DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION, MEDICARE BUREAU

ATTACHMENT A   Exhibit A

FORM APPROVED
OMB NO. 66-R-0060

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED
C907286	A. BUILDING ______ B. WING ______	06-02-82

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYOR M. J. NEVILLE MANOR	650 CONCORD AVENUE CAMBRIDGE MA 02138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD 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
	RESURVEY			
T116	1 ICF CODE 249.12(A)(7)(V) STATE REG1 150.009(F)(2) DIET DESSERTS WERE CHANGED FROM THE MENU FOR 5-19, AND 5-20. THE ITEMS SERVED WERE NOT RECORDED IN THE SUBSTITUTION BOOK. STANDARD CONSIDERED NOT MET.	T116	This was an isolated incident. Changes are now recorded as required.	8/26/82
F222	2 SNF CODE 405.1125(C) STATE REG1 150.009(C) CALORIE-RESTRICTED DIETS SERVED 5-19 AND 5-20 WERE NOT IN ACCORDANCE WITH THE POSTED MENUS. THE DESSERTS SERVED WERE NOT OF EQUAL CALORIES AS ON THE MENUS. ON 5-20, THE DESSERT SERVED WAS NOT WITHIN ACCEPTABLE PRACTICES FOR DIABETIC PATIENTS. STANDARD MET.	F222	This has been corrected through staff ~~education~~ & reinforcement by management.	6/10/82
F224	3 SNF CODE 405.1125(C)2 STATE REG1 150.009(C)(2) STATE REG2 150.009(C)(1) THERE WAS NOT A MENU FOR THE 60 GRAM PROTEIN 2 GRAM SODIUM DIET. REFER TO 150.009(C) CALORIE RESTRICTED DIETS SERVED.		Consultant Dietitian has now written a meal plan for 60gm Protein 2g Na Diet & it is posted daily.	6/9/82
F237 T117	4 SNF CODE 405.1125(E) ICF CODE 249.12(A)(7)(VI) STATE REG1 150.009(G) *** CONTINUATION PAGE FOLLOWS ***	F237 T117	See Next Page	

		REVIEWED BY (INITIALS)	DATE	PROVIDER REPRESENTATIVE'S SIGNATURE	(X6) DATE
APPROVED BY STATE CERTIFYING AGENCY	☐			William E. [signature]	8/26/82
DISAPPROVED BY STATE CERTIFYING AGENCY	☐				
APPROVED BY DHEW REGIONAL OFFICE	☐	REVIEWED BY (INITIALS)	DATE	TITLE	
DISAPPROVED BY DHEW REGIONAL OFFICE (MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.)	☐			Administrator	

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HEALTH CARE FINANCING ADMINISTRATION, MEDICARE BUREAU

Exhibit A

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MAYOR M. J. NEVILLE MANOR	650 CONCORD AVENUE CAMBRIDGE MA 02138

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	RESURVEY PLEASE REFER TO 150.009(I)(1). NOURISHMENT KITCHENS NOT MAINTAINED IN A SANITARY MANNER. A MILK CONTAINER WAS DATED 5-16, OBSERVED 5-20 ON WEST I IN THE NOURISHMENT REFRIGERATOR. WHEN OPENED, THE MILK WAS ODOROUS. STANDARD NOT MET.		Dietary staff rotate perishable floor supplies daily & discard as per Dietary policy stated in Dietary Procedures Manual. This policy has been reinforced.	6/16/82
F239	5 SNF CODE 405.1125(E)2 STATE REG1 150.009(C)(5) REFER TO 150.009(F)(2) AND 150.009 (C), DIET DESSERT CHANGES NOT RECORDED AND DIET DESSERTS SERVED NOT OF EQUAL CALORIC VALUE AS PLANNED ON THE MENUS.		Isolated incidents - have now been corrected with staff education	6/10/82
F244	6 SNF CODE 405.1125(6) STATE REG1 150.009(I)(1) NOURISHMENT KITCHENS WERE NOT MAINTAINED IN A SANITARY MANNER FOR EXAMPLE FOODS WERE NOT COVERED OR LABELED, BAIT PELLETS WERE IN BOXES AND NEAR BOXES WERE SMALL BLACK PARTICLES, WALLS HAD STAINED SPOTS, FLOORS HAD DEBRIS, DUST, SHELVES WERE LINED WITH ABSORBENT MATERIALS. STANDARD NOT MET.		All floor supplies delivered by Dietary are covered & labeled. Dietary staff cleans refrigerators & the shelves they use on a continual basis as per nursing home policy. This has been reinforced.	6/16/82
	7 STATE REG1 150.009(I)(4) PLASTIC GLASSES WERE STACKED WITH *** CONTINUATION PAGE FOLLOWS ***		See Next PAGE	—

