

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 03/19/2025
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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>45984</p> <p>Based on observations and interviews, the facility failed to ensure staff treated residents in a dignified manner during the dining experience. Specifically, the facility failed to ensure staff were sitting at eye level when assisting a resident with feeding.</p> <p>Findings include:</p> <p>Review of the facility policy titled Quality of Life - Dignity, revised and dated August 2009, indicated the following:</p> <ul style="list-style-type: none"> - Residents shall be treated with dignity and respect at all times. <p>The surveyor made the following observations:</p> <ul style="list-style-type: none"> - During the lunch service on 3/18/25 in the second-floor dining room, a staff member was standing over a resident in a Broda chair while assisting with feeding from 12:22 P.M. through 12:34 P.M. - During breakfast on 3/19/25 at 8:28 A.M., the same staff member was standing over the same resident who was in his/her bed while assisting with feeding. <p>During an interview on 3/19/25 at 9:27 A.M., Unit Manager #1 said staff should not be standing over residents while assisting them with feeding.</p> <p>During an interview on 3/19/25 at 10:05 A.M., the Director of Nursing said staff should not be standing over residents while assisting them with feeding.</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>36431</p> <p>Based on record review and interview the facility failed to ensure for one Resident (#21), out of a total sample of 13 residents, that the Health Care Agent was provided the correct risks and benefits related to the administration of an antipsychotic medication. (An Invoked Health Care Proxy (HCP) allows the Health Care Proxy Agent to make medical decision, when a person is determined by a physician/nurse practitioner to lack the capacity to make health care decisions).</p> <p>Findings include:</p> <p>Review of the facility's policy, titled Informed Consent for Psychotropic Medication, not dated included but was not limited to the following:</p> <p>Consistent with the mission of the facility and the rights afforded patients by Massachusetts General Laws Chapter 111 Section 70E, the facility recognizes the right of its residents/patients to be free from physical or chemical restraints except to provide and to be involved in decisions about treatment and any changes in care and treatment. To that end, informed written consent will be obtained as provided in this policy whenever a psychotropic medication is utilized. The drug's prescriber will discuss the following with the Resident or the Resident's representative prior to administering the medication. The purpose for administering the psychotropic drug. The prescribed dosage; and any known effect or side effects of the psychotropic medication.</p> <p>Resident #21 was admitted to the facility in May 2021 with diagnoses that included dementia, deaf nonspeaking, cognitive communication deficit, and major depressive disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 2/5/25, indicated Resident #21 scored a 1 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam, indicating he/she as having severe cognitive impairment. Further review of the MDS indicated the Residents' Health Care Proxy (HCP) as invoked, and Resident #21 is administered antipsychotic medication.</p> <p>Review of Resident #21's physician's orders included:</p> <p>-Seroquel (an antipsychotic medication) 25 mg, po (by mouth) at HS (hour of sleep) dated 1/31/25.</p> <p>-Review of the Medication Administration Record, indicated:</p> <p>Seroquel Oral Tablet 25 MG, Give 1 tablet by mouth one time a day related to Major Depressive Disorder, Recurrent, Unspecified.</p> <p>Review of the document titled, Informed Consent for Psychotropic Administration Form, dated 1/31/25 and signed by the Invoked HCP indicated Seroquel 25 MG at HS PO, Purpose of Medication: Major Depressive Disorder. The document listed the risk and benefits of Anti-Depressant administration and failed to include an appropriate diagnosis, and the accurate risk benefits associated with antipsychotic medication.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/19/25 at 10:47 A.M., Nurse #2 said seroquel is an antipsychotic medication. Nurse #2 said Resident #21 was experiencing agitation, believing others were talking about him/her and was fixated on things that were not real, and this is why the seroquel was started. Nurse #2 said informed consent is obtained for the medication and would include the risks and benefits of the medication.