| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>A Recertification survey was conducted at Twin Oaks Rehab and Nursing from 5/29/19 through 6/4/19 for compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities and the following deficiencies were cited: | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the | F 550 | | 7/13/19 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/23/2019

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 1<br>resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, policy review and interview, the facility staff failed to provide a dignified existence to promote, maintain or enhance the quality of life for 2 Residents (#56 and #88) out of a total sample of 20 Residents and failed to provide a dignified dining experience for the residents on one out of 3 units.<br><br>1. For Resident #56 the facility staff failed to protect the Resident's personal information and dignity with a visible sign on his/her door.<br><br>Review of the facility policy titled, "Resident Dignity", dated 11/2017 indicated the following:<br><br>*Staff shall maintain an environment in which confidential clinical information is protected<br><br>*Signs indicating the resident's clinical status or care needs shall not be openly posted in the resident's room unless specifically requested by the resident or family member.<br><br>Resident #56 was admitted to the facility in 2/2019 with diagnoses including Alzheimer's Disease and dementia. | F 550 | Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by both federal and state laws.<br><br>The sign for Resident #56 was removed during survey.<br><br>Resident #88 had facial hair removed during survey.<br><br>The first floor□s direct care staff were in-serviced to utilize glasses for drinks; ensure residents seated together will eat together; use appropriate name and/or nicknames of residents, will not refer to residents as a feed and remove warming trays under the plates.<br><br>DON has conducted an audit of current residents□ rooms on each floor, and no additional signs were found. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 2<br>The latest significant change Minimum Data Set assessment (MDS) dated 4/10/19, indicated the Resident had moderately impaired cognition, and was dependent for most aspects of his/her activities of daily living.<br><br>During the initial tour of the 3rd floor unit on 5/29/19, at 1:18 P.M., the surveyor observed a sign on the closed door to the resident's room facing the unit hallway. The sign indicated the following:<br><br>-(Resident's Name), USE FOOTPLATES AT ALL TIMES, PILLOW ON LEFT TO INCREASE POSTURE, AFTER LUNCH RETURN TO BED.<br><br>On 5/30/19, at 9:32 A.M., the surveyor again observed the sign on the closed door to the Resident's room.<br><br>During an interview on 5/31/19, at 1:50 P.M., the Director of Nursing said that she took the sign down because it gave too much resident information and should not have been visible on his/her door.<br><br>2. For Resident #88, the facility staff failed to remove facial hair as part of the daily grooming tasks.<br><br>Resident #88 was admitted to the facility in 4/2019 with diagnoses that included high blood pressure, pain and history of falls.<br><br>Review of the most recent comprehensive Minimum Date Set (MDS) dated 5/8/19, revealed that Resident #88 had a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15, which indicated that he/she was cognitively intact. | F 550 | DON and/or designee conducted an audit of current female residents on each floor. Grooming was provided to remove facial hair on residents that require assistance.<br><br>DON and/or designee audited dining rooms on each floor, to ensure the dining experience maintains residents□ dignity and rights.<br><br>The Staff Development Coordinator (SDC) and/or designee will in-service the direct care and rehab staff on Residents Rights, specifically to not post signs displaying residents□ clinical information, and offer assistance with removal of facial hair and report to charge nurse if resident refuses. Direct care staff will be educated on enhancing the meal experience, specifically utilizing the appropriate name of the resident, not referring to residents as a feed, sit when feeding the residents, utilize glasses for drinks, remove the warming trays under the plates to promote a home like environment. Residents will be awake and ready to enjoy their meal at time of serving. New meals will be obtained from the kitchen if compromised by another resident.<br><br>The DON and/or designee will perform random weekly audits on each floor to ensure no signs are posted displaying the residents□ clinical information.<br><br>The DON and/or designee will perform random weekly audits on each floor to ensure residents□ facial hair will be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 3<br>The MDS also indicated that the Resident required extensive assistance for all self-care activities.<br><br>Review of the facility policy titled, "Resident Dignity", dated 11/2017 indicated the following:<br><br>*Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.)<br><br>On all days of survey, Resident #88 was observed with long, gray/white chin hair.<br><br>During an interview on 5/31/19, at 8:30 A.M., Resident #88 said he/she would like his/her facial hair to be removed and no staff has offered assistance with this task.<br><br>During an interview on 5/31/19, at 10:10 A.M., Certified Nursing Assistant #2 said that removing facial hair is part of daily grooming for residents.<br><br>3. The facility staff failed to provide a dignified dining experience on the first floor unit.<br><br>Review of the facility policy titled "Resident Dignity", dated 11/2017, indicated the following:<br><br>*Residents shall be treated with dignity and respect at all times.<br><br>*Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not "labeling" or referring to the resident by his or her room number, diagnosis or care needs.<br><br>The following observations were made in the first floor unit dining room on 5/29/19, at 8:27 A.M., | F 550 | trimmed and/or removed as appropriate.<br><br>The DON and/or designee will audit the dining experience on each floor to ensure staff are utilizing the appropriate name of the resident, not referring to residents as a feed, sit when feeding the residents, utilize glasses for drinks, remove the warming trays under the plates, residents are awake and new meals are obtained if compromised by another resident.<br><br>The three audits will be done weekly for four weeks, followed by monthly for two months.<br><br>The results of the audits will be reviewed and discussed at the monthly QAPI committee meeting for three months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 4<br>during the breakfast meal:<br><br>*Four out of 7 residents did not have their milk poured into drinking glasses and were observed drinking milk out of milk cartons.<br><br>*A Certified Nursing Assistant (CNA) yelled from across the room to ask if one resident was a "feed".<br><br>*There were 5 residents sitting at a table. Three of the residents received their meals and began eating. The other 2 residents waited 20 minutes for their trays to arrive. One resident said to the surveyor that the other men were able to eat before him/her.<br><br>*The Activity Assistant was observed calling 2 female residents by "sweetie" and "honey".<br><br>*A nurse was observed assisting a resident with his/her meal. The nurse was standing beside him/her and did not get a seat to be at the resident's level.<br><br>The following observations were made in the first floor unit dining room on 5/29/19, at 12:40 P.M., during the lunch meal:<br><br>*Half of the residents had their lunches served with the warming trays kept underneath the lunch plate. The other half of the residents had their lunches serviced on the plate with the warming tray removed from underneath.<br><br>*A CNA asked from across the room which residents were "feeds".<br><br>*Five residents were sitting at one table. Three of | F 550 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 5<br>the residents required assistance with their meals. The 2 residents that were able to eat independently received their meals first and began to eat. The other 3 residents who required assistance waited 15 minutes for their lunch.<br><br>The following observations were made in the first floor unit dining room on 5/30/19, at 8:53 A.M., during the breakfast meal:<br><br>*One resident did not have his milk poured into a drinking glass was observed drinking his/her milk out of a milk carton.<br><br>*A Nurse pointed to two residents from across the room to tell a CNA that they were "feeds".<br><br>The following observations were made in the first floor unit dining room on 5/31/19, at 8:39 A.M., during the breakfast meal:<br><br>*The Assistant Director of Nursing referred to one resident as a "feed"<br><br>*Four residents did not have their milk poured into a drinking glass and were observed drinking milk out of milk cartons.<br><br>*A CNA yelled from across the room that a resident was "a feed".<br><br>*A CNA was observed calling two different residents "Honey" and "Sweetie".<br><br>*Two residents were sitting at the same table. One of the residents was asleep with his/her tray in front of him/her. The second resident reached across the table and took his/her breakfast tray. When the Activity Assistant came to deliver the | F 550 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 6<br>second resident his/her breakfast, she realized that the second resident had taken the other resident's breakfast. She then delivered this meal to the sleeping resident. | F 550 | | |
