STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225785	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New England Pediatric Care	78 Boston Road North Billerica, MA 01862

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** 41019 Based on record review and interview, the facility failed to follow the plan of care for one Resident #44, out of a total sample of 21 residents. Specifically, the facility provided Resident #44 with a toy that was not deemed safe, resulting in Resident #44 coughing on a piece of the toy. Findings include: Resident #44 was admitted in November 2012 with diagnoses including PICA (an eating disorder where a person eats non-food items) of infancy and childhood. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #44 is severely impaired and did not score on a Brief Interview for Mental Status (BIMS). Review of the MDS indicates that Resident #44 requires substantial to maximal assist with walking and dependent with wheelchair mobility. Review of the care plan for Resident #44 indicated the following: PICA/SAFETY/RESTRAINTS: He/she exhibits potentially self-injurious behaviors of putting small objects in his/her mouth which puts him/her at risk for aspiration, choking. (initiated 4/22/2013) -Position Resident #44 away from other residents and equipment. Ensure that there are no small objects within his/her reach. Closely supervise Resident #44 in CR and TR when working with objects. (initiated 7/21/2015) Review of the Incident/Accident Report, dated 3/21/24, indicated that Resident #44 returned to his/her unit from education with a foam toy. The report indicates that, unwitnessed, Resident #44 bit off a piece of foam toy and began choking. Resident #44 was able to cough up full piece of said toy. Review of the report did not indicate that any witness statements were obtained from the staff directly involved. Review of the report did not indicate how Resident #44 obtained the foam toy. (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	During an interview on 4/8/24 at 1:18 P.M., Educator #1 said that she did not give Resident #44 the foam toy and that her staff are aware of which toys Resident #44 is supposed to have. Educator #1 said that Resident #44 leaves school at 2:30 P.M. and only leaves with toys that are approved for him/her. Educator #1 said that Resident #44 could have grabbed a toy from another Resident, but doesn't believe that is what occurred because it would have only happened when walking back to the unit with a staff member. Educator #1 said that Resident #44 is brought back to the unit by staff and cannot propel him/herself in the wheelchair. During an interview on 4/8/24 at 2:11 P.M., Certified Nursing Aide (CNA) #1 said that he was walking by Resident #44 in the hallway and saw him/her coughing. CNA #1 said that Resident #44 was not turning blue and was able to breathe okay, but was just coughing on something. CNA #1 said he got the nurse and when the nurse arrived, Resident #44 coughed up the piece of a foam toy with some saliva. CNA #1 said that Resident #44 was not choking, but was coughing on the small piece of toy. CNA #1 said that Resident #44 was able to expel it him/herself. CNA #1 said that staff did not have to perform any sort of heimlich maneuver (an action to help dislodge an item from a person's airway) or help Resident #44 remove the piece of toy. During an interview on 4/8/24 at 10:40 A.M., the Director of Nursing said that Resident #44 had the toy in his/her mouth and gagged and spit it the toy out him/herself. The Director of Nursing said that the staff educator was aware that she should not provide toys like that to Resident #44. Resident #44 has certain toys that are deemed safe that he/she can't bite into. The Director of Nursing said that Resident #44 shouldn't have anything he/she can bite off. See F689.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to prevent a choking incident for one Resident (#44), specifically the Resident choked on a piece of foam toy, out of a total sample of 21 residents. Findings include: Review of the facility policy titled, Accidents/Incidents, dated 10/2021 indicated the following: -An incident is defined as any occurrence not consistent with the routine operation of the Center of normal care of the resident. An incident can involve a visitor or staff member, malfunctioning equipment, or observation of a situation that poses a threat to safety or security. Resident #44 was admitted in November 2012 with diagnoses including PICA (an eating disorder where a person eats non-food items) of infancy and childhood. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #44 is severely impaired and did not score on a Brief Interview for Mental Status (BIMS). Review of the MDS indicates that Resident #44 requires substantial to maximal assist with walking and dependent with wheelchair mobility. Review of the care plan for Resident #44 indicated the following: PICA/SAFETY/RESTRAINTS: He/she exhibits potentially self-injurious behaviors of putting small objects in his/her mouth which puts him/her at risk for aspiration, choking. (initiated 4/22/2013) -Position Resident #44 away from other residents and equipment. Ensure that there are no small objects within his/her reach. Closely supervise Resident #44 in CR and TR when working with objects. (initiated 7/21/2015) Review of the Incident/Accident Report, dated 3/21/24, indicated that Resident #44 returned to his/her unit from education with a foam toy. The report indicates that, unwitnessed, Resident #44 bit off a piece of foam toy and began choking. Resident #44 was able to cough up full piece of said toy. Review of the report did not indicate that any witness statements were obtained from the staff directly involved. Review of the report did not indicate how Resident #44 obtained the foam toy. During an interview on 4/8/24 at 1:18 P.M., Educator #1 said that she did not give Resident #44 the foam toy and that her staff are aware of which toys Resident #44 is supposed to have. Educator #1 said that Resident #44 leaves school at 2:30 P.M. and only leaves with toys that are approved for him/her. Educator #1 said that Resident #44 could have grabbed a toy from another Resident, but doesn't believe that is what occurred because it would have only happened when walking back to the unit with a staff member. Educator #1 said that Resident #44 is brought back to the unit by staff and cannot propel him/herself in the wheelchair. (continued on next page)

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