STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225318	A. Building B. Wing	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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 0689 Level of Harm - 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** 37375 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had a diagnosis of right sided hemiparesis (muscle weakness or partial paralysis on one side of the body) and required physical assistance from staff with transfers, the Facility failed to ensure staff provided an appropriate level of assistance in an effort to maintain his/her safety to prevent incidents/accidents resulting in an injury. -On 05/14/22, Certified Nurse Aide (CNA) #1 assisted Resident #1 into his/her wheelchair and wheeled him/her into the bathroom, but remained behind the wheelchair during the transfer. CNA #1 was not in a position to reach or provide physical assistance to Resident #1 when he/she attempted to transfer from the wheelchair to the toilet. Resident #1 stood up from his/her wheelchair, as he/she attempted to transfer onto the toilet one of his/her legs got caught on one the legs of the over the toilet commode, and he/she fell . Resident #1 was transferred to the Hospital Emergency Department where he/she was diagnosed with fractures of his/her right and left nasal bones. Findings Include: Review of the Facility Policy titled Falls and Risk, dated 2017, indicated that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and to try to minimize complications from falling. Review of the Facility Policy titled Falls-Clinical Protocol, dated 2017, indicated that risk factors for subsequent falling included gait and balance disorders, cognitive impairment, weakness, environmental hazards, and illnesses affecting the central nervous system. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 01/13/22, indicated he/she was admitted to the Facility in April 2021, diagnoses included; cerebral vascular accident (also known as a stroke or CVA), spastic hemiplegia (spasticity affecting one side of the body) and hemiparesis (weakness or inability to move one side of the body) following a CVA affecting right dominant side, aphasia (loss of ability to understand or express speech, caused by brain damage) following a CVA, anxiety, and depression. The MDS indicated that Resident #1 required extensive physical assistance of one staff member for transfers. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225318	A. Building B. Wing	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's At Risk for Falls Care Plan, dated as revised 02/14/2022, indicated Resident #1 was at risk for falls related to deconditioning, gait and balance problems, incontinence, and psychoactive medications. Review of Resident #1's Incident Report, dated 05/14/22, indicated that Nurse #1 heard a call for help, ran to Resident #1's room where she observed him/her on the floor with the top half of his/her body in the doorway to an adjoining room and his/her legs in the bathroom (bathroom was shared with two rooms with doors from each room leading to shared bathroom). The Report indicated that Resident #1's nose, bridge of nose, and left eye were bleeding, 911 was called, and he/she was transferred to the Hospital Emergency Department. Review of Resident #1's Nurse Progress Note, dated 05/14/22, indicated that Resident #1 was transferred out of the Facility via 911 at 6:55 A.M. due to a fall with a head strike. The Note indicated that Resident #1's foot got caught on the leg of the commode (which was positioned over the toilet to create a raised seat) during a transfer, he/she fell to the floor, and the CNA was unable to stop the fall. The Note indicated that Resident #1 fell on to his/her face, he/she had a cut on the [NAME] of his/her nose, and his/her left eye and nose were bleeding. Review of Certified Nurse Aide (CNA) #1's Written Witness Statement, dated 05/14/22, indicated that at 6:45 A.M., while she was transferring Resident #1 to the toilet, his/her foot got caught on the leg of the over the toilet commode, and he/she fell on his/her face. The Statement indicated that CNA #1 tried not to let it happen, was holding Resident #1 but could not stop the fall. During an interview on 06/22/22 at 10:51 A.M., CNA #1 said that at approximately 6:30 A.M. on 05/14/22, she helped transfer Resident #1 out of bed into his/her wheelchair by placing a gait belt on him/her and said although Resident #1 was able to stand and pivot, he/she was very unsteady. CNA #1 said Resident #1 required physical assistance of one staff member for transfers. CNA #1 said after Resident #1 was in his/her her wheelchair, she wheeled him/her to the bathroom and she remained standing behind the wheelchair while Resident #1 pulled himself/herself to a standing position using the grab bar on the wall across from the toilet. CNA #1 said as Resident #1 attempted to transfer himself/herself to the toilet, his/her left foot got caught on the leg of the over toilet commode. CNA #1 said although she had a gait belt on Resident #1, said she was only able to hold on it as Resident #1 stood up because she was behind the wheelchair. CNA #1 said when Resident #1's foot got caught, he/she fell forward and she was unable to stop him/her from falling because she was behind the wheelchair. CNA #1 said she should have been in front of Resident #1 to assist him/her during the transfer. During an interview on 05/14/22 at 12:13 P.M., Nurse #1 said that, at approximately 6:30-6:40 A.M. on 05/14/22, she heard CNA #1 yelling for help and when she arrived in Resident #1's room, she observed Resident #1 face down on the floor with his/her legs in the bathroom and much of his/her body (through the doorway) and on the floor in an adjoining room that shared the bathroom. Nurse #1 said Resident #1's past medical history included a stroke which left him/her completely weak on one side. Review of Resident #1's Hospital Diagnostic Imaging Report, dated 05/14/22, indicated that a CT scan of his/her head, cervical spine, and facial bones revealed fractures of his/her right and left nasal bones. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225318	A. Building B. Wing	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 06/27/22 at 11:03 A.M., the Occupational Therapist (OT) said prior to Resident #1's fall, on 05/14/22, Resident #1 required the use of a gait belt and physical assistance of one staff member for transfers. The OT said Resident #1's fall was the result of the CNA not being in the proper position when Resident #1 attempted to transfer onto the toilet. The OT said Resident #1 had an over the toilet commode over in his/her bathroom and said because the commode had four legs a resident could trip on them. The OT said due to Resident #1's dementia, symptoms from his/her CVA, fluctuating lower body strength and coordination issues, the CNA should have gotten in front of his/her wheelchair to guide and bring the wheelchair into the bathroom, so that she was positioned appropriately and in front of Resident #1 to assist with the transfer. The OT said that if the CNA was in the right position when Resident #1 attempted to transfer onto the toilet, she could have guided him/her when his/her foot got stuck, and would have been there to help. The OT said the CNA would have also been able to better see if Resident #1's feet were in the proper position and therefore provide the proper compensation. The OT said that the CNA should have held Resident #1's gait belt during his/her entire transfer and said if he/she attempted to use the gait belt from behind his/her wheelchair, it would not have been effective. The OT said gait belts were used for safety during transfers to provide assistance for residents with balance deficits during transfer, for safe body maneuvering, and in order to safely lower a resident to the floor or wheelchair to help prevent injury if a resident should start to fall. During an interview on 05/14/22 at 1:22 P.M., the Director of Nursing (DON) said Resident #1 had right sided weakness and for transfers. The DON said CNA #1 should have used the gait belt appropriately when she assisted Resident #1 to the bathroom and was going to need her assistance with transfer from the wheelchair to the toilet. The DON said after she investigated Resident #1's fall, she determined that CNA #1 should have been in front of Resident #1 rather than behind him/her when she assisted him/her with transferring from the wheelchair to the toilet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225318	A. Building B. Wing	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37375 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had a diagnosis of a cerebral vascular accident (CVA, also known as stroke) and right hemiparesis (muscle weakness or partial paralysis on one side of the body), the Facility failed to ensure they maintained a complete and accurate Medical Record when his/her Activity of Daily Living Care Plan was not updated and conflicted with other information and assessments in his/her medical record. Findings Include: Review of the Facility Policy titled Care Plans-Comprehensive, dated 2017, indicated the Facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 01/13/22, indicated he/she was admitted to the Facility in April 2021, diagnoses included; cerebral vascular accident (also known as a stroke or CVA), spastic hemiplegia (spasticity affecting one side of the body) and hemiparesis (weakness or inability to move one side of the body) following a CVA affecting right dominant side, aphasia (loss of ability to understand or express speech, caused by brain damage) following a CVA, anxiety, and depression. The MDS indicated that Resident #1 required extensive physical assistance of one staff member for transfers. Review of Resident #1's Activities of Daily Living (ADL) Care Plan, dated as initiated on 05/06/21 and revised on 06/13/22, indicated Resident #1 required extensive assistance of two staff members for transfers. Review of Resident #1's Documentation Survey Report, dated May 2022, indicated that CNAs documented that Resident #1 required the assistance of one staff member for transfers. Review of Resident #1's Physical Therapy (PT) Evaluation and Plan of Care, dated 05/16/22, indicated that Resident #1 was evaluated because he/she had a witnessed fall in the bathroom when his/her foot got caught on an over the toilet commode leg. The Evaluation indicated that Resident #1 was last discharged from PT at a level requiring the assistance of one staff member for transfers, and that it did not appear that Resident #1 had a decline in his/her transfer status. The PT Evaluation and Plan of Care indicated that he/she continued to require contact guard to physical assistance for transfers. Review of Resident #1's Occupational Therapy (OT) Evaluation and Plan of Care, dated 05/18/22, he/she had required physical assistance of one staff member for transfers. Review of Resident #1's Documentation Survey Report, dated May 2022, indicated Certified Nurse Aides (CNAs), during the day shift and evening shifts, documented that Resident #1 was provided assistance of one staff member for toileting and transfers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225318	A. Building B. Wing	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/22/22 at 10:51 A.M., CNA #1 said she had provided care to Resident #1 several times and said he/she required the assistance of one staff member for transfers. During an interview on 06/22/22 at 11:12 A.M., CNA #2 said she had provided care in the past for Resident #1 and said he/she required the assistance of one staff member for transfers. During an interview on 06/22/22 at 11:29 A.M., CNA #3 said she had provided care several times in the past for Resident #1 and said he/she required the assistance of one staff member for transfers. During an interview on 06/27/22 at 11:03 A.M., the Occupational Therapist (OT) said Resident #1 required the use of a gait belt and the assistance of one staff member for transfers. During an interview on 05/14/22 at 1:22 P.M., the Director of Nursing (DON) said the DON said Resident #1 had right sided weakness and said he/she required staff assistance for transfers. The DON said Resident #1 required the assistance of one staff member since her initial baseline Care Plan and said although Resident #1's current ADL Care Plan indicated he/she required assistance of two staff members for transfers, said his/her ADL Care Plan was incorrect and he/she only required the assistance of one staff member for transfers.