| F 552 SS=D | Right to be Informed/Make Treatment Decisions<br>CFR(s): 483.10(c)(1)(4)(5)<br><br>§483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:<br><br>§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.<br><br>§483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.<br><br>§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility staff failed to obtain consent for treatment for 1 Resident (#41) out of a total sample of 20 sampled residents.<br><br>Resident #41 was admitted to the facility in 9/2018 with diagnoses that included dementia without behavioral disturbance, heart failure and adult failure to thrive. | F 552 | Resident #41 will have the admission consent for treatment, Health Drive, Influenza immunization, pneumococcal vaccine and homestead dementia care program completed.<br><br>The DON and/or designee will audit current residents□ medical records to ensure admission consents are signed. | 7/13/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 552 | Continued From page 7<br>Review of the most recent quarterly Minimum Data Set (MDS) dated 3/21/19, revealed that Resident #41 had a Brief Interview for Mental Status (BIMS) score of 1 out of a possible 15, which indicated that he/she had significant cognitive impairment. Further record review indicated that Resident #41's Health Care Proxy was invoked and he/she had a legal guardian in place.<br><br>Review of Resident #41's medical record indicated that Resident #41's admission consents for treatment, Health Drive, influenza immunization, pneumococcal vaccination, and homestead/dementia care program authorization were not signed.<br><br>During an interview on 6/4/19 at 8:30 A.M., the Director of Nursing said consents are to be signed upon admission. | F 552 | SDC and/or designee will educate the licensed nurses and admissions coordinator regarding the residents right to be informed and make treatment decisions, specifically to ensure the admission consents are signed.<br><br>The Admissions Coordinator and/or designee will audit new admission charts weekly to ensure the admission consents are completed. The audit will be completed weekly for four weeks, followed by monthly for two months.<br><br>The results of the audits will be reviewed and discussed at the monthly QAPI committee meeting for three months. | |
| F 584 SS=F | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. | F 584 | | 6/6/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 584 | Continued From page 8<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility staff failed to ensure that residents had a safe, comfortable and home-like environment on 3 of 3 nursing units.<br><br>Findings include:<br><br>1. During all days of survey, the surveyor observed the following on the first floor unit:<br><br>- 4 out of 5 ceiling lights not working in the day room<br>- 4 out of 8 ceiling lights not working in the dining | F 584 | 1st floor unit:<br><br>Day room and Dining Room ceiling lights that were not working were replaced. The day room and dining room ceiling lights are now in working order.<br><br>Gouges in the hallway walls and damage in the day room walls will be repaired and painted.<br><br>Rm. 114-Broken radiator was repaired, with no sharp edges exposed. Water stain | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 584 | Continued From page 9<br>room<br>- significant damage to the hallway walls, with multiple areas of gouges to the paint and sheet rock exposing plaster.<br>- all four walls of the day room were damaged with exposed plaster.<br>- a broken radiator with a sharp edge exposed in room 114<br>- ceiling water stain in the bathroom of room 114<br>- a rusted, dirty toilet seat in the bathroom of room 114<br>- wall damage with exposed plaster behind the third bed in room 115<br>- unpainted plaster on the wall by the door of room 115<br>- damage to the wall below the sink in the bathroom of room 115<br>- two holes in the wall by the door in room 113<br>- damage to the walls above the headboard of the first and third beds in room 111<br>- significant rust to the radiator in room 111<br>- a rusted commode in the bathroom of room 111<br>- damage to the wall with exposed plaster in room 109<br>- gouges to the wall with plaster exposed behind the headboard of the second bed in room 108<br>- damage to the baseboard and wall as you enter the bathroom in room 108<br>- a yellow stain with plaster damage on the ceiling of bathroom 108<br>- the door to room 108 is worn with significant wood stain missing<br>- holes in the wall by the glove box holder in room 108<br>- significant gouges and plaster exposed behind the headboard of the bed in room 102<br>- unpainted plaster on the wall of room 102<br><br>2. During all days of survey the surveyor | F 584 | removed from Bathroom ceiling. Rusted dirty toilet seat in bathroom was replaced.<br><br>Rm-115 Exposed plaster behind bed C will be repaired and painted. Plaster on wall by the door will be painted. Damage to wall below the sink in bathroom will be repaired and painted.<br><br>Rm-113 2 holes in walls by the door will be repaired and painted.<br><br>Rm. 111 damage to walls above A&C bed will be repaired and painted. Rust from radiator will be removed. Rusty commode in bathroom was discarded.<br><br>Rm. 109 exposed plaster on walls will be repaired and painted.<br><br>Rm. 108 gouges to wall behind headboard of B bed will be repaired and painted. Wall damage near baseboard and walls as you enter room will be repaired and painted. Yellow stain on bathroom ceiling will be removed and plaster damage in the bathroom will be repaired and painted. Wood door will be repaired. Holes in the wall near glove box holder will be repaired and painted.<br><br>Rm. 102 gouges behind the headboard will be repaired and painted. Unpainted plaster on walls will be painted.<br><br>2nd Floor<br><br>Rm. 203 dresser was removed. Chair rail molding was secured. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 584 | Continued From page 10<br>observed the following on the second floor unit:<br><br>- dresser with veneer missing exposing particle board and sharp frayed edges in room 203<br>- missing chair molding exposing sheet rock in room 203<br>- stained privacy curtain in room 204<br>- rusted commode in bathroom of 204<br>- veneer on bathroom door with exposed splintered wood in room 204<br>- dim lighting in the bathroom of room 204 and resident states he/she is not able to perform morning care due to inadequate lighting<br>- out of order sign on the bathroom door across from room 205<br>- cracked and missing chair molding with jagged sharp edges and exposed sheet rock in room 207<br>- strong foul odor in the hallway outside rooms 210, 211, 212, and 213<br>- headboard missing molding exposing particle board in room 215<br>- gouges in wall behind bed exposing sheet rock in room 215<br>- soap dispenser fallen off the wall and resting on the sink counter in bathroom of 215<br><br>During an interview with the Administrator, on 6/4/19, at 11:45 A.M., she said that the strong odor outside rooms 210, 211, 212 and 213 had been a chronic issue that they were trying to resolve. She also said there are renovations scheduled, but she has not been told what they will consist of or when they will begin.<br><br>During an interview with the Maintenance Director, on 6/4/19, at 2:30 P.M., he said that there was a broken drain in the hallway bathrooms that has been out of order for about 1 year. He said he was having a hard time getting | F 584 | Rm. 204 Stained privacy curtain was replaced. Bathroom door will be repaired so there is no splintered wood. Bulbs for lighting was replaced.<br><br>Bathroom across from room 205 is no longer out of order.<br><br>Rm. 207 Chair rail molding will be repaired. Exposed sheet rock will be repaired.<br><br>Odor outside of room 210,211, 212 and 213 is resolved.<br><br>Rm 215 headboard was removed and replaced. Gouges behind bed will be repaired and painted. Soap dispenser in bathroom was secured on the wall.<br><br>3rd Floor<br><br>Couch in DR will be removed. Couches and chairs were inspected for worn material and discarded as needed.<br><br>Rm. 301 Rusty commode over toilet was removed and replaced. Gloves on top of resident belongings were removed. Dust filled ceiling vents in Shower room were cleaned. The shower rooms were checked for dirty ceiling vents and cleaned.<br><br>Rm. 305 Torn pillows were discarded. Linen audit completed and torn pillows were discarded. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 584 | Continued From page 11<br>a plumber to work in the facility. He said he does not have a schedule to follows for a preventative maintenance program. He repairs things that are reported to him by staff and explained there may be renovations planned for the facility, however he is not aware of when they will begin.<br>3. During the initial tour of the third floor on 5/29/19, the surveyor observed the following:<br><br>-A couch in the dining room with material eroded from the the cushions.<br><br>-A commode over a toilet in room 301 with rust on the front crossbar and leg.<br><br>-Discarded disposable gloves lying on top of resident belongings.<br><br>-Dust-filled ceiling vents in the shower room.<br><br>-Pillows with multiple tears in outer lining on a resident bed in room 305.<br><br>-A toilet in room 302 missing a toilet seat with a commode in the tub in the bathroom, the crossbar of the commode was rusted.<br><br>-A used spoon on top of a linen cart with white stains around it.<br><br>-A wheelchair scale with sediment and unclean platform with disposable gloves laying on top of it.<br><br>-Discolored ceiling tiles in a closet with the facility laundry chute.<br><br>-Kitchenette with a toaster with crumbs and debris coated on top and inside, a microwave discolored black on the inside, a refrigerator with | F 584 | Rm. 302 toilet seat obtained and rusted commode was removed.<br>Used spoon on top of linen cart was removed; linen cart cleaned and free of stains.<br><br>Wheelchair scale was cleaned, and gloves were removed.<br><br>Facility Laundry Chute- Ceiling tile stain will be repaired.<br><br>Kitchenette □ Toaster was cleaned. Microwave was replaced.<br><br>Microwaves on other units were inspected and had no issues.<br><br>Refrigerator will be repaired. Refrigerators on the units to be inspected weekly for cracks. Ceiling light was cleaned and is free of debris. Ceiling lights in kitchenettes on the units were cleaned.<br><br>The Maintenance Director will audit the remaining bedrooms and resident care areas on each floor. Any identified areas will be repaired and/or replaced as appropriate.<br><br>The SDC and/or designee will in-service the staff to utilize the maintenance binders to document any maintenance issues to the Maintenance Director and to ensure dirty gloves are discarded appropriately.<br><br>The Maintenance Director and/or designee will perform weekly rounds of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 584 | Continued From page 12<br>cracks in the frame and staining, and a ceiling light with bugs/debris visible through the translucent covering. | F 584 | the units to identify any areas requiring repair and/or replacement. The audits will be completed weekly for four weeks, followed by monthly for two months.<br><br>The audits will be reviewed and discussed at the monthly QAPI Committee meeting for three months. | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility staff failed to prevent verbal abuse that was sexual in nature for 1 resident (#11) out of a total of 20 sampled residents.<br><br>Findings include:<br><br>Review of the facility policy titled "Abuse Prohibition", dated 11/28/17, indicated the following: | F 600 | Resident #11□ allegation of verbal abuse that was sexual in nature from Resident #58 was investigated and reported to the Department of Public Health.<br><br>Resident #58 behavior care plan will be reviewed by the Interdisciplinary Team to develop interventions to manage his sexually inappropriate behaviors and update as appropriate. | 7/13/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 600 | Continued From page 13<br><br>The Center will implement an abuse prohibition program through the following:<br><br>-Identification of possible incidents or allegations which need investigation<br>-Investigation of incidents and allegations<br>-Protection of patients during investigations<br>-Verbal abuse is any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within their hearing distance, regardless of their age, ability to comprehend , or disability.<br><br>-Sexual abuse is a non-consensual sexual contact of any type with a resident. It includes but is not limited to sexual harassment, sexual coercion, or sexual assault.<br><br>Actions to prevent abuse, neglect, exploitation, or mistreatment will include:<br><br>-Identifying, correcting, and intervening in situation in which abuse, neglect, and/or misappropriation of patient property is more likely to occur.<br>-If the suspected abuse is patient-to-patient, the patient who has in any way threatened or attacked another will be removed from the setting or situation.<br><br>Resident #11 was admitted to the facility in 7/2018 with diagnoses including dementia, anxiety disorder, and depression.<br><br>The latest quarterly minimum data set (MDS) dated 2/13/19, the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental | F 600 | Resident #58 was seen by psych on 6/8/19 with recommendations for change in medications to address the target behaviors.<br><br>SDC and/or designee will educate staff regarding abuse prevention, specifically implementing interventions to prevent verbal abuse of a sexual nature.<br><br>During clinical report, the DON and/or designee incident reports will identify residents with verbally abusive behaviors of a sexual nature to ensure appropriate interventions are implemented to prevent verbal abuse. The audit will be completed weekly for four weeks, followed by monthly for two months.<br><br>The results of the audits will be reviewed and discussed at the monthly QAPI committee meeting for three months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 600 | Continued From page 14<br>Status (BIMS) indicating severe cognitive impairment. The Resident required assistance or supervision with most aspects of his/her activities of daily living.<br><br>Review of Resident #11's nursing progress notes dated 5/8/19 indicated the following two notes:<br><br>A. Resident's Health Care Proxy, (HCP), told this writer that another Resident (#58) on the unit has asked for sexual favors when in day room. Resident states it's been happening for quite a while. This writer spoke to Resident #11 and asked him/her to stay away from Resident #58 and walk away when he/she says bad words and let the nurse know.<br><br>B. Resident #11 was told to stay away from Resident #58 sit with same sex resident in dining room, report to nurse on duty if he/she feels harassed by someone.<br><br>The surveyor interviewed Resident #11 on 6/3/19 at 11:32 A.M. Resident #11 said, Resident #58 said something to me a few days ago and it bothered me. I told the staff and they told me to just stay away from him/her.<br><br>Review of the facility's incident reports dated 5/8/19 for Resident #58 indicated a resident reported to supervisor that Resident #58 asked him/her on many occasions for a "blow job." He/She reported that this occurred in the dining room.<br><br>The incident report failed to indicate that staff working during the time of the allegation, the residents involved in the allegation, other residents who may have witnessed the incident, | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 600 | Continued From page 15<br>or if Resident #11's healthcare proxy were interviewed regarding the incident per policy.<br><br>There was no evidence to indicate that the facility followed its Abuse Policy to implement interventions, other than telling Resident #11 to stay away from Resident #58, to protect Resident #11 from and prevent ongoing verbal abuse. | F 600 | | |
| F 607 SS=D | Develop/Implement Abuse/Neglect Policies<br>CFR(s): 483.12(b)(1)-(3)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and policy review, the facility staff failed to implement their policy to investigate an allegation of abuse for 1 Resident (#88) out of a total sample of 20 Residents.<br><br>Findings include:<br><br>Review of the facility policy titled "Abuse Prohibition", dated 11/28/17, indicated the following:<br><br>*Anyone who witnesses an incident of | F 607 | Resident #88□s report of allegation of physical abuse was investigated and reported to the Department of Public Health.<br><br>Nurse #2 was disciplined and re-educated on the Abuse Policy with a focus on what to do if a resident makes an allegation against a staff member.<br><br>The SDC and/or designee will educate the staff on the Abuse policy, specifically to ensure the following are completed | 7/13/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 607 | Continued From page 16<br>suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately.<br><br>*The notified supervisor will report the suspected abuse immediately to the Center Executive Director or designee and other officials in accordance with the state law<br><br>*The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation.<br><br>On 5/31/19, at 8:00 A.M., Resident #88 told the surveyor that during his/her morning bathing and dressing, the Certified Nursing Assistant was rough with him/her and he/she wanted to tell someone about it. The Surveyor called Nurse #2 over and the Resident explained the situation. The nurse shrugged her shoulders while looking at the surveyor, turned to the Resident and said "Okay", and then went back to passing out her morning medications. During this time, Certified Nursing Assistant (CNA) #8 was in another resident's room providing morning care with the door closed.<br><br>On 5/31/19, at 8:12 A.M., Nurse #2 approached the surveyor and said that residents have their preferences of who works with them and this may be why Resident #88 complained about the CNA. When asked if this should be investigated to determine if it was because of preference or potential abuse, Nurse #2 said "yes".<br><br>The surveyors interviewed Nurse #2 on 5/31/19, at 8:16 A.M., Nurse #2 said the policy of the | F 607 | immediately: separate the resident from the accused, send the accused home, and to report the incident to the Administrator and/or DON.<br><br>The DON and/or designee will randomly ask staff how they would respond in different circumstances to ensure the resident is separated immediately from the accused, the accused is removed from the center and reported to the Administrator and/or DON.<br><br>The audits will be completed weekly for four weeks, followed by monthly for two months.<br><br>The results of the audits will be reviewed and discussed at the monthly QAPI committee meeting for three months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |



| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 607 | Continued From page 17<br>facility is that if an allegation of abuse is made the first step is to make sure the resident is safe and then remove the accused staff member from the floor/building. When asked if she had followed this policy, she said "no". When asked where the CNA was at this point in time, Nurse #2 said that she was currently providing care behind closed doors. She said she would remove her from the room immediately and have her wait at the nursing station until the supervisor came to the floor.<br><br>At approximately 8:30 A.M., the surveyor went to the nursing station and did not see CNA #8 waiting there. The surveyor then asked Nurse #2 where CNA #8 was. Nurse #2 said that she was still providing care. The surveyor walked to the room with Nurse #2 and she removed the CNA from the room and the Administrator sent her home pending investigation. | F 607 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other | F 609 | | 7/13/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 609 | Continued From page 18<br>officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility staff failed to report allegations of abuse to the state agency in a timely manner for 1 Resident (#11) out of a possible sample of 20 Residents.<br><br>Findings include:<br><br>Review of the facility policy titled "Abuse Prohibition" indicated the following:<br><br>-The Center will implement an abuse prohibition program through the following:<br>-Identification of possible incidents or allegations which need investigation<br>-Investigation of incidents and allegations<br>-Protection of patients during investigations<br>-Reporting of incidents, investigations, and Center response to the results of their investigations.<br><br>-Sexual abuse is a non-consensual sexual contact of any type with a resident. It includes but is not limited to sexual harassment, sexual coercion, or sexual assault. | F 609 | Resident #11□s allegation of verbal abuse that was sexual in nature from Resident #58 was investigated and reported to the Department of Public Health.<br><br>DON and/or designee will review the current incident reports for the last 30 days to ensure any allegations of abuse were investigated and reported.<br><br>The SDC and/or designee will educate the Administrator and DON regarding abuse reporting, specifically to report allegations of abuse within two hours.<br><br>The SDC and/or designee will educate the staff on the Abuse policy, specifically to ensure allegations of abuse are reported immediately to the Administrator and/or DON.<br><br>The DON and/or designee will randomly ask staff how they would respond in | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 609 | Continued From page 19<br><br>Upon receiving a report of suspected of alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following:<br>-Enter allegation into the incident reporting system.<br>-Report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made.<br><br>Initiate an investigation within 24 hours of an allegation of abuse that focuses on:<br>-whether abuse or neglect occurred and to what extent<br>-clinical examination for signs of injuries, if indicated<br>-causative factors<br>-interventions to prevent further injury.<br><br>-The investigation will be thoroughly documented. Ensure that documentation of witnessed interviewed is included.<br><br>The Administrator or designee will:<br>-Take all necessary corrective action depending on the results of the investigation.<br>-Report findings of all completed investigations within five working days to the Department of Health using the state on-line reporting system or state-approved forms.<br><br>For Resident #11, the facility staff failed to report an allegation of verbal abuse that was sexual in nature.<br><br>Resident #11 was admitted to the facility in 7/2018 with diagnoses including dementia, anxiety disorder, and depression. | F 609 | different circumstances to ensure the incident is immediately reported to the Administrator and/or DON.<br><br>The audits will be completed weekly for four weeks, followed by monthly for two months.<br><br>The results of the audits will be reviewed and discussed at the monthly QAPI committee meeting for three months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 609 | Continued From page 20<br><br>The latest quarterly minimum data set (MDS) dated 2/13/19 indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The Resident required assistance or supervision with most aspects of his/her activities of daily living.<br><br>Review of Resident #11's nursing progress notes dated 5/8/19 indicated the following two notes:<br><br>A. Resident's Health Care Proxy, (HCP), told this writer that another Resident (#58) on the unit has asked for sexual favors when in day room. Resident states it's been happening for quite a while. This writer spoke to Resident #11 and asked him/her to stay away from Resident #58 and walk away when he/she says bad words and let the nurse know.<br><br>B. Resident #11 was told to stay away from Resident #58 and sit with residents of the same sex in the dining room, report to nurse on duty if he/she feels harassed by someone.<br><br>The surveyor interviewed Resident #11 on 6/3/19 at 11:32 A.M. Resident #11 said "Resident #58 said something to me a few days ago and it bothered me. I told the staff and they told me to just stay away from him/her."<br><br>During an interview on 6/4/19 at 9:00 A.M., the Administrator said she had not reported the incident, that it had not been reported to her as was described in the incident report/nursing progress notes.<br><br>During an interview on 6/4/19 at 12:30 P.M., the | F 609 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 609 | Continued From page 21<br>Administrator said that she had reported the incident to the Department of Public Health, 27 days after the initial allegation was made. | F 609 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility staff failed to thoroughly investigate allegations of abuse for 1 Resident (#11) out of a possible sample of 20 Residents.<br><br>Findings include:<br><br>Review of the facility policy titled "Abuse Prohibition" indicated the following:<br><br>-The Center will implement an abuse prohibition program through the following: | F 610 | Resident #11□s allegation of verbal abuse that was sexual in nature from Resident #58 was investigated and reported to the Department of Public Health.<br><br>DON and/or designee has checked the current incident reports to ensure any allegations of abuse have been reported residents have timely investigations with appropriate interventions in place. | 7/13/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 610 | Continued From page 22<br>-Identification of possible incidents or allegations which need investigation<br>-Investigation of incidents and allegations<br>-Protection of patients during investigations<br>-Reporting of incidents, investigations, and Center response to the results of their investigations.<br><br>-Sexual abuse is a non-consensual sexual contact of any type with a resident. It includes but is not limited to sexual harassment, sexual coercion, or sexual assault.<br><br>-Physical abuse includes hitting, slapping, punching, kicking, etc., as well as controlling behavior through corporal punishment.<br><br>Upon receiving a report of suspected of alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following:<br><br>-Enter allegation into the incident reporting system.<br>-Report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made.<br><br>Initiate an investigation within 24 hours of an allegation of abuse that focuses on:<br><br>-whether abuse or neglect occurred and to what extent<br>-clinical examination for signs of injuries, if indicated<br>-causative factors<br>-Interventions to prevent further injury.