STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225769	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alliance Health at Braintree	175 Grove Street Braintree, MA 02184

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 - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on observations, interviews, and record review, the facility failed to ensure that individualized, comprehensive care plans were developed and consistently implemented for one Resident (#38), out of a total sample of 18 residents. Specifically, the facility failed to ensure a resident specific care plan was developed to address the resident's medical, physical, mental and psychosocial needs following the Resident's recent suicide attempt at the facility. Findings include: Resident #38 was admitted to the facility in June 2024 with diagnoses including non-Alzheimer's dementia and had an activated Health Care Proxy (someone designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions). Review of the Minimum Data Set assessment, dated 6/10/24, indicated Resident #38 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 11 out of 15, and had no behaviors. Review of a Nursing Note, dated 7/10/24, indicated at around 10:45 P.M., Resident #38 was very agitated and hit his/her right leg and right hand against the side rails. A lot of blood was noted on the floor and bed. The Nurse applied dressings to the injury, and 10 minutes later, while the Certified Nursing Assistant (CNA) was trying to change the linen and put a clean johnny (a gown usually made of cotton, with an open back that fastens with ties around the back and neck) on him/her, the CNA observed the Resident trying to choke him/herself with the johnny and stated he/she wanted to kill him/herself. 911 was called immediately, and the Resident was sent to the emergency room for evaluation. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Health Care Facility Reporting System (web-based system that health care facilities must use to report incidents and allegations of abuse, neglect, and misappropriation) and a Accident/Incident Report and Investigation Form indicated Resident #38 had a suicide attempt in the facility on 7/10/24. Further review of the report indicated the Resident presented with an acute change in mental status and delirium on the 7:00 A.M. to 3:00 P.M. shift. When the Resident's family member was preparing to leave, the Resident began to cry and was repeatedly saying I want to go home with you, get me out of here. At approximately 10:45 PM, when a CNA was assisting the Resident to change his/her johnny the Resident pulled the johnny out of the CNA's hands and twisted the johnny around his/her neck. As the Resident was doing this, he/she stated, I'm going to kill myself. The Nurse called 911. The CNA's statement indicated she was sitting with the Resident and noted that the johnny was tied and knotted so badly, the police officer had to cut it off. The Resident was transferred to the hospital for evaluation. Review of the Emergency Department Encounter note, dated 7/11/24, indicated Resident #38 presented to the emergency department following a reported suicide attempt by tying a johnny around his/her neck. The Resident was admitted for attempted suicide, altered mentation, and a urinary tract infection. The discharge notes indicated in the Assessment/Plan: Principal Problem: Acute encephalopathy Active Problems: Hypotension, UTI, COVID, Suicidal Ideation Resident #38 was discharged back to the facility on [DATE]. Review of comprehensive care plans indicated, but was not limited to: -Problem: Mood State (6/19/24) -Approaches identified include: Encourage Resident to participate in activities of choice; encourage Resident to talk about recent life changes; monitor for mood or behavior changes; provide 1:1 visits as needed to provide support; refer to Psych as needed. -Problem: Behavioral symptoms (6/19/24) -Approaches identified include: Always approach Resident in a calm manner; involve psych services prn (as needed); labs/urine as ordered by MD to rule out medical cause -Problem: Resident has a urinary tract infection (7/18/24) -Approaches identified include: administer antibiotic therapy as ordered, monitor/document for side effects and efficacy; encourage adequate fluids; monitor/document/report to MD as needed for signs/symptoms of UTI: frequency, urgency, malaise, foul smelling urine, dysuria, fever, nausea and vomiting, flank pain, supra-pubic pain, hematuria, cloudy urine, altered mental status, loss of appetite, behavioral changes; obtain and document vital signs per MD order. Further review of comprehensive care plans failed to indicate an individualized care plan was developed that identified and addressed the Resident's new diagnosis of suicidal ideation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/24 at 9:10 A.M., the surveyor observed Resident #38 lying on his/her left side in bed awake. The Resident wore a hospital johnny that was secured around his/her neck only. No other ties were secured in the back of the johnny. The Resident repeatedly pulled the johnny away from his/her body in an