</p> <p>During an interview on 3/19/25 at 11:13 A.M., Unit Manager #1 said seroquel is a psychotropic medication. Unit Manager #1 said Resident #21 HCP was aware and consented to the use of Seroquel. Unit Manger #1 reviewed the Informed Consent document and said the risk benefits listed were for an anti-depressant medication and not for antipsychotic medication and that was an error.</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846</p> <p>Based on observations, interviews, and record review, the facility failed to assess the use of foam wedges as a potential restraint for one Resident (#14) out of a total sample of 13 residents.</p> <p>Findings include:</p> <p>The facility was unable to provide a policy related to restraints.</p> <p>Resident #14 was admitted to the facility in December 2020 with diagnoses that included dementia, legal blindness, deaf non speaking, and schizophrenia.</p> <p>Review of Resident #14's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she was assessed by nursing staff to have severe cognitive impairment.</p> <p>On 3/18/25 at 7:18 A.M. and 1:26 P.M., the surveyor observed Resident #14 in bed with foam wedges lining the sides of his/her bed.</p> <p>Review of Resident #14's fall care plan, dated 6/16/22, indicated Foam wedge pads placed on each side of bed.</p> <p>Review of Resident #14's fall risk assessment, dated 2/13/25, indicated he/she scored a 19 and is at high risk for falls.</p> <p>Review of Resident #14's nursing progress note, dated 2/17/25, indicated Resident found crawling out of bed at about 0600 (6:00 A.M.),resident took off the wedge, resident was dry.</p> <p>Review of Resident #14's assessments failed to indicate a restraint assessment was completed for the use of the foam wedges.</p> <p>During an interview on 3/18/25 at 1:27 P.M., Nurse #1 said Resident #14 is a fall risk and has fallen in the past. Nurse #1 said when the Resident wants something he/she will throw his/her legs over the side of the bed. Nurse #1 said it is a fall intervention to use the foam wedges while the Resident is in bed.</p> <p>During an interview on 3/18/25 at 1:29 P.M., Unit Manager #1 said Resident #14 is a fall risk and has fallen in the past. Unit Manager #1 said the Resident does get anxious and try to wiggle out of bed and toss his/her legs over the side of the bed. Unit Manager #1 said staff have not completed a restraint assessment for the use of the foam wedges.</p> <p>During an interview on 3/18/25 at 2:31 P.M., Director of Nurses (DON) said Resident #14 is at risk for falls and the use of the wedges are a fall intervention. The DON said the facility does do restraint assessments but staff did not complete one for the Resident's foam wedges.</p>		

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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>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** 45984</p> <p>Based on observations, record review and interviews, the facility failed to ensure resident centered care plans were developed for one Resident (#27) out of a total sample of 13 residents. Specifically, for Resident #27, the facility failed to develop a comprehensive, resident centered care plan for a pacemaker.</p> <p>Findings include:</p> <p>Review of the facility policy titled Pacemaker, Care of a Resident with, revised and dated December 2015, indicated the following:</p> <p>- For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission, a. the name, address and telephone number of the cardiologist, b. type of pacemaker, c. type of leads, d. Manufacture and model, e. serial number, f. date of implant, g. paced rate.</p> <p>Resident #27 was admitted to the facility in January 2025 with diagnoses including acute and chronic respiratory failure with hypoxia, pneumonia, chronic obstructive pulmonary disease and presence of cardiac pacemaker.</p> <p>Review of Resident #27's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 15 out of 15 indicating intact cognition. Further review of Resident #27's MDS indicated the presence of a cardiac pacemaker.</p> <p>Review of Resident #27's electronic medical record including physician's orders and care plans, and paper medical records failed to indicate any information relating to the care of a pacemaker including a serial number, cardiologist information, a paced rate and a way to transmit information from the pacemaker to the appropriate physician.</p> <p>During an interview on 3/19/25 at 9:14 A.M., Nurse #2 said when a resident has a pacemaker the facility should be monitoring the resident's heart rate to ensure its in the appropriate range for the pacemaker, should have the cardiologist's information and a way to transmit the information from the pace maker to the cardiologist. Nurse #2 reviewed Resident #27's medical record and did not see any information relating to his/her pacemaker.</p> <p>During an interview on 3/19/25 at 9:27 A.M., Unit Manager #1 said Resident #27 should have information in his/her medical record relating to his/her pacemaker including a paced rate, cardiologist information and transmitter information.