<br>-The investigation will be thoroughly documented. Ensure that documentation of witnessed | F 610 | The SDC and/or designee will educate the Administrator and DON regarding completing allegations of abuse investigations.<br><br>SDC and/or designee will educate the licensed staff on the abuse policy, specifically to thoroughly investigate allegations of abuse.<br><br>The DON and/or designee will audit incident reports daily to ensure a thorough and timely investigation with report to Administrator and/or DON.<br><br>The audit will be completed weekly for four weeks, followed by monthly for two months.<br><br>The results of the audits will be reviewed and discussed at the monthly QAPI committee meeting for three months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 610 | Continued From page 23<br>interviewed is included.<br><br>The Administrator or designee will:<br><br>-Take all necessary corrective action depending on the results of the investigation.<br>-Report findings of all completed investigations within five working days to the Department of Health using the state on-line reporting system or state-approved forms.<br><br>Resident #11 was admitted to the facility in 7/2018 with diagnoses including dementia, anxiety disorder, and depression.<br><br>The most recent quarterly minimum data set (MDS) dated 2/13/19, indicated that Resident #11 scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The latest quarterly MDS dated 2/13/19 indicated the Resident required assistance or supervision with most aspects of his/her activities of daily living.<br><br>Review of Resident #11's nursing progress notes dated 5/8/19 indicated the following two notes:<br><br>A. Resident's Health Care Proxy, (HCP), told this writer that another Resident (#58) on the unit has asked for sexual favors when in day room. Resident states it's been happening for quite a while. This writer spoke to Resident #11 and asked him/her to stay away from Resident #58 and walk away when he/she says bad words and let the nurse know.<br><br>B. Resident #11 was told to stay away from Resident #58 and to sit with other residents of the same sex in the dining room. Resident #11 was to | F 610 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 610 | Continued From page 24<br>report to the nurse on duty if he/she feels harassed by someone.<br><br>Further review of Resident #11's progress notes from 5/2019 failed to indicate any further follow-up to the allegation of 5/8/19.<br><br>Review of Resident #11's physician assistant's progress note dated 5/10/19 for annual history and physical failed to indicate any follow up with the resident regarding the allegation made on 5/8/19.<br><br>During an interview on 6/3/19 at 11:32 A.M., Resident #11 said (Resident #58) said something to me a few days ago and it bothered me. I told the staff and they told me to just stay away from him/her.<br><br>Review of the facility's incident reports indicated an incident report dated 5/8/19 for Resident #58. The incident report indicated a resident reported to supervisor that Resident #58 asked him/her on many occasions for a "blow job." He/She reported that this occurred in the dining room.<br><br>The incident report failed to indicate that staff working during the time of the allegation, the residents involved in the allegation, other residents who may have witnessed the incident, or Resident #11's healthcare proxy were interviewed regarding the incident per policy.<br><br>During an interview on 6/4/19 at 9:00 A.M., the Administrator said that the incident had been discussed at morning meeting the next day (5/9/19), and the interdisciplinary team did not believe the incident was an allegation of abuse. Therefore, an investigation was not conducted | F 610 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 610 | Continued From page 25<br>per policy. | F 610 | | |
| F 623 SS=B | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; | F 623 | | 7/13/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 623 | Continued From page 26<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy | F 623 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 623 | Continued From page 27<br>for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility staff failed to provide written notification of transfer or discharge for 4 of 20 Residents (#26, #50, #62, and #85) that were transferred to the hospital.<br><br>Findings include:<br><br>1. Resident #26 was admitted to the facility in 9/2017 with diagnoses which included chronic kidney disease, high blood pressure and heart failure.<br><br>Review of the clinical record indicated that Resident #26 was transferred to an acute care hospital on 4/3/19. The clinical record failed to include a notice of intent to transfer resident with less that 30 day notice. | F 623 | Residents #26, #50, #62 and #85 Notices of transfer were given, and faxed to the Ombudsman□s office.<br><br>Copies of notices of intent to transfer or discharge residents will be faxed to the Ombudsman□s office.<br><br>The SDC will in-service the Social Worker and licensed direct care staff to provide a notice of transfer/discharge to the resident and fax a copy to the Ombudsman□s office.<br><br>The Social Worker will perform audits during clinical report to ensure the notices of intent to transfer/discharge were faxed to the Ombudsman□s office. The Social | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 623 | Continued From page 28<br><br>2. Resident #50 was admitted to the facility in 11/2018 with diagnoses which included Diabetes Mellitus, stroke and anxiety.<br><br>Review of the clinical record indicated that Resident #50 was transferred to an acute care hospital on 4/6/19, 4/13/19, 4/28/19, 5/18/19 and 5/29/19. The clinical record failed to include a notice of intent to transfer resident with less than 30 days notice.<br><br>3. Resident #85 was admitted to the facility in 3/2018 with diagnoses which included Diabetes Mellitus, congestive heart failure and clostridium difficile.<br><br>Review of the clinical record indicated that Resident #85 was transferred to an acute care hospital on 3/3/19 and 4/13/19. The clinical record failed to include a notice of intent to transfer resident with less than 30 days notice.<br>4. Resident #62 was admitted to the facility on 2/4/19 with diagnoses including dementia, atrial fibrillation, and osteoarthritis.<br><br>Review of Resident #62's medical record indicated he/she sustained an unwitnessed fall on 2/1/19, struck his/her head, and was transfered to an acute care hospital for evaluation.<br><br>Further review of Resident #62's medical record failed to indicate a written notice of transfer/discharge was provided on 2/1/19.<br><br>During an interview on 5/31/19 at 12:33 P.M., the administrator said there has not been a consistent social worker since December 2018. She said they have had inconsistent social | F 623 | Worker will keep a copy of the notice as well.<br><br>The audits will be completed weekly for four weeks, followed by monthly for two months.<br><br>The results of the audits will be reviewed and discussed at the monthly QAPI committee meeting for three months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 623 | Continued From page 29<br>services coverage from multiple social workers. The administrator said a new social worker had been hired and would be starting in 6/2019 and a system will be put in place to make sure the transfer/discharge documents are completed. | F 623 | | |
| F 625 SS=B | Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2)<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br>This REQUIREMENT is not met as evidenced by: | F 625 | | 7/13/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 30<br>Based on record review and staff interviews, the Facility staff failed to provide written notification of the facility bed hold policy for 4 of 20 Residents (#26, #50, #62, and #85) that were transferred to the hospital.<br><br>Findings include:<br><br>Review of the facility policy titled Bed Hold, effective 11/2017, indicated that prior to transfers and therapeutic leave, residents or resident representative will be informed in writing of the bed-hold and return policy.<br><br>1. Resident #26 was admitted to the facility in 9/2017 with diagnoses which included chronic kidney disease, high blood pressure and heart failure.<br><br>Review of the clinical record indicated that Resident #26 was transferred to an acute care hospital on 4/3/19. The clinical record failed to include a written notification of a bed hold and return policy.<br><br>2. Resident #50 was admitted to the facility in 11/2018 with diagnoses which included Diabetes Mellitus, stroke and anxiety.<br><br>Review of the clinical record indicated that Resident #50 was transferred to an acute care hospital on 4/6/19, 4/13/19, 4/28/19, 5/18/19 and 5/29/19. The clinical record failed to include a written notification of the bed hold and return policy.<br><br>3. Resident #85 was admitted to the facility in 3/2018 with diagnoses which included Diabetes Mellitus, congestive heart failure and clostridium | F 625 | Residents # 26, #50, #62 and #85 Notice of Bed Hold will be sent to the resident.