STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225784	A. Building B. Wing	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New England Sinai Hospital Transitional Care Unit	150 York Street Stoughton, MA 02072

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 28450 Based on record review, policy review, and interview, the facility failed to ensure written notice for transfer and discharge was provided to Residents and/or Resident Representative prior to hospital transfer for one Resident (#9), out of a total sample of 10 residents. Findings include: Review of the facility's policy titled Notice of Discharge or Transfer, revision date 10/28/22, indicated but was not limited to: - In general, written notice of facility-initiated discharges or transfers must be provided to patients or legal representative 30 days prior to the discharge date , unless: -The patient's welfare is at risk, -The health or safety of others is endangered -In those situations, notice must be provided as soon as practicable. - A written notice must be provided in an easily understood format and in language that the patient (or legal representative) can understand and must include the following information: is being transferred or discharged . Written notice must be provided in an easily understood format and in language that patient. a. The reason for transfer or discharge b. The expected date of transfer or discharge c. The location to which the patient is being transferred or discharged . d. A statement regarding the patient's right to appeal the transfer or discharge. e. The name, address, telephone, and email of the State Long-term Care Ombudsman (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Copies of these notices are sent to the State Ombudsman at the time they are delivered to the patient. Resident #9 was admitted to the facility in October 2023. Review of the medical record indicated Resident #9 transferred to the hospital on 10/23/23. Further review of the paper and electronic medical records failed to indicate the transfer or discharge notice was provided to Resident #9 or his/her representative before/upon transfer to the hospital. During an interview on 12/01/23 at 1:10 P.M., the Director of Nurses (DON), after reviewing Resident #9's medical record, said that she did not see a notice for transfer to the hospital. The DON said that she was not aware that a notice of transfer was not provided. During an interview on 12/01/23 at 1:30 P.M., Social Worker #1 she said she did not know who handles the transfer/discharge paperwork. She said she usually found out in the morning at meeting when someone was transferred and make a note of it. During an interview on 12/01/23 01:45 P.M., the Administrator said the social worker should know about it. The Administrator said if it is not being retrieved it was not done. During an interview on 12/05/23 at 08:30 A.M., the Ombudsman said they have not been consistently sending transfer discharge to her office. The Ombudsman said that the facility had not sent her or the regional office copies of transfer or discharge notifications.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 28450 Based on policy review, record review, and interview, the facility failed to provide written notification of the bed hold policy to the Resident or Resident Representative prior to discharge to the hospital for one Resident (#9), out of a total sample of 10 residents. Findings include: Review of the facility's policy titled Bed Hold and Readmission, undated, indicated but was not limited to: - If a private patient is admitted to a hospital from the TCU, the TCU will hold said Patient's bed for the Patient at the full rate until Patient/Responsible Party advises the TCU that such bed is no longer to be held. Resident #9 was admitted to the facility in October 2023 with diagnoses including rheumatoid arthritis, type 2 diabetes, and history of gastrointestinal bleeding. Review of the medical record indicated Resident #9 transferred to the hospital on 10/23/23 due to a change in condition. Further review of the paper and electronic medical records failed to indicate the transfer or discharge was provided to Resident #9 or his/her representative before/upon transfer to the hospital. During an interview on 12/01/23 at 1:10 P.M., the Director of Nurses (DON), after reviewing Resident #9's medical record, said that she was not aware that the bed hold was not provided. During an interview on 12/01/23 at 1:30 P.M., Social Worker #1 said she did not complete a bed hold for Resident #9. During an interview on 12/01/23 01:45 P.M., the Administrator said the social worker should know about the process for bed hold. The Administrator said the bed hold notification was not done.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 15214 Based on record review, policy review, and staff interview, the facility failed to ensure that a baseline care plan was developed within 48 hours of admission, for 3 Residents (#6, #10, #71), of a total sample of 10 residents, that included the instructions needed to provide effective, person -centered care of the resident, that met professional standards of practice. Specifically, 1. For Resident #6, the facility failed to develop a baseline care plan to address the Resident's risk for falls. 2. For Resident #10, the facility failed to develop a baseline care plan to address the Resident's risk for falls. 