</p> <p>During an interview on 3/19/25 at 10:05 A.M., the Director of Nursing said Resident #27 should have a care plan for his/her pacemaker including a serial number, the type of device, a way to monitor the pacemaker and cardiologist information.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876</p> <p>Based on observation, record review and interview, the facility failed to follow professional standards of nursing practice for two Residents (#2 and #7) out of a sample of 13 residents. Specifically, 1. the facility failed to initiate a physician's order for Zofran (an anti-nausea medication) for Resident #2 and 2. the facility failed to specify what setting Resident #7's air mattress should be set to in the physician's order.</p> <p>Findings include:</p> <p>1. Resident #2 was admitted to the facility in May 2023 with diagnoses including dementia and dysphagia.</p> <p>Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #2 was significantly cognitively impaired evidenced by a score of one out of a possible 15 on the Brief Interview for Mental Status Exam.</p> <p>Review of the Nurse Practitioner progress note dated 2/17/25 indicated: Asked to f/u with patient regarding reports of vomiting x 1 today and some nausea. No SOB (shortness of breath) or chest pain. Appetite is poor due to illness. No fever. BP (blood pressure) slightly elevated today. Assessments/Plans: Nausea with vomiting, unspecified - R11.2-Patient has vomiting x 1 today but is not feeling well. If vomiting persists, may use Zofran 4mg po (by mouth) Q8 (every eight hours) prn (as needed).</p> <p>Review of the physicians orders and Medication Administration Record (MAR) dated February 2025 indicated the order for Zofran was not implemented.</p> <p>Review of the nurse progress note dated 2/18/25 indicated: Resident had diarrhea and brown emesis this evening. He/she drank some ginger ale and fluids was encouraged for the rest of the shift. Resting in bed for now.</p> <p>During an interview on 3/18/25 at 12:20 P.M. the surveyor and the Nurse Practitioner (NP) reviewed her note written 2/17/25. The NP said that she would have expected staff to implement the Zofran as needed order for Resident #2 and was not aware it was not initiated.</p> <p>During an interview on 3/19/25 8:06 A.M., Unit Manager #1 said she was unaware of the NP order for Resident #2, and that nursing staff should be reading the NP notes and enter orders.</p> <p>45984</p> <p>2. Resident #7 was admitted to the facility May 2020 with diagnoses including chronic obstructive pulmonary disease and reduced mobility.</p> <p>Review of Resident #7's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 3 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the resident is at risk of developing pressure ulcers/injuries.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The surveyor made the following observations:</p> <ul style="list-style-type: none"> - Throughout the survey period from 3/18/25 through 3/19/25, Resident #7's air mattress was set at the third light of Firmness scale and the fourth light of the Alternating Pressure Cycle Time scale. <p>Review of Resident #7's physician's order dated 2/7/25 indicated the following: Air Mattress Check for placement and function every shift.</p> <p>The physician's order failed to specify what function and settings the air mattress should be set to.</p> <p>Review of Resident #7's Kardex (a document that summarizes a resident's needs) indicated the following: Resident #7 requires an air mattress on his/her bed.</p> <p>Review of Resident #7's pressure ulcer care plan revised and dated 2/7/25 indicated the following intervention: Resident #7 requires an air mattress on his bed.</p> <p>Review of Resident #7's document titled Norton Scale for Predicting Risk of Pressure Ulcers dated 2/27/25 indicated that the Resident scored a 10 which indicated he/she is a high risk to develop pressure ulcers.</p> <p>Review of Resident #7's document titled Wound Evaluation & Management Summary dated 3/11/25 conducted by the wound physician indicated that the Resident has a non-pressure wound to the right, posterior thigh.</p> <p>Review of Resident #7's weekly skin assessment dated [DATE] indicated the following:</p> <ul style="list-style-type: none"> - Reddened area noted to left posterior back skin fold. Three open areas noted to posterior thigh measuring 4mm (millimeter) in diameter. Pink moist wound bed. <p>During an interview on 3/19/25 at 9:14 A.M., Nurse #2 said Resident #7's physician's order should specify what setting his/her air mattress should be set to.</p> <p>During an interview on 3/19/25 at 9:27 A.M., Unit Manager #1 said Resident #7's physician's order should specific what level of firmness his/her air mattress should be set to.