upward direction as if trying to pull it off his/her body. During an interview on 7/24/24 at 12:35 P.M., Social Worker (SW) #1 said Resident #38 had a suicide attempt at the facility on 7/10/24. She said the Resident has a history of delusions that he/she is pregnant but has never had suicidal ideation before. She said when a resident returns from the hospital for a psychiatric issue, she contracts for safety, makes a referral to psychiatric services, and updates the care plan upon their return. She said she did not develop a Resident centered care plan to reflect the Resident's suicide attempt and suicidal ideation. The Social Worker said the Resident's name was placed in the consultant psychiatric Nurse Practitioner's (NP) book to alert them that the Resident needed to be seen on their next visit. She said the NP was out of the country and did not see the Resident and they do not have another provider to come in. During an interview on 7/25/24 at 7:36 A.M., the Director of Nursing (DON) said a care plan was not developed to address the Resident's suicidal ideation and attempt because they believe it was due to delirium from a UTI. During an interview on 7/25/24 at 4:05 P.M., Resident Representative #1 said Resident #38 has a history of frequent urinary tract infections with delirium, and he/she has never had suicidal ideations or a suicide attempt prior to 7/10/24.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48695 Based on observations, record review, and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Maintain the ice machine in a clean and sanitary manner in one out of three kitchenettes; and 2. Ensure staff implemented and followed their policy related to safe and sanitary storage, handling, and consumption of foods items stored in the Resident's personal refrigerator/freezer. Findings include: 1. Review of the facility's policy titled Ice Machine, last revised 4/11/22, indicated but was not limited to: - Policy: it is the policy of this Facility that the ice machine be maintained in a clean and sanitary manner. - Process: - Monthly 1. Empty ice from storage bin 2. Clean outside and inside with solution of 1 part bleach to 9 parts water 3. Discard the first batch of ice after cleaning 4. Check machine to ensure that ice is being made normally 5. The ice machine should be emptied and sanitized at least quarterly - Bi-annually 1. The ice machine vendor is responsible for cleaning the ice making components of the machine twice a year. 2. This preventative maintenance cleaning involves cleaning the water filters, checking components, making necessary repairs and ensuring the machine is functioning properly. 3. Maintenance is responsible for the documentation that shows the machine has been cleaned by the vendor on a timely basis. On 7/23/24 at 12:53 P.M., the surveyor observed the following in the Third-Floor kitchenette: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A large ice machine. Inside the ice machine on one of the plastic components there was pink and black discoloration. The discolored component had condensation dripping down into the ice cubes. - A sticker affixed to the front of the ice machine indicated but was not limited to: - Name of the company and their phone number that last serviced the ice machine. - Ice Machine Cleaned and Sanitized Date: 1/24; By: Consultant #1. - Ice Chest Cleaning Sheet indicated the ice machine was last cleaned on 7/15/24. On 7/24/24 at 8:39 A.M., the surveyor observed the following in the Third-Floor kitchenette: - A large ice machine. Inside the ice machine on one of the plastic components there was pink and black discoloration. The discolored component had condensation dripping down into the ice cubes. During an interview with observation on 7/24/24 at 8:58 A.M., the Director of Maintenance (DOM) said he cleans the ice machine himself once a month by removing the ice from the ice machine and wiping down the ice machine. The DOM and surveyor observed pink and black discoloration on the plastic components and there were water droplets sliding down the pink and black discoloration dripping into the ice. The DOM reviewed the Ice Chest Cleaning sheet and said the ice machine was last cleaned on 7/15/24. During an interview with observation on 7/24/24 at 9:26 A.M., the DOM said the pink and black mold comes back quickly, and that maybe the ice machine needed to be cleaned more frequently. The surveyor observed the DOM wipe the pink and black substance with a disposable cloth and close the cover to the ice machine. The pink and black substance was able to be wiped off and was not a permanent stain. The surveyor and the DOM observed water droplets touching the pink and black substance dripping into the ice and potentially contaminating it. During an interview with observation on 7/25/24 at 9:44 A.M., Consultant #1 said he worked for the company that last serviced the ice machine in January 2024. Consultant #1 said his company recommended the ice machine be serviced and sanitized quarterly, but the facility preferred to have it done every six months. Consultant #1 and the surveyor observed the inside of the ice