	REVIEWED BY (INITIALS)	DATE	PROVIDER REPRESENTATIVE'S SIGNATURE	X6 DATE
APPROVED BY STATE CERTIFYING AGENCY ☐ DISAPPROVED BY STATE CERTIFYING AGENCY ☐			Wilbur E. [illegible]	8/26/82
APPROVED BY DHEW REGIONAL OFFICE ☐ DISAPPROVED BY DHEW REGIONAL OFFICE ☐ (MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.)	REVIEWED BY (INITIALS)	DATE	TITLE ADMINISTRATOR	

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FORM HCFA-2567

5. PROVIDER

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION, MEDICARE BUREAU

FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X3) DATE SURVEY COMPLETED: 06-02-82

NAME OF PROVIDER OR SUPPLIER: MAYOR M. J. NEVILLE MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE: 650 CONCORD AVENUE CAMBRIDGE MA 02138

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	RESURVEY MOISTURE ON THE INSIDE AND OUTSIDE SURFACES, THUS NOT AIR-DRIED. PLASTIC CUPS WERE STORED WET ON THE TRAY MATS ON THE TRAYS.		as of July 1, 1982 we have changed to using a more effective drying agent.	7/1/82
F47	8 SNF CODE 405.1121(G) 6 STATE REG1 150.002(D)(6)(A) SEVENTEEN OF TWENTY-FIVE PERSONNEL RECORDS REVIEWED WERE WITHOUT DOCUMENTATION OF CURRENT TUBERCULIN TESTING.	F47	~~Medical Director [illegible]~~ CHEST Films will be Updated by 9/30/82	9/30/82
F102	9 SNF CODE 405.1123(A) STATE REG1 150.005(F)(2) STATE REG2 150.003(B)(1) THREE OF 6 LEVEL 2 PATIENT RECORDS REVIEWED INDICATED THAT INITIAL PHYSICAL EXAMINATIONS WERE NOT DOCUMENTED WITHIN 5 DAYS PRIOR TO ADMISSION OR 48 HOURS FOLLOWING ADMISSION. STANDARD IS NOT MET.	F102	medical Director Has contacted each physician and APPRISED them of Requirements. Target date of 11/1/82 has been Set For Full compliance	11/1/82
F114	10 SNF CODE 405.1123(B)9 FOUR OF 6 LEVEL 2 PATIENTS' RECEIVING SPECIALIZED REHABILITATIVE SERVICES WERE ON ALTERNATE SCHEDULES FOR PHYSICIANS' VISITS. 11 STATE REG1 150.015(C)(2) *** CONTINUATION PAGE FOLLOWS ***	F114	Patients in this classification Now being seen on 30 day Schedule.	8/25/82

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DISAPPROVED BY STATE CERTIFYING AGENCY	☐				
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DISAPPROVED BY DHEW REGIONAL OFFICE (MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.)	☐		-	Administrator	