<br><br>An audit will be done of the current residents. Any residents who are out on an MLOA will be issued a notice of bed hold as appropriate.<br><br>The SDC and/or designee will in-service the licensed direct care staff and social worker to provide a notice of bed hold to the resident or responsible party, ie HCP, guardian, etc. upon discharge to the hospital.<br><br>The Social Worker and/or designee will perform audits during clinical report to ensure the notice of bed hold was provided to the resident or the appropriate party.<br><br>The audits will be completed weekly for four weeks, followed by monthly for two months.<br><br>The results of the audits will be reviewed and discussed at the monthly QAPI committee meeting for three months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 31<br>difficile.<br><br>Review of the clinical record indicated that Resident #85 was transferred to an acute care hospital on 3/3/19 and 4/13/19. The clinical record failed to include a notice of a written notification of the bed hold and return policy.<br><br>4. Resident #62 was admitted to the facility on 2/4/19 with diagnoses including dementia, atrial fibrillation, and osteoarthritis.<br><br>Review of Resident #62's medical record indicated he/she sustained an unwitnessed fall on 2/1/19, struck his/her head, and was transferred to an acute care hospital for evaluation.<br><br>Further review of Resident #62's medical record failed to indicate a written copy of the bed hold policy was provided on 2/1/19.<br><br>During an interview on 5/31/19 at 12:33 P.M., the Administrator said there has not been a consistent social worker since December 2018. She said they have had inconsistent social services coverage from multiple social workers. The Administrator said a new social worker had been hired and would be starting in 6/2019 and a system will be put in place to make sure the correct process is completed. | F 625 | | |
| F 636 SS=D | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. | F 636 | | 7/13/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 636 | Continued From page 32<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this | F 636 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 636 | Continued From page 33<br>chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to conduct a timely comprehensive Minimum Data Set (MDS) for 1 Resident (R3) in a total sample of 6 residents reviewed.<br><br>Findings include:<br><br>For Resident R3, an annual Minimum Data Set (MDS) dated 3/12/18 was completed. Quarterly MDS assessments were completed on 6/12/18, 9/6/18, 12/7/18 and 3/7/19. The clinical record failed to indicate that an annual MDS had been completed for 3/2019.<br><br>During an interview with the MDS nurse on 5/30/19 at 4:00 P.M., she the 3/7/19 quarterly MDS should have been a comprehensive annual assessment. | F 636 | Resident R3 had an Annual MDS completed.<br><br>An audit was completed by the MDS coordinator and/or designee for current residents to ensure each resident has had a comprehensive MDS is completed annually.<br><br>The SDC and/or designee will in-service the MDS coordinator to ensure each resident has had a comprehensive MDS completed annually.<br><br>The MDS coordinator and/or designee will perform random audits to ensure each resident has a Comprehensive MDS completed annually.<br><br>The audits will be completed weekly for four weeks, followed by monthly for two months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 636 | Continued From page 34 | F 636 | The results of the audits will be reviewed and discussed at the monthly QAPI committee meeting for three months. | |
| F 638 SS=D | Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)<br><br>§483.20(c) Quarterly Review Assessment<br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to conduct a quarterly Minimum Data Set (MDS) in a timely manner for 2 Residents (R2 and R7) in a total sample of 6 residents reviewed.<br><br>Findings include:<br><br>1. For Resident R2, an admission Minimum Data Set (MDS) dated 12/10/18 was completed. There was a quarterly MDS assessment scheduled for 5/23/19. The clinical record failed to indicate that a quarterly MDS had been completed for 3/2019.<br><br>During an interview with the MDS nurse on 5/30/19 at 4:00 P.M., she said that there should have been a quarterly MDS completed in 3/2019.<br><br>2. For Resident R7, an admission MDS was completed for 1/25/18. There was a quarterly MDS completed for 5/28/19. The clinical record failed to indicate that a quarterly MDS had been completed in 4/2019.<br><br>During an interview with the MDS nurse on 5/30/19 at 4:00 P.M., she said that the quarterly | F 638 | Residents R2 and R7 had quarterly MDS assessments completed.<br><br>An audit was completed by the MDS coordinator and/or designee for current residents to ensure each resident has had a quarterly MDS assessment completed every 3 months.<br><br>The SDC and/or designee will in-service the MDS coordinator to ensure each resident has had a quarterly MDS assessment completed every 3 months.<br><br>The MDS coordinator and/or designee will perform random audits to ensure each resident has a Quarterly MDS assessment completed every 3 months.<br><br>The audits will be completed weekly for four weeks, followed by monthly for two months.<br><br>The results of the audits will be reviewed and discussed at the monthly QAPI | 7/13/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 638 | Continued From page 35<br>MDS should have been completed 4/27/19. | F 638 | committee meeting for three months. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to | F 656 | | 7/13/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 36<br>local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and interview, the facility staff failed to implement interventions for behavioral management for 2 Residents, (#58 and #62) out of a total sample of 20 residents; failed to iplement an ordered fluid restriction for 1 Resident (#17) out of a total sample of 20 residents, and failed to follow physician orders for 2 Residents (#29 and #41) out of a total sample of 20 Residents.<br><br>1. Resident #58 was admitted to the facility in 1/2019 with diagnoses including dementia, psychotic disorder, and anxiety disorder. The latest quarterly minimum data set (MDS) dated 4/12/19, the Resident scored a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The Resident required assistance or supervision with most aspects of his/her activities of daily living.<br><br>Review of Resident #58's transfer paperwork from another facility indicated he/she was transferred to the facility in 1/2019.<br><br>Review of Resident #58's progress note from the transferring facility, dated 12/15/18, indicated the following: Resident was accused of entering another resident's room and kissing her on the cheek. | F 656 | Resident #58 behavior care plan will be reviewed the Interdisciplinary Team to develop interventions to manage his sexually inappropriate behaviors and update as appropriate.<br><br>Resident #62 behavioral care plan interventions will be reviewed by the Interdisciplinary Team and updated as appropriate.<br><br>Resident #17 fluid restriction distribution will be re-evaluated by the resident & Interdisciplinary Team, and redistributed accordingly. The care plan will be updated as appropriate.<br><br>Resident #29 will have weekly skin checks. The nurse will document refusals.<br><br>Resident #41 nutrition care plan and status will be reviewed by the Interdisciplinary team, and updated as appropriate.<br><br>The SDC and/or designee will in-service the direct care staff, social worker and MDS coordinator regarding development and implementation of the care plan, specifically implementing interventions for | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 37<br>Review of Resident #58's nurse practitioner note dated 11/27/18 indicated the following: Patient recently seen by psych for sporadic medication noncompliance, care non-compliance and sexually inappropriate behavior.<br><br>Review of Resident #58's behavioral care plan indicated the following: Resident had a history of aggression and sexually inappropriate behavior at a previous nursing center. Resident's triggers for physical aggression are someone in his/her personal space.<br><br>Resident #58's behavioral care plan failed to indicate any interventions to manage his/her sexually inappropriate behaviors.<br><br>Review of another resident's clinical record indicated the following note dated 5/8/19: Resident's Health Care Proxy, (HCP), told this writer that another Resident (#58) on the unit has asked for sexual favors when in day room. Resident states it's been happening for quite a while.<br><br>Review of the facility's incident reports dated 5/8/19 for Resident #58 indicated a resident reported to supervisor that Resident #58 asked him/her on many occasions for a "blow job." He/She reported that this occurred in the dining room.<br><br>During an interview on 5/31/19 at 2:22 P.M., Certified Nursing Assistant (CNA) #7 said Resident #58 has behaviors of refusing care at times and she informs the nurse if he/she has behaviors. She was unaware of the incident on 5/8/19 and unaware of the intervention to separate Resident #58 from residents of the | F 656 | sexually inappropriate behaviors, fluid restriction redistribution, weekly skin checks with documentation of refusals and weight monitoring.