machine and saw a pink and black substance on one of the plastic components, a black substance on the inside of the upper front panel, and a black substance on a sensor. Consultant #1 said the black and pink residue was mold. Consultant #1 said the DOM was responsible for contacting the company and setting up the cleaning. During an interview on 7/25/24 at 10:57 A.M., the Administrator said the Facility does not have a contract with the company that comes in to service the ice machine, but schedules service every six months. The Administrator reviewed the last two invoices for ice machine cleaning which indicated that the ice machine was last serviced on 1/11/24 and 4/19/23, indicating eight months between cleanings. The Administrator said the Facility had been late in cleaning the ice machine. During an interview on 7/25/24 at 12:37 P.M., Consultant #1 said if the ice machine has mold, then it should not be used. Consultant #1 said when there is mold, it is not good. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/25/24 at 12:53 P.M., the DOM said when he cleaned the ice machine, he would use a nine to one ratio of water to bleach. The DOM said he usually emptied the ice out of the ice machine, and he would only clean the ice bucket. The DOM said if he saw something on the top component then he would clean it but did not clean it regularly. The DOM said he did not remember if he saw any pink and black discoloration on the plastic components. The DOM said he probably did not check it right. 34145 2. Review of the dietary policy titled Food Storage, last revised 2/28/23, indicated but was not limited to the following: -Individual Resident refrigerators a. If the resident chooses to have their own individual refrigerators in their room, the following requirements must be met for sanitation and safety purposes: -The resident/family will assume sole responsibility to clean the refrigerator and keep it in a sanitary manner. -The resident/family will be responsible for ensuring any perishable food is stored at less than or equal to 41 degrees. -Open food must be dated and should not be kept in the refrigerator any longer than 48 hours. The resident/family will be responsible for discarding appropriately. -The facility reserves the right to ask for the refrigerator to be removed if practices on maintaining it are not sanitary and do not meet with industry standards. Resident #27 was admitted to the facility in October 2022 and had diagnoses including dementia and Parkinson's disease. Review of the Minimum Data Set assessment, dated 5/30/24, indicated Resident #27 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 6 out of 15. During an interview with observation on 7/23/24 at 9:12 A.M., with the Resident's permission, the surveyor inspected the Resident's personal refrigerator/freezer located in the corner of his/her room. The Resident opened the refrigerator/freezer and said he/she keeps food in it and takes care of it him/herself. The Resident said he/she could not remember when he/she put the food items in there. The surveyor observed the following in the Resident's personal Refrigerator/freezer: -there was no thermometer inside either the refrigerator or freezer; -the top shelf of the refrigerator was glass and had condensation dripping onto items on the glass shelf below; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-the second shelf of the refrigerator was glass and had brown/yellow stains on the surface as well as pieces of cardboard stuck to the shelf; -the inside edges, gasket and floor of the refrigerator were covered in large spills and splatters of a brown/yellow sticky substance; and -the freezer had a thick build-up of ice on all surfaces including the floor which was also covered in a light pink substance. The surveyor observed the following food items in the refrigerator/freezer: -uncovered thermal cup of soup, undated; -a sandwich wrapped in cellophane, undated; -a small individually wrapped (clear cellophane original packaging), cheese pizza with black and dark green fuzzy material visible on the edges of the pizza, undated -a red plastic plate of partially eaten food (unidentifiable contents); and -a covered thermal cup, undated and unidentifiable contents. During an interview on 7/24/24 at 9:17 A.M., the Maintenance Director said for refrigerators that are brought into the facility by families, it is the family's responsibility to clean and maintain them. Review of the medical record indicated following surveyor inquiry on 7/24/24, the facility contacted Resident #27's Health Care Proxy (HCP) regarding maintenance of the refrigerator/freezer. The HCP said they are unable to maintain the refrigerator/freezer and requested it be removed. During an interview on 7/25/24 at 7:36 A.M., the Director of Nursing (DON) said it is the facility's policy that either residents or their families are responsible for maintaining personal refrigerators. The DON said she didn't know how the facility ensures that families are maintaining safe and sanitary storage of food and proper functioning of the refrigerator but the facility should ensure safe storage.