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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	RESURVEY ON THE SECOND DAY OF VISIT A PATIENT WAS OBSERVED RESTRAINED WITH A SHEET. PREVIOUSLY CITED 1981.	F114	This incident was oversight. Sheets not used as restraints	8/25/82
F172 T104	12 SNF CODE 405.1124(D)3 STATE REGS 150.007(D)(2)(G) PATIENT CARE PLANS OTHER THAN FOR NURSING WERE IRREGULARLY UPDATED DATES RANGED FROM FEBRUARY THROUGH MAY.	F172 T104	Care plans now being updated on a regular basis.	8/25/82
F257	13 SNF CODE 405.1126(B)3 FIVE APPLICABLE LEVEL 2 RECORDS REVIEWED GAVE NO INDICATION OF OCCUPATIONAL OR PHYSICAL THERAPY PERSONNEL REPORTING PATIENTS PROGRESS TO THE ATTENDING PHYSICIANS WITHIN 2 WEEKS OF THE INITIATION OF SPECIALIZED REHABILITATIVE SERVICES.	F257	Progress reports of each service are now provided as required.	8/26/82
	14 STATE REGS 150.010(F)(2) PHYSICAL THERAPY DIRECT SERVICES WERE NOT DOCUMENTED AS PROVIDED BUT ON A MONTHLY BASIS.	14 State	Services are now documented as required.	8/26/82
T84 T85	15 ICF CODE 249.12(B)(4)(11) STATE REGS 150.011(G)(2) * FIVE OF 6 LEVEL 3 AND 3 OF 6 LEVEL 2 PATIENT RECORDS REVIEWED *** CONTINUATION PAGE FOLLOWS ***	T84 T85	NOTES ARE NOW WRITTEN Daily. NOTES ARE PRESENTLY current and will be	

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DATE

PROVIDER REPRESENTATIVE'S SIGNATURE: William E. [illegible]
X6 DATE: 8/26/82

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DISAPPROVED BY DHEW REGIONAL OFFICE ☐
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TITLE: ADMINISTRATOR

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	RESURVEY DID NOT HAVE CURRENT SOCIAL SERVICE PROGRESS NOTES. STANDARD NOT MET FOR LEVEL 3. PREVIOUSLY CITED 1981.		maintained on a current basis	8/3/82
F310	16 SNF CODE 405.1130(A) 1 STATE REG1 150.011(G)(3) ALL 12 LEVEL 2 AND 3 RECORDS REVIEWED LACKED UPDATING OF DISCHARGE PLANS. 3 OF 4 LEVEL 2 AND 2 OF 3 LEVEL 3 DISCHARGE RECORDS REVIEWED WERE LACKING SOCIAL SERVICE DISCHARGE SUMMARIES PREVIOUSLY CITED 1981.	F310	Discharge Plans Presently 65% updated. Will be fully updated September 30th Discharge Records: Summaries completed at discharge. Backlog to be completed by 9/30/82	9/30/82 9/30/82
F34C	17 SNF CODE 405.1132(A) 4 THE LAST DOCUMENTATION OF VISIT BY THE MEDICAL RECORD CONSULTANT WAS 9-12-1980.	F340	Consultant has been continuously available by telephone - on site consultation by 11/1/82	11/1/82
F354	18 SNF CODE 405.1132(E) 1 STATE REG1 150.013(E) TWO OF 3 LEVEL 3 AND 4 OF 5 LEVEL 2 RECORDS REVIEWED WERE NOT COMPLETED WITHIN 2 WEEKS OF DISCHARGE, PLEASE REFER TO 150.011(G)(3).	F354	Physicians have been informed of requirements. Every effort being made to bring this item into compliance	8/26/82
F357	19 SNF CODE 405.1132(G) A MEDICAL RECORD INDEX WAS NOT AVAILABLE FOR REVIEW. *** CONTINUATION PAGE FOLLOWS ***	F357	Index was available - will be updated by 12/1/82	12/1/82