<br><br>The DON and/or designee will audit the care plans for residents with sexually inappropriate behaviors, fluid restriction for distribution, completion of weekly skin checks with documentation of refusals, weight monitoring.<br><br>The audits will be completed weekly for four weeks, followed by monthly for two months.<br><br>The results of the audits will be reviewed and discussed at the monthly QAPI committee meeting for three months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 38<br>opposite sex.<br><br>During an interview on 5/31/19 at 2:24 P.M., Nurse #5 said Resident #58 can yell out at times but staff redirect him. She was unaware of the incident on 5/8/19 and unaware of the intervention to separate Resident #58 from residents of the opposite sex.<br><br>Despite having knowledge of Resident #58's sexually inappropriate behaviors, the facility staff failed to develop and implement a behavioral careplan to address the sexual behaviors.<br><br>2. Resident #62 was admitted to the facility in 9/2018 with diagnoses including dementia, depression, and neurocognitive disorder.<br><br>The latest quarterly minimum data set (MDS) dated 4/14/19 indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The Resident required assistance or supervision with most aspects of his/her activities of daily living.<br><br>During the initial tour on 5/29/19 at 8:54 A.M., the surveyor observed an alarmed floor mat at the entrance to Resident #62's room.<br><br>Review of Resident #62's behavioral care plan indicated the following:<br><br>- Behaviors sexually inappropriate, verbally abusive, and physically aggressive.<br>- Intervention dated 10/10/18 to utilize alarm to signal staff when out of room for close supervision. | F 656 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 39<br>On 5/31/19 at 7:47 A.M., the surveyor observed Resident #62 exit his/her room, the floor alarm sounded briefly and staff on the unit did not respond to the alarm. The Resident walked back into his/her room and staff did not react or observe where the Resident had moved to.<br><br>On 5/31/19 at 7:45 A.M., the surveyor observed Resident #62 exit his/her room. The alarm sounded intermittently and he/she ambulated to the dining room without staff responding to the alarm or supervising the Resident. Three residents of the opposite sex were present in the dining room. No staff were present in the dining room. Resident #62 ambulated to a table and sat in the dining room without staff supervision with the three other residents until 8:10 A.M. when staff entered the dining room.<br><br>During an interview on 5/31/19 2:45 P.M., Nurse #5 said the alarm at Resident #62's door is in place so staff will know if the resident leaves the room so he/she can be supervised while on the unit secondary to his/her sexual and aggressive behaviors and safety.<br><br>On 6/3/19 at at 1:15 P.M., the surveyor observed Resident #62 exit his/her room, the alarm sounded as he/she exited. Resident #62 ambulated to the nurses station with no staff in the area. The Resident stood at the nurses station until 1:21 P.M., and then ambulated back to his/her room. As he/she entered the doorway, the alarm sounded. No staff responded to either of the alarms.<br><br>During an interview on 6/3/19 at 6:55 P.M., Certified Nursing Assistant (CNA) #6 said Resident #62 has an alarmed floor pad so staff | F 656 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 40<br>will know if another resident enters his/her room because he/she can be physically aggressive/inappropriate with them. She was unaware the Resident required supervision when out of his room on the unit.<br><br>During an interview on 6/3/19 at 7:16 P.M., CNA #5 said the floor alarm is in place outside Resident #62 so the staff know when the resident leaves his/her room because he/she wanders on the unit. She said she was unaware of the Resident's sexual behaviors.<br><br>During an interview on 6/3/19 at 7:28 P.M., Nurse #3 said Resident #62 has made inappropriate sexual comments to her. She was unaware of why the floor pad alarm was at the Resident's doorway or that the Resident required supervision when on the unit.<br><br>During an interview on 6/3/19 at 8:01 P.M., CNA #2 said Resident #62 wanders, but was unaware of why the floor pad alarm was at the Resident's doorway, that the Resident required supervision when on the unit, and of his/her sexual behaviors.<br><br>During an interview on 6/3/19 at 6:57 P.M., CNA #10 said she was unaware of the Resident having behaviors other than getting upset when people try to change the television. She was unaware of the incident on 5/8/19 and unaware of the intervention to separate the Resident from residents of the opposite sex.<br><br>During an interview on 6/3/19 at 7:08 P.M., Nurse #10 said she believes Resident #58 has had altercations in the past but was unsure of what happened; she was unaware of the intervention to separate the Resident from residents of the | F 656 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 41<br>opposite sex.<br><br>During an interview 6/3/19 at 7:15 P.M., CNA #5 said Resident #58 can be verbally sexual and inappropriate. She was unaware of the incident on 5/8/19 and unaware of the intervention to separate the Resident from residents of the opposite sex.<br><br>During an interview 6/3/19 at 7:28 P.M., Nurse #3 said Resident #58 has been sexually inappropriate with her verbally, but she was unaware of the incident on 5/8/19 and unaware of the intervention to separate the Resident from residents of the opposite sex.<br><br>During an interview on 6/3/19 at 7:57 P.M., CNA #2 said Resident #58 often has vulgar verbal behaviors towards staff and residents. She was unaware of the incident on 5/8/19 and unaware of the intervention to separate the Resident from residents of the opposite sex. She said she would ask the Nurses on the unit or use the kardex for updates on a resident's plan of care.<br><br>The facility failed to implement interventions for managing Resident #62's behaviors.<br><br>3. Resident #17 was admitted to the facility in 8/2018 with diagnoses including dementia, schizophrenia, and end stage renal disease.<br><br>The latest quarterly minimum data set (MDS) dated 2/14/19 indicated the Resident scored a 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The Resident required assistance with most aspects of his/her activities of daily living. | F 656 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 42<br><br>Review of Resident #17's medical record indicated a physician's order dated 11/29/18 for 1200 milliliter (ml) Fluid Restriction, Nursing=600ml, Dietary=600ml. The 600ml allotted to dietary were divided over three meals as follows:<br><br>-Breakfast=240ml, Lunch=120ml, Dinner=240ml.<br><br>Review of Resident #17's care plan indicated the following:<br><br>-Intervention dated 11/29/19 1200ml fluid restriction.<br>-Intervention dated 11/5/18 to provide and serve diet as ordered.<br><br>On 5/31/19 at 8:28 A.M., the surveyor observed Resident #17 eating breakfast in the unit dining room. His/her diet slip on the table indicated 240ml with breakfast secondary to fluid restriction, 4 ounces (oz) milk, 4oz coffee. The Resident had an 8oz milk carton, 7oz cup of water, and an 8oz cup of coffee with him/her at breakfast totalling 690 ml, which exceded the restricted amount by 450ml.<br><br>On 5/31/19 at 12:30 P.M., the surveyor observed Resident #17 eating lunch in the unit dining room. He/She had an 8oz milk on the table with his/her lunch.<br><br>During an interview on 6/3/19 at 11:33 A.M., the Dietician said the facility kitchen had been ordering 8oz cartons of milk, but the staff should be pouring the milk into a 4oz cup and disposing of the carton when the Resident's meal is served in order to maintain his/her fluid restriction. | F 656 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 43 | F 656 | | |

4. For Resident #29, the facility staff failed to follow physician orders to obtain weekly skin checks.

Resident #29 was admitted to the facility in 1/2018 with diagnoses that included dementia without behavioral disturbances, major depression, high blood pressure, and osteoporosis.

Review of the annual Minimum Data Set (MDS) dated 1/18/19, revealed that Resident #29 had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15, which indicated that he/she had significant cognitive impairment. The MDS also indicated that Resident #29 required extensive assistance for all self-care activities.

Review of Resident #29's medical record on 6/3/19 at 7:11 P.M., indicated a physician's order initiated on 2/28/19, to obtain weekly skin checks.

Review of the weekly skin assessment documentation for the 13 weeks since the physician order was written, the facility staff had only completed 6 weekly skin assessments. There was no evidence to indicate that the skin assessments for the other 7 weeks were completed or that Resident #29 refused to have the skin assessment completed.