</p> <p>During an interview on 3/19/25 at 10:05 A.M., the Director of Nursing said Resident #7's physician's order should specific what level of firmness his/her air mattress should be set to.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846</p> <p>Based on observation, record review and interview, the facility failed to provide treatment and care in accordance with professional standards of practice for two Residents (#28, and #15), out of a total sample of 13 residents. Specifically,</p> <ol style="list-style-type: none"> 1. For Resident #28, the facility failed to notify the Medical Doctor or Nurse Practitioner to initiate a new order for an oral antibiotic medication to treat his/her osteomyelitis recommended by the infectious disease provider. 2. For Resident #15, the facility failed to obtain a urine specimen timely and failed to notify the Nurse Practitioner or Medical Doctor that the urine specimen was not obtained resulting in Resident #15 being transferred to the emergency department and treated for cystitis (inflammation of the bladder). <p>Findings include:</p> <p>Resident #28 was admitted to the facility in February 2025 with diagnoses that included extradural and subdural abscess, osteomyelitis, sepsis, and mild cognitive impairment.</p> <p>Review of Resident #28's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 15 out of 15 on the Brief Intervention for Mental Status (BIMS) indicating intact cognition.</p> <p>Review of Resident #28's Nurse Practitioner note, dated 3/3/25, indicated F/u (follow up) with the Infectious Disease Doctor in ID (Infectious Disease) is scheduled for today.</p> <p>Review of Resident #28's nursing progress note, dated 3/3/25, indicated Resident arrived from hospital around 4:45 P.M No new orders.</p> <p>Review of Resident #28's infectious disease clinic note, dated 3/3/25, indicated Has received almost 8 weeks of parenteral antimicrobial therapy. On 3/6 will go ahead and discontinue the vancomycin, ceftriaxone. The Resident's PICC (IV line) line will be removed on that day. At which point, I recommend starting Trimethoprim-Sulfamethoxazole (antibiotic) 1 double strength tablet by mouth twice daily for 28 days.</p> <p>During an interview on 3/18/25 at 12:59 P.M., Medical Doctor (MD) #1 said Resident #28 was on Intravenous (IV) antibiotics for many weeks for osteomyelitis but has completed his/her course of antibiotics. MD #1 said the facility staff never relayed the Infectious Disease Doctors recommendations to start by mouth antibiotics and they should have.</p> <p>During an interview on 3/18/25 at 1:07 P.M., Nurse Practitioner (NP) said Resident #28 finished his/her course of IV antibiotics and does not think he/she is on any other antibiotics at this time. The NP said nursing never relayed the recommendations on 3/3/25 infectious disease clinic and should have been told the recommendations so the Resident could start the medication after 3/6/25.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/18/25 at 1:18 P.M., Nurse #1 said the Resident is not on antibiotics currently.</p> <p>During an interview on 3/18/25 at 1:20 P.M., Unit Manager #1 reviewed the Residents physician orders with the surveyor and said the Resident is not on any antibiotics at this time. Unit Manager #1 reviewed the Infectious Disease consult note from 3/3/25 and said the nurse that received the Resident back from his/her appointment should have called the MD or NP about the new medication recommendations but did not.</p> <p>During an interview on 3/18/25 at 2:30 P.M., the Director of Nurses (DON) said when a Resident returns from an appointment with new medication recommendations the nurse should be calling the provider to initiate the medications and write a nursing progress note.</p> <p>36431</p> <p>2. Resident #15 was admitted to the facility in January 2021 and has diagnoses that include mild cognitive impairment, heart failure, unspecified visual loss, and sensorineural bilateral hearing loss.</p> <p>Review of the Minimum Data Set assessment, dated 1/15/25 indicated Resident #15 scored a 2 out of 15 on the Brief Interview for Mental Status Exam, indicating severe cognitive impairment, is occasionally incontinent of urine, and requires supervision for toileting and has physical behavioral symptoms.</p> <p>Review of Resident 15's clinical record indicated the following:</p> <p>-A Plan of Care note dated 2/3/25 and entered by the Social Worker, included but was not limited to a care plan meeting was held with HCP (Health Care Proxy) on the phone. Resident had a fall on 2/2/25. He/she has had some increased confusion. Due to increase confusion testing will be done for a UTI (Urinary Tract Infection).</p> <p>Review of the physician's orders in the electronic medical record failed to indicate an order to obtain a UA C and S (Urine Analysis with Culture and Sensitivity) was entered.