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FORM HCFA-2567 5. PROVIDER

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HEALTH CARE FINANCING ADMINISTRATION, MEDICARE BUREAU

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	RESURVEY 20 STATE REG1 150.017(B)(2)(D)(3) LOCKS ON CABINETS IN ALL UTILITY ROOMS WERE NOT IN WORKING ORDER DOORS WERE HELD SHUT WITH ADHESIVE TAPE.	20	ALL LOCKS to be Replaced by 11/1/82. ORIGINAL manufacturer NO LONGER IN BUSINESS	11/1/82
	21 STATE REG1 150.017(B)(7)(H) EPOXY BATHROOM AND TOILET FLOORS THROUGHOUT THE FACILITY WERE BADLY STAINED AND EVIDENCED A BUILD-UP OF DUST AND DEBRIS IN CORNERS.		Employees instructed to be More diligent IN cleaning Daily	8/26/82
	22 STATE REG1 150.015(F)(1) A MINIMUM OF 22 PATIENT ROOMS HAD SCRATCHED WALLS. 3 ROOMS HAD STAINED CEILINGS AND A WINDOW BY THE FRONT DOOR HAD BROKEN GLASS. A WINDOW IN ROOM 214 COULD NOT BE OPENED.	22	Window Replaced. There is an ongoing program for Patient Room maintenance	8/26/82
	23 STATE REG1 150.016(C) DUMPSTERS WERE OVERFLOWING AND DOORS WERE OPEN ON A 1 DAYS OF SURVEY, PREVIOUSLY CITED 1981.	23	City provided Service — 3 Dumpsters — Serviced daily — containers have no covers.	8/26/82
	24 STATE REG1 150.016(E)(1) FLOORS IN PATIENT ROOMS THROUGHOUT THE FACILITY SHOWED A BUILDUP OF DUST AND DEBRIS IN CORNERS, ALONG BASEBOARDS AND *** CONTINUATION PAGE FOLLOWS ***	24	Patient Beds now Removed From Room for PURPOSE of daily cleaning.	8/26/82

APPROVED BY STATE CERTIFYING AGENCY ☐ REVIEWED BY (INITIALS) DATE

DISAPPROVED BY STATE CERTIFYING AGENCY ☐

PROVIDER REPRESENTATIVE'S SIGNATURE: [signature] X6 DATE: 8/26/82

APPROVED BY DHEW REGIONAL OFFICE ☐ REVIEWED BY (INITIALS) DATE

DISAPPROVED BY DHEW REGIONAL OFFICE ☐

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TITLE: Administrator

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	RESURVEY BEHIND PATIENT BEDS. EPOXY FLOORS THROUGHOUT THE FACILITY WERE STAINED. CEILING IN 1 WEST LOUNGE HAD LARGE HOLES. PAILS WERE CATCHING RAIN WATER. CITED 1981	24	Ceiling repairs contingent upon roof repairs which are scheduled to be completed by 1/1/83.	8/26/82
F527	25 SNF CODE 405.1137(H) A COORDINATED PROGRAM OF DISCHARGE PLANNING WAS NOT PROVIDED AS INDICATED BY THE FOLLOWING DEFICIENCIES. THIS LEVEL 2 STANDARD WAS NOT MET.	F527	Discharge planning is now coordinated at Daily Rounds	8/3/82
F528	26 SNF CODE 405.1137(H)1 AN ORGANIZED DISCHARGE PLANNING PROGRAM WAS NOT IN EVIDENCE AS REVIEW OF 6 LEVEL 2 PATIENT RECORDS INDICATED THE FOLLOWING DEFICIENCIES.	F528	SEE F527	8/3/82
F533	27 SNF CODE 405.1137(H)3(3) ALL 6 LEVEL 2 PATIENT RECORDS REVIEWED LACKED EVIDENCE OF REVIEW AND UPDATING OF DISCHARGE PLANNING FOR THE FIRST 3 MONTHS AFTER ADMISSION AND AS REQUIRED THEREAFTER.	F533	Discharge Plans are being reviewed at U.R.C meeting as Required	8/3/82
F535	28 SNF CODE 405.1137(H)3(5) ALL 6 LEVEL 2 PATIENT RECORDS REVIEWED LACKED UPDATING OF *** CONTINUATION PAGE FOLLOWS ***	F535	Discharge Plans are being reviewed Monthly	8/3/82

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FORM HCFA-2567 (11-75) (FORMERLY SSA-2567) 5. PROVIDER