3. For Resident #71, the facility failed to develop a baseline care plan to address the use of anticoagulants and risk for bleeding. Findings include: Review of Interdisciplinary Care Planning, dated 4/2018, indicated, but was not limited to: Baseline Care Plan 1. The facility will develop and implement a baseline care plan for each patient that included the instructions needed to provide effective and person-centered care within professional stands of quality care. 2. The baseline care plan must: a. Be developed within 48 hours of admission. b. Include the minimum healthcare information necessary to properly care for a patient including, but not limited to: i. Initial patient goals identified during evaluations. ii. Physician orders iii. Dietary orders iv. Therapy services v. Social services (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vi. PASSRR recommendations, if applicable vii. Nursing services and ADL status and safety needs. Review of the facility's Falls Management Program, dated 4/19/18, indicated, but was not limited to: Policy All Transitional Care Unit (TCU) employees are responsible for creating a safe environment of care. Measures are taken by direct care providers to identify fall risk and put interventions in place, based on the individual needs and goals of the patient. Procedure Fall Risk Evaluation a. All patients will be evaluated using the John Hopkins Fall Risk Fall Risk Assessment, as needed, but no less than on admission or readmission, quarterly, with significant change in condition and following a fall. b. An interdisciplinary fall prevention care plan for patients identified as being at risk for falls will be initiated using individualized fall prevention strategies based on patient's needs and goals. These care plans will be periodically reviewed (but not less than within 72 hours of admission and quarterly thereafter) 1. Resident #6 was admitted in October 2023 with diagnoses which included, status post left hip replacement, a history of falls, high risk for falls. The medical record indicated the Resident sustained two falls in the six months prior to admission. Record review on 11/29/23 indicated, although a baseline care plan was developed upon admission in October 2023, the falls/safety section of the baseline care plan failed to identify individualized fall prevention strategies, goals/interventions, and failed to include the instructions needed to provide effective and person-centered care that met professional standards of quality care 2. Resident #10 was admitted in November 2023 with diagnoses which included, status post fall with head strike, femur fracture with right hip arthroplasty, and multiple strokes. Record review on 11/29/23, indicated that the Resident was a fall risk and a baseline care plan was initiated at the time of admission. However, further review of the baseline care plan on 11/29/23, indicated that the safety part of the baseline care plan was not completed, and there were no fall prevention goals/strategies developed in order for the staff to provide effective and person-centered care for the Resident. 3. Resident #71 was admitted in August 2023 with diagnoses which included, atrial fibrillation, cerebrovascular accident, chest pain, congestive heart failure, and gastrointestinal bleeding. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 12/1/23, indicated that a baseline care plan was initiated at the time of admission. However, the baseline care plan failed to include goals/strategies for staff monitoring the Resident for signs and symptoms of bleeding, due to the use of the blood thinning agents Apixaban (Eliguis) 5 mg (milligrams) twice daily, and aspirin 81 mg daily. During an interview on 12/1/23 at 4:45 P.M., the DON said that the facility had work to do to ensure baseline care plans, and care plans in general, are complete, include goals/interventions, and provide enough information in order for staff to provide person-centered care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 15214 Based on record review, policy review, and staff interview, the facility failed to ensure that for 1 Resident (#71), of a total sample of 10 residents, that a comprehensive, person-centered care plan was developed and implemented, that included measurable objectives and timeframes to meet the needs of the resident. Specifically, For Resident #71, the facility failed to develop and implement a comprehensive care plan that included monitoring the Resident for bleeding, due to the use of anticoagulant medication. Review of the Interdisciplinary Care Planning Policy, dated 4/2018, indicated, The care plan process also addresses the ongoing execution of care and services, which include but are not limited to patient safety, discharge planning, patient specific diagnoses, rehab and education needs, behavior management, patient specific treatments and monitoring that includes use of medical devices, assistive devices, etc. The policy further delineated that comprehensive care plans are developed by the interdisciplinary team representing all appropriate health care workers. -As soon as possible after admission to address key clinical areas. -No later than 7 calendar days after completion of the comprehensive MDS for additional triggered areas. -Quarterly -With a change in patient status -Per regulatory mandates. Resident #71 was admitted in August 2023 with diagnoses which included, atrial fibrillation, cerebrovascular accident, chest pain, congestive heart failure, and history of gastrointestinal bleeding. Record review on 12/1/23, indicated that the Resident received the anticoagulant medications Apixaban (Eliguis) 5 mg (milligrams) twice daily, and aspirin 81 mg daily. A pharmacy Medication Regimen Review on 10/3/23, recommended to the physician that the Resident be monitored for bleeding, H/H (hemoglobin/hematocrit), and Renal. The Physician Assistant (PA) accepted the recommendation on 10/16/23, and indicated he would implement the recommendation for monitoring for bleeding as made by the pharmacist. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record, and review of the MAR (medication administration record) on 12/1/23, indicated that there was no monitoring of the Resident by staff for signs and symptoms of bleeding. During an interview on 12/1/23 at 4:45 P.M., the DON said that the facility had a lot of work to do to ensure care plans are complete, comprehensive, and include person-centered care. She said that the Resident's plan of care should have included monitoring the Resident for bleeding due to the use of anticoagulants.