</p> <p>Review of the 'Interim Physician's Order Sheet' located in the paper clinical record indicated an order: UA C+S, dated 2/3/2025.</p> <p>Further review of Resident #15's medical record indicated the following:</p> <p>-Health Status Note, dated 2/4/2025 at 06:27 (6:27 A.M.) indicated Resident in bed all shift sleeping. Unable to get a urine specimen today due to staying in bed all shift.</p> <p>-Health Status Notes dated 2/5/25 at 21:35 (9:35 P.M.) note text included but not limited to; Witnessed fall today in the sunroom. No injuries reported. Unable to obtain urine for C and S (Culture and Sensitivity) on shift, will continue to try.</p> <p>-Health Status note effective date 2/7/2025 at 22:00 (10:00 P.M.) Note text: Resident sent to hospital ER (emergency room) for changed in mental status evaluation at 5pm.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Health Status Note, date 2/8/2025 at 04:53 (4:53 A.M.) Resident has been in bed asleep since coming back at 11:15 pm via ambulance after being D/C (discharged) from the hospital. NO (new order) for Cefixime (an antibiotic that may be used to treat many different types of infections caused by bacteria) 400 mg daily for 5 days TO (telephone order) from Dr's office noted. Supervisor is aware of NO (new order) and DX (diagnosis) of Acute Cystitis (inflammation of the urinary bladder).</p> <p>Review of the clinical record failed to indicate the nursing staff notified the Nurse Practitioner or Physician that a urine specimen was not obtained.</p> <p>During an interview on 3/19/25 at 10:55 A.M., Nurse #2 reviewed Resident #15's clinical record and said there were no recent laboratory results for a UA C and S. Nurse #2 said if an order is obtained for a UA, the Nurse Practitioner or Doctor should be made aware that it has not been obtained after a few days to determine a plan. Nurse #2 reviewed the record and said the urine was not obtained. Nurse #2 reviewed the hospital 'After Visit Summary', dated 2/7/25 and said Resident #15 was prescribed an antibiotic for a bladder infection. Nurse #2 said if the urine was obtained as ordered the transfer to the ER may have been avoided.</p> <p>During an interview on 3/19/25 at 11:25 A.M., Unit Manager #1 said Resident #15 had a fall and was exhibiting increased confusion. Unit Manager #1 said the order for a UA C and S was written on 2/3/25 and that Resident #15 is deaf and blind, and it could be a challenge to obtain a urine specimen. Unit Manager #1 said the nursing staff should have notified the urine specimen was not collected as ordered. Unit Manager #1 said obtaining the order UA and CS could have avoided Resident #15 from going to the ER.</p> <p>During the interview on 3/19/25 at 11:25 A.M., with Unit Manger #1 the Director of Nursing came said nursing staff should notify the doctor or Nurse Practitioner after a few days if they are unable to obtain the urine specimen.</p>		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984</p> <p>Based on observations, record review and interview, the facility failed to provide respiratory care services in accordance with professional standards of practice for one Resident (#27) out of a total sample of 13 residents. Specifically, the facility failed to ensure Resident #27 had a physician's order for the use of supplemental oxygen therapy while he/she was receiving supplemental oxygen.</p> <p>Findings include:</p> <p>Review of the facility policy titled Oxygen Administration, revised and dated October 2010, indicated the following:</p> <ul style="list-style-type: none"> - Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. <p>Resident #27 was admitted to the facility in January 2025 with diagnoses including acute and chronic respiratory failure with hypoxia, pneumonia, chronic obstructive pulmonary disease and presence of cardiac pacemaker.</p> <p>Review of Resident #27's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 15 out of 15 indicating intact cognition.</p> <p>The surveyor made the following observations:</p> <ul style="list-style-type: none"> - On 3/18/25 at 7:37 A.M., Resident #27 was lying in his/her bed receiving supplemental oxygen at 1 liter via nasal cannula. With the assistance of an interpreter, Resident #27 said it can be hard to breath sometimes. - On 3/18/25 at 12:00 P.M. and 2:03 A.M., Resident #27 was sitting in his/her wheelchair in the hallway receiving supplemental oxygen via nasal cannula. - On 3/18/25 at 4:05 P.M., Resident #27 was observed in his/her wheelchair with his/her eyes closed. Resident #27 was receiving supplemental oxygen via nasal cannula at 1 liter. - On 3/19/25 at 6:52 A.M., Resident #27 was sleeping in his/her bed receiving supplemental oxygen at 1 liter via nasal cannula. - On 3/19/25 at 9:11 A.M., Resident #27 was lying in bed receiving supplemental oxygen at 2 liters via nasal cannula. With the assistance of an interpreter, Resident #27 told the surveyor it is hard to breathe. <p>Review of Resident #27's active physician's order failed to indicate that the Resident has an order to receive supplemental oxygen therapy.