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	RESURVEY DISCHARGE PLANS. 3 OF 4 DISCHARGE RECORDS REVIEWED LACKED FINAL DISCHARGE SUMMARIES. PREVIOUSLY CITED 1981.	F335	Current discharge records summaries are being completed at discharge. Backlog to be completed 9/30/82	8/3/82 9/30/82
	29 STATE REG1 150.008(C)(7) A CURRENT MEDICATION REFERENCE BOOK WAS NOT PROVIDED AT EACH NURSE'S STATION. 1981 EDITION OF THE PDR WAS IN USE.		P.D.R.'s were on order. Received day following survey. Now current.	8/25/82
F202	30 SNF CODE 405.1124(I) STATE REG1 150.008(D)(13) DISCONTINUED MEDICATIONS WERE NOT REMOVED FOR PROPER DISPOSAL AS EVIDENCED ON E2,W2 LEVEL 3 UNITS.	F202	Discontinued medications now removed weekly.	8/25/82
	31 STATE REG1 150.008(D)(1) THE MEDICATION ROOM ON E ONE WING LEVEL 2 UNIT WAS UNLOCKED WHEN LEFT UNATTENDED ON 5/20/82. THE SLIDING DOOR TRACKS FOR THE MEDIPREP UNITS THROUGHOUT THE FACILITY WERE SOILED AND DIRTY		Licensed personnel have been reminded to keep medication room locked when absent. Door tracks have been cleaned	8/25/82
	32 STATE REG1 150.008(D)(6) HYDROGEN PEROXIDE, RUBBING ALCOHOL ,ANTISEPTICS, CLINITEST TABLETS, WERE STORED IN UNLOCKED CABINETS IN THE STORAGE ROOMS ON E2, W2 LEVEL 3 UNITS, EXTERNAL *** CONTINUATION PAGE FOLLOWS ***		Licensed personnel have been reminded of the necessity of keeping said items under lock.	8/25/82

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APPROVED BY DHEW REGIONAL OFFICE ☐ DISAPPROVED BY DHEW REGIONAL OFFICE ☐ (MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.)			ADMINISTRATOR

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FORM HCFA-2567 5. PROVIDER

HEALTH CARE FINANCING ADMINISTRATION, MEDICARE BUREAU

OMB NO. 66-R-0060

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	RESURVEY PREPARATIONS WERE STORED WITH INTERNAL MEDICATIONS AS EVIDENCED ON THE W2 LEVEL 3 UNIT AND ON THE E ONE LEVEL 2 UNIT		Internal and external medications are currently separated as required.	8/25/82
F206	33 SNF CODE 405.1124(I)5 STATE REGI 150.008(E) THE CONTENTS OF THE EMERGENCY DRUG KITS WERE STORED IN OVERSIZED PLASTIC BASKETS WHICH COULD NOT BE PROPERLY SEALED TO ENSURE SECURITY AND WERE STORED IN THE STORAGE ROOMS ON EACH FLOOR ACCESSIBLE TO ALL THE STAFF --------- END ---------	F206	Emergency kits have been replaced and are now in compliance. They are kept under lock.	8/25/82

	REVIEWED BY (INITIALS)	DATE	PROVIDER REPRESENTATIVE'S SIGNATURE	X6 DATE
APPROVED BY STATE CERTIFYING AGENCY ☐ DISAPPROVED BY STATE CERTIFYING AGENCY ☐			William E. [illegible]	8/26/82
APPROVED BY DHEW REGIONAL OFFICE ☐ DISAPPROVED BY DHEW REGIONAL OFFICE ☐ (MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.)	REVIEWED BY (INITIALS)	DATE	TITLE Administrator	

*Any deficiency statement ending with an asterisk (*) denotes a condition which the insitution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients.
(See cover sheet for further instructions.)

FORM HCFA-2567 (11-79) (FORMERLY SSA-2567)

5. PROVIDER

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

ATTACHMENT B

Exhibit B

Form Approved
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 0907286

(X2) MULTIPLE CONSTRUCTION: A. BUILDING ______ B. WING ______

(X3) DATE SURVEY COMPLETED: 11/23/82

NAME OF PROVIDER OR SUPPLIER: MAJOR M.J. NEVILLE MANOR N.H.

STREET ADDRESS, CITY, STATE, ZIP CODE: 65 Concord Avenue, Cambridge, Massachusetts 02138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD 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
F47	405.112 (G)(6), 150.002 (D)(6)(A) Not Corrected: 18 of 34 employee records did not contain evidence of a current testing for Tuberculosis.			
F102	405.1123 (A), 150.005 (F)(2), 150.003 (B)(1) Corrected: 5 of 6 Level 2 Records contained evidence of a current Admission Physical Examination for each patient. Standard Level 2 is met.			
F114	405.1123 (B)(10) Corrected: There were no Level 2 patients receiving rehabilitative services on alternate physician schedules.			
F257	405.1126 (B)(3) Corrected: 2 of 2 Level 2 Records contained Documentation of a 2 week progress report from the physio-therapist to the attending physician.			