During an interview on 5/31/19 at 10:38 A.M., Nurse #2 said that weekly orders show up on the medication administration record and/or the treatment administration record and the nurses are responsible for checking daily and completing all orders.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 44<br><br>5. For Resident #41, the facility staff failed to follow physician orders to obtain weekly weights.<br><br>Resident #41 was admitted to the facility in 9/2018 with diagnoses that included dementia without behavioral disturbance, heart failure and adult failure to thrive.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 3/21/19, revealed that Resident #41 had a Brief Interview for Mental Status (BIMS) score of 1 out of a possible 15, which indicated that he/she had significant cognitive impairment. The MDS also indicated that Resident #41 required extensive assistance for all self-care activities.<br><br>Review of Resident #41's medical record on 5/30/19 at 1:40 P.M., indicated a physician's order initiated on 3/4/19, to obtain weekly weights.<br><br>Review of the weekly weight documentation for the 13 weeks since the physician order was written on 3/4/19, the facility staff had only obtained a weekly weight 6 times. There was no evidence to indicate that weights were obtained for the other 7 weeks or that Resident #41 refused to have the weekly weights completed.<br><br>During an interview on 5/31/19 at 10:38 A.M., Nurse #2 said that weekly orders show up on the medication administration record and/or the treatment administration record and the nurses are responsible for checking daily and completing all orders. | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii) | F 657 | | 7/13/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 45<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, the facility staff failed to hold an interdisciplinary care plan meeting following the completion of the Minimum Data Set (MDS) comprehensive assessments to review or revise care plans for 3 Residents (#23, #29, and #41) and failed to revise a plan of care with effective interventions to address sexually inappropriate behaviors for 1 Resident (#58), out of a sample of | F 657 | Residents #23, #29 and #41 will have a care plan meeting.<br><br>Resident #58 behavior care plan will be reviewed the Interdisciplinary Team to develop interventions to manage his sexually inappropriate behaviors and update as appropriate. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 46<br>20 residents.<br><br>Findings include:<br><br>Review of the facility policy titled, "Care Planning - Interdisciplinary team", dated 3/17 indicated the following:<br><br>*The care planning/interdisciplinary team is responsible for the review and updating of care plans at least quarterly.<br><br>1. For Resident #23 the facility staff failed to hold two interdisciplinary care plan meetings following quarterly MDS Assessments.<br><br>Resident #23 was admitted to the facility in 2/2018 with diagnoses that included dementia without behavioral disturbance, chronic respiratory failure and high blood pressure.<br><br>Review of the Resident's quarterly Minimum Date Set (MDS) dated 2/24/19, revealed that Resident #23 had a Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15 which indicated that he/she had a moderate cognitive impairment. The MDS also indicated that Resident #23 required extensive assistance for all self-care activities.<br><br>Review of the Resident's clinical record on 5/31/19, at 9:51 A.M., the surveyor was unable to locate documentation that a care plan meeting was held following the completion of a quarterly MDS in 11/2018 and 2/2019 to review and revise the Resident's care plan.<br><br>2. For Resident #29 the facility failed to hold an interdisciplinary care meeting following the | F 657 | The MDS coordinator and/or designee will complete an audit of the current residents records for care plan meetings. Any residents identified who have not had a care plan meeting will have one done.<br><br>The DON and/or designee will audit the care plans of current residents who have sexually inappropriate behaviors to ensure interventions are in place.<br><br>The SDC and/or designee will in-service the MDS coordinator to ensure each resident has a care plan meeting following completion of the MDS.<br><br>The SDC and/or designee will in-service the direct care staff, social worker and MDS coordinator regarding revision of the care plan, specifically implementing interventions for sexually inappropriate behaviors.<br><br>The MDS coordinator and/or designee will randomly audit the current resident records to ensure each has had a care plan meeting after the completion of the MDS assessment.<br><br>The DON and/or designee will audit the care plans for residents with sexually inappropriate behaviors to ensure they are revised as appropriate.<br><br>Both audits will be completed weekly for four weeks, followed by monthly for two months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 47<br>completion of a quarterly MDS assessment.<br><br>Resident #29 was admitted to the facility in 1/2018 with diagnoses that included dementia without behavioral disturbances, major depression, high blood pressure and osteoporosis.<br><br>Review of the annual Minimum Data Set (MDS) assessment dated 1/18/19, revealed that Resident #29 had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15, which indicated that he/she had moderate cognitive impairment. The MDS also indicated that Resident #29 required extensive assistance for all self-care activities.<br><br>Review of the Resident #29's clinical record on 5/31/19, at 8:37 A.M., failed to indicate that a care plan meeting was held following the completion of a quarterly MDS in 7/2018 to review and revise the Resident's care plan.<br><br>3. For Resident # 41 the facility staff failed to hold an interdisciplinary care plan meeting following the completion of a quarterly MDS assessment.<br><br>Resident #41 was admitted to the facility in 9/2018 with diagnoses that included dementia without behavioral disturbance, heart failure and adult failure to thrive.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 3/21/19, revealed that Resident #41 had a Brief Interview for Mental Status (BIMS) score of 1 out of a possible 15, which indicated that he/she had significant cognitive impairment. The MDS also indicated that Resident #41 required extensive assistance for all self-care activities. | F 657 | The results of the audits will be reviewed and discussed at the monthly QAPI committee meeting for three months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 48<br><br>Review of the clinical record on 5/31/19, at 9:51 A.M., the surveyor was unable to locate documentation that a care plan meeting was held following the completion of a quarterly MDS in 3/2019 to review and revise the Resident's care plan.<br><br>During an interview on 6/4/19 at 10:00 A.M., the Social Worker said that interdisciplinary care plan meetings should be held every three months or if there is a significant change in a resident's status. She said that the MDS Coordinator provides the appropriate staff that is to attend the meetings with the schedule of care plan meetings that will be occurring. The Social Worker said that she has been working at the facility since March and has never received a schedule for care plan meetings.<br><br>During an interview in 6/4/19 at 10:36 A.M., the MDS Coordinator said that interdisciplinary care plan meetings should be held every 3 months. She said that she is responsible for making the care plan schedule and schedules the meetings based on the MDS schedule.<br><br>During an interview on 6/4/19 at 10:43 A.M., the Activities Director said she attends the interdisciplinary meetings for the residents on the first floor. She confirmed no care plan meetings were held in the above time periods for Residents #23, #29, and #41.<br><br>4. For Resident #58, the facility staff failed to revise his/her plan of care for his sexually inappropriate behaviors following a resident-to-resident altercation. | F 657 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225198 | A. BUILDING _____ B. WING _____ | 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN OAKS REHAB AND NURSING | 63 LOCUST STREET DANVERS, MA 01923 |



| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 49<br>Resident #58 was admitted to the facility in 1/2019 with diagnoses including dementia, psychotic disorder, and anxiety disorder.<br><br>The latest quarterly minimum data set (MDS) dated 4/12/19 indicated the Resident scored a 12 out of a 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The latest quarterly MDS dated 4/12/19 indicated the Resident required assistance or supervision with most aspects of his/her activities of daily living.<br><br>Review of Resident #58's behavioral care plan, dated 1/3/19, indicated the following: Resident had a history of aggression and sexually inappropriate behavior at a previous nursing center. Resident's triggers for physical aggression are someone in his/her personal space.<br><br>Review of the facility's incident report dated 5/8/19 for Resident #58 indicated that a resident reported to the supervisor that Resident #58 asked him/her on many occasions for a "blow job." He/She reported that this occurred in the dining room. The report also indicated an intervention to for Resident #58 to be separated from residents of the opposite sex.<br><br>Resident #58's behavioral care plan was not revised to include this intervention.<br><br>Review of Resident #58's care kardex failed to indicate an intervention to separate Resident #58 from residents of the opposite sex.<br><br>Review of Resident #58's physician orders failed to indicate an intervention to separate Resident | F 657 | | |