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #27's Kardex (a nursing care card) failed to indicate that the Resident was receiving supplemental oxygen therapy.</p> <p>Review of Resident #27's pneumonia care plan dated 3/18/25 indicated the following intervention: oxygen therapy as ordered.</p> <p>Review of Resident #27's nursing progress notes indicated the following:</p> <p>- On 3/17/25 at 11:58 A.M. and 9:48 P.M., 3/18/25 at 11:47 P.M., 3/19/25 at 3:52 P.M. indicated that Resident #27 was receiving oxygen at 1 liter via nasal cannula.</p> <p>Review of Resident #27's Medication and Treatment Administration Records for March 2025 did not indicate that Resident #27 was receiving oxygen therapy.</p> <p>During an interview on 3/19/25 at 9:14 A.M., Nurse #2 said Resident #27 is currently receiving supplemental oxygen at 1 liter and there should be a physician's order indicating that a resident is receiving oxygen therapy. Nurse #2 and the surveyor reviewed Resident #27's physician's order and there was no active order for supplemental oxygen therapy.</p> <p>During an interview on 3/19/25 at 9:27 A.M., Unit Manager #1 said all residents need a physician's order to receive supplemental oxygen therapy. Unit Manager #1 said Resident #27 should have a physician's order for oxygen if he/she is receiving it.</p> <p>During an interview on 3/19/25 at 10:05 A.M., the Director of Nursing said all residents receiving supplemental oxygen therapy need an active physician's order, she continued to say Resident #27 should have one.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45984</p> <p>Based on observation and interview, the facility failed to properly follow food storage and food handling practices to prevent the risk of foodborne illness in accordance with professional standards for food service safety. Specifically, A) the facility failed to properly store food items in the kitchen to prevent the risk of foodborne illness and B) the facility failed to properly handle food and dinnerware in accordance of professional standards of practice in the second-floor dining room.</p> <p>Findings include:</p> <p>A) During the initial walk-through of the kitchen on 3/18/25 at 7:04 A.M., the surveyor observed the following:</p> <p>In the walk-in refrigerator:</p> <ul style="list-style-type: none"> - Three carafes containing a yellow liquid, red liquid and clear liquid with no labels indicating what the product was or with a date. - Opened containers with no identifier label with no dates for: three bottles of juice, one container of milk, one container of soy milk, one container of Lactaid milk, three containers of thickened juice, and eight containers of soda. - An opened bag of chocolate whipped cream with no identifier label or date. <p>In the reach-in refrigerator:</p> <ul style="list-style-type: none"> - A container labeled as carrots with a use by date of 3/13. - An unlabeled and undated container of a food resembling tuna salad. - A container labeled as cheese with a use by dated of 3/12. - An unlabeled and undated container of a food resembling coleslaw. - An unlabeled and undated container of a food resembling baked beans. <p>During an interview on 3/19/25 at 10:34 A.M., the Foodservice Director (FSD) said any container of an opened food or drink should have a label identifying what it is and have a date on it. The FSD then said after three days of the written date, the food item should be discarded.</p> <p>B) The surveyor made the following observations on the second-floor dining room on 3/18/25:</p> <ul style="list-style-type: none"> - At 12:11 P.M., a staff member touched a resident's dinner roll with her bare hands to spread butter on it and the proceeded to sanitize her hands. At 12:12 P.M., the same staff member touched a different resident's dinner roll with her bare hands to spread butter on it. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- At 12:20 P.M., the same staff member opened three straws for a Resident's drinks. The staff member touched the straw where the resident's mouth would touch with her bare hands. The resident proceeded to take sips from the straws where the staff member touched.</p> <p>During an interview on 3/19/25 at 10:05 A.M., the Director of Nursing said staff should not be touching food or dinnerware directly with bare hands.</p> <p>During an interview on 3/19/25 at 10:34 A.M., the Foodservice Director said no staff should be directly touching a resident's food with their bare hands.</p>		