	REVIEWED BY (INITIALS)	DATE	PROVIDER REPRESENTATIVE'S SIGNATURE	X6 DATE
APPROVED BY STATE CERTIFYING AGENCY ☐ DISAPPROVED BY STATE CERTIFYING AGENCY ☐				
APPROVED BY DHEW REGIONAL OFFICE ☐ DISAPPROVED BY DHEW REGIONAL OFFICE ☐ (MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.)	REVIEWED BY (INITIALS)	DATE	TITLE	

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(See cover sheet for further instructions.)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION

Form Approved
OMB No. 066-R-0060

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Continuation Sheet	(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED
	0907286	M.J. Neville Manor N.H. A BUILDING B. WING	11/23/82

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETION DATE
	150.010 (f)(2) Corrected: Physio-therapy provided to patient was Documented in a timely manner.			
T84 T85	249.12 (B)(4)(11), 150.011 (G)(2) Corrected: 4 of 6 Level 2 Records contained current Social Service Documentation. 2 of 3 Level 3 Records contained current Social Service Documentation.			
F310	405.1130 (A) 1; 150.011 (G)(3) Corrected: 12 of 12 current records and 3 of 3 discharge records contained timely updating of discharge plans. 3 of 3 discharge records contained a Social Service Summary.			
F340	405.1132 (A)(4) Not Corrected: The last Documentation by the Medical Records librarian was 9/12/80.			
	150.015 (C)(2) Corrected: No patients were observed being restrained with a sheet.			

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION

Form Approved
OMB No. 066-R-0060

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Continuation Sheet	(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED
	0907286	A. BUILDING M.J. Neville Manor N.H. B. WING	11/23/82

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETION DATE
F172 T104	405.1124 (D) 3; 150.007 (D)(2)(g) Corrected: 9 of 9 patient care plans contained evidence of timely review by all disciplines.			
	150.016 (C) Not Corrected: Although dumpsters were not overflowing, the covers were left open during all days of this visit.			
F354	405.1132 (E) 1; 150.013 (E) 1; 150.013 (E) Corrected: 3 of 3 discharge records were completed in a timely manner.			
F357	405.1132 (G) Not Corrected: A Medical Record Index was not available for review. Standard Not Met.			
F527	405.1137 (H) Corrected: 9 of 9 Records contained evidence of a coordinated program for discharge planning. Standard Level 2 Met.			
F528	405.1137 (H) Corrected: 9 of 9 Records contained evidence of an organized discharge planning program.			

FORM HCFA-2567A (11-75) (FORMERLY SSA-2567A)

1 HEALTH INSURANCE REGIONAL OFFICE OR OFFICE OF LONG-TERM CARE

Form Approved
OMB No. 066-R-0060

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Continuation Sheet

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED
0907286	M.J. Neville Manor N.H. A. BUILDING B. WING	11/23/82

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETION DATE
F533	405.1137 (H) (3)(3) Corrected: 6 of 6 Level 2 Records contained evidence of discharge planning review and updating in a timely manner.			
F535	405.1137 (H)(3)(5) Corrected: 6 of 6 Level 2 Records contained evidence of updating of discharge plans. 3 of 3 discharge records contained discharge summaries.			
	150.017 (B)(2)(D)(3) Corrected: Locks on cabinets in utility rooms were operable.			
	150.017 (B)(7)(H) Corrected: Except for epoxy stains, bathroom and toilet floors were maintained in a sanitary manner.			
	150.015 (f)(1) Corrected: Except for epoxy stains, toilet floors were free of dust and debris. Patient bedroom walls were properly maintained. Window in front entrance has been replaced. Two windows in patient rooms could not be closed.			

