordering replacement wheelchairs.</p> <p>During an interview with the Rehabilitation Director on 3/20/24 at 9:50 A.M., she said it was the responsibility of who the Resident told about the condition of the wheelchair, or who may have observed its condition, to report the issue to the Maintenance Director. The Rehabilitation Director said that if the Maintenance Director was unable to make the repairs, the Maintenance Director would inform her or someone in the department and she would order a new wheelchair. The Rehabilitation Director said no one informed her about the condition of Resident #18's wheelchair and she was not aware of it.</p> <p>On 3/20/24 at 9:35 A.M., the surveyor, accompanied by the ASL interpreter and the Rehabilitation Director, visited Resident #18, who was sitting in his/her wheelchair in the Sunroom. The Rehabilitation Director assessed the condition of the wheelchair and said it needed to be replaced because of its broken components and age.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225768	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2024
NAME OF PROVIDER OR SUPPLIER  New England Homes for the Deaf, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  154 Water 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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/20/24 at 9:37 A.M., Resident #18 said a couple of months ago he/she told nursing and maintenance staff the wheelchair needed to be replaced, but no action was taken.</p> <p>During an interview with the Maintenance Director on 3/20/24 at 11:00 A.M., he said he had not made any repairs to Resident #18's wheelchair, no one told him about its condition, and was unaware it was broken. The Maintenance Director said either nursing or rehabilitation staff will tell him if there is an issue with a wheelchair and he will attempt a repair.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225768	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2024
NAME OF PROVIDER OR SUPPLIER  New England Homes for the Deaf, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  154 Water 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 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984</b></p> <p>Based on observation, record review and interview, the facility failed to regularly inspect bed frames to identify areas of potential entrapment. Specifically, the facility failed to regularly inspect and document findings regarding zone 7 (the space between the mattress and the foot of the bed) for 27 of 27 Residents' beds in the facility for potential areas of entrapment, as evidenced by not providing an effective bed bolster for Resident #3.</p> <p>Findings include:</p> <p>According to The Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment Document issued on March 10, 2006, by the U.S. Department of Health and Human Services Food and Drug Administration Center for Devices and Radiological Health, the HBSW (Hospital Bed Safety Workgroup) identified 7 potential entrapment zones for hospital beds.</p> <p>Resident #3 was admitted to the facility in December 2005 with diagnoses including traumatic brain injury with loss of consciousness and aphasia (loss of ability to understand or express speech, caused by brain damage).</p> <p>Review of Resident #3's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident had a Brief Interview for Mental Status exam score of 0 out of a possible 15, indicating severe cognitive impairment. Further review of the MDS indicated that Resident #3 is dependent on staff for all activities of daily living (ADLs).</p> <p>The surveyor made the following observations:</p> <p>*On 3/19/24 at 1:55 P.M., Resident #3 was observed sleeping in his/her bed with a scoop mattress in place. A bolster was observed between the mattress and the footboard of the bed. The bolster was about half the height of the mattress, a visible gap was present from the top of the bolster to the top of the mattress.</p> <p>*On 3/20/24 at 7:15 A.M., Resident #3 was observed sleeping in his/her bed with a scoop mattress in place. A bolster was observed between the mattress and the footboard of the bed. The bolster was about half the height of the mattress, a visible gap was present from the top of the bolster to the top of the mattress.</p> <p>*On 3/20/24 at 7:43 A.M., the surveyor measured roughly six inches of space between the top of the bolster to the top of the mattress, roughly 7 inches of space between the footboard and the edge of the mattress above the bolster along the entire length of the bolster measuring roughly 36 inches long going the entire width of Resident #3's bed.</p> <p>Review of Resident #3's Bed Rail assessment dated [DATE] indicated the following:</p> <p>*Summary of findings: Resident #3 has a history of rolling out of bed. Concave mattress. Resident #3 has no awareness of his/her bed parameters and uses a concave mattress.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225768	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2024
NAME OF PROVIDER OR SUPPLIER  New England Homes for the Deaf, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  154 Water 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 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident #3's Bed Rail Assessment failed to indicate that Zone 7 was assessed for entrapment.</p> <p>Review of Resident #3's Kardex (a document summarizing a resident's care needs) indicated the following under the safety section:</p> <p>* Hx (history) of rolling out of bed, he/she has no safety awareness. Currently using a concave mattress.</p> <p>Review of Resident #3's ADL self-care performance deficit care plan indicated the following intervention dated 3/5/2018:</p> <p>*Hx (history) of rolling out of bed, he/she has no safety awareness. Currently using a concave mattress.</p> <p>Review of Resident #3's most recent Fall Risk assessment dated [DATE] indicated a moderate risk for falls.</p> <p>Review of the facility binder titled Electric Beds Inspection included the following documents:</p> <p>*Review of the document titled New England Homes for the Deaf 7 Zones of Entrapment Checklist dated 2021 indicated the seven zones of entrapment for each of the facility's resident beds. No recent documentation of the bed zones for any of the beds being checked was provided by the facility.</p> <p>*Review of the document titled Bed System Measurement Device Test Results Worksheet portrays a diagram of a resident bed with potential entrapment zones. The most recent documentation of testing was from 2020.</p> <p>During an interview on 3/20/24 at 10:54 A.M., the Maintenance Director said he checks for bed entrapments once a year. When asked if there was more recent documentation of resident bed entrapment inspections, he said the most recent documentation is from 2021.</p> <p>During an interview on 3/20/24 at 11:31 A.M., Unit Manager (UM) #1 and the surveyor observed Resident #3's bed. UM #1 said Resident #3's bolster needs to be corrected as it does not go high enough to be flush with the mattress since it is a concave mattress, and it is an entrapment risk. UM #1 continued to say the facility has other bolsters that go higher, she said maintenance is responsible for the bolsters. UM #1 observed the surveyor put his arm within the gap between the bolster and the mattress.</p> <p>During an interview on 3/20/24 at 11:58 A.M., UM #1 said she has added a second bolster on top of the existing one to Resident #3's bed to lower the risk of entrapment.</p> <p>During an interview on 3/21/24 at 8:56 A.M., the Administrator and the surveyor went through the facility binder titled Electric Beds Inspection and he said he cannot speak as to why the entrapment zone sheets have not been completed since 2021.</p>