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION

Form Approved
OMB No. 066-R-0060

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Continuation Sheet	(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED
	0907286	A. BUILDING M.J. Nevelle Manor N.H. B. WING	11/23/82

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETION DATE
	150.016 (E)(1) Not Corrected: The ceiling in "West I" sitting room has not been repaired. "2" patient bedroom floors had pools of urine on them. One patients toilet had feces smeared on toilet and handwash. Cockroaches were noticed in 2 patient bedrooms. "2" patient bedrooms had stained ceiling tiles.			
	150.008 (C)(7) Corrected: A 1982 Medication Reference Book was provided for each nursing station.			
F202	405.1124 (1)(1); 150.008 (D)(13) Corrected: No discontinued medications were stored in medicine closets.			
	150.008 (D)(1) Corrected: Medication room doors were always locked or attended. Sliding door tracks in medicine closets were clean.			
	150.008 (D)(6) Corrected: All external medications were stored in separate locked compartments.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED
0907286	M.J. Neville Manor N.H. A. BUILDING B. WING	11/23/82

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETION DATE
F206	405.1124 (1) 5; 150.008 (E) Corrected: Emergency drugs were stored in containers that were properly sealed. The kits were stored in the locked medicine cabinets.			
T116	249.12 (A)(7)(10); 150.009 (F)(2) Not Corrected: Raisin toast was substituted for english muffins for breakfast on 11/23/82. The menu did not contain this substitution. Standard Considered Met.			
F222	405.1125 (C); 150.009 (C) Corrected: Calorie restricted diets were served according to posted menus. Standard Met.			
F224	405.1125 (C)2; 150.009 (C)(2); 150.009 (C)(1) Corrected: All therapeutic diets served were according to posted menus.			
F237 T117	405.1125 (E); 249.12 (A)(7)(Vl); 150.009 (G) Corrected: Please refer to 150.009 (I)(1) Nourishment kitchens were maintained in a sanitary manner. All items including milk containers had current expiration dates. Standard Met.			

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION

Form Approved
OMB No. 066-R-0060

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Continuation Sheet	(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED
	0907286	M.J. Neville Manor N.H. A. BUILDING ____ B. WING ____	11/23/82

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETION DATE
	150.009 (1)(4) Not Corrected: Plates and plastic cups were stacked with moisture on inside and outside surfaces, thus not air dried.			
F239	405.1125 (E) 2; 150.009 (C)(5) Corrected: Refer to 150.009 (F)(2) and 150.009 (C): Changes in menu did not effect calorie value of food planned on the menu.			
F244	405.1125 (G); 150.009 (1)(1) Corrected: Nourishment kitchens were maintained in a sanitary manner. Foods were covered and labeled, walls and floors were clean; shelves were not lined. Although there were bait pellets in a corner on floor no black particles were noticed near them. Standard Considered Met.			

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Exhibit C

Form Approved
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED
0907286	A. BUILDING ____ B. WING ____	11-23-82

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayor M.J. Neville Manor Nursing Home	650 Concord Avenue, Cambridge, Ma. 02138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD 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
	Interim Visit			
F25	405.1121 (E); 249.12 (A) (1); 150.002 (C) Level II standard not met in the area of administrative responsibilities. Refer to cited deficiencies in nursing care, lack of nursing staff, safety and sanitation.			
	150.002 (B) (4) The administrator was not working the hours indicated on weekly time schedules; on one occassion the alternate could not locate the administrator.			
F42	405.1121 (G) Administration was not implementing and maintaining policies and procedures that support sound patient care.			

	REVIEWED BY (INITIALS)	DATE	PROVIDER REPRESENTATIVE'S SIGNATURE	X6 DATE
APPROVED BY STATE CERTIFYING AGENCY ☐ DISAPPROVED BY STATE CERTIFYING AGENCY ☐				
APPROVED BY DHEW REGIONAL OFFICE ☐ DISAPPROVED BY DHEW REGIONAL OFFICE ☐ (MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.)	REVIEWED BY (INITIALS)	DATE	TITLE	

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(See cover sheet for further instructions.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

(X1) PROVIDER NUMBER: 0907286

(X2) MULTIPLE CONSTRUCTION: A. BUILDING ______ B. WING ______

(X3) DATE SURVEY COMPLETED: 11-23-82

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD 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
F43	405.1121 (G) (2); 150.002 (D) (5) The administrator complained about staff performance, however a review of employee records did not indicate any staff problems identified or actions taken by the administrator.			
F173 T105	405.1124 (E); 249.12 (A) (9) (v); 150.007 (E) SNF standard for rehabilitative nursing care was not met. Please refer to deficiencies cited in ambulation, positioning, incontinent care and staffing to provide needed services.			
F75	405.1121 (K) (5) (9); 249.12 (A) (1) (11) (B) (10); 150.007 (G) (1) (E) 2 patients were observed using commodes in their bedrooms neither patients bedside curtain was in place around them to assure their privacy.			
F123 T95	405.1124; 249.12 (A) (9); 150.007 (A) SNF Condition for satisfactory nursing services was not met. Please refer to cited deficiencies			

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

(X1) PROVIDER NUMBER: 0907286

(X2) MULTIPLE CONSTRUCTION: A. BUILDING ______ B. WING ______

(X3) DATE SURVEY COMPLETED: 11-23-82

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD 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
F135	405.1124 (C); 150.007 (B) (3) (E) Nursing service was not providing a sufficient number of nursing personnel to meet patient needs; personnel on absences were not replaced. On three weeks time reviewed (SNF Units) less than 1.4 hours unlicensed staff was noted- i.e. week ending 10-30-82 only 1.27 hours provided w.I.; 1.27 hours on E.I..			
F134	405.1124 (C); 150.007 (A) (1) SNF standard not met: Adequate nursing service and a sufficient number of nursing personnel to meet total nursing needs were not provided. Please refer to the following cited deficiencies.			
F136	405.1124 (C) (2); 150.007 (G) (1) (A) 150.007 (G) (1) Policies that state that care will be provided to keep patients comfortable, clean, well groomed and provided with rehabilitative nursing care were not followed.			
	150.007 (G) (1) (C) Observations at rounds indicated 5 patients were soiled with urine, 2 patients were soiled with feces. 5 patients eyes were crusted and/or reddened. 3 male patients needed shaves.			

FORM HCFA-2567A (11-75) (FORMERLY SSA-2567A)

1. HEALTH INSURANCE REGIONAL OFFICE OR OFFICE OF LONG-TERM CARE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Continuation Sheet	(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION: A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	0907286		11-23-82

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD 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
	150.007 (C) (7) Charge nurses were assigned as telephone receptionists when the assigned receptionists were not on duty.			
	150.007 (B) (4) (E) 3 weeks of time schedules were reviewed on the level III unit and less than 1.0 hours of unlicensed nursing staff per patient per day were provided. I.E. 97 hours week ending 9/23/82, .87 hours week ending 10/30/82, .95 hours week ending 11/6/82.			
	150.007 (G) (5) (2) During several visits to the level 2 units, there was little or no exercising of non-ambulatory patients observed.			
	150.007 (G) (5) (F) Most level 2 patients who could not ambulate or were blind were noticed sitting at their bedside. Some complained there was nothing to do.			
	150.007 (G) (5) (L) The following was observed on the level 2 units: 4 patients did not have either shoes or slippers. 4 patients wore Johnnies under their clothes. 1 patient wore a sweater without buttons with a safety pin holding front of sweater closed. 1 patients' Johnny was soiled with food particles.			

FORM HCFA-2567A (11-75) (FORMERLY SSA-2567A)   1. HEALTH INSURANCE REGIONAL OFFICE OR OFFICE OF LONG-TERM CARE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

(X1) PROVIDER NUMBER: 0907286

(X2) MULTIPLE CONSTRUCTION:
A. BUILDING ________
B. WING ________

(X3) DATE SURVEY COMPLETED: 11-23-82

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD 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
	150.007 (G) (5) (M) There was insufficient nursing staff on the level 2 units to ambulate patients.			
	150.007 (E) (3) (A) 3 patients in geri-chairs did not have foot rests in place. chairs, (2) did not have foot rests and the other had not been adjusted. 9 patients had not been positioned or supported properly. 4 patients did not have supports or splints to prevent contractures.			
	150.007 (E) (3) (G) During visits to the level 2 units there was little or no ambulation of non-ambulatory patients observed.			
F178	405.1124 (F) (1), 150.007 (F) (1) During visits to level 2 units, 2 patients requested drinks of water. They did not have drinking water at bedside.			
F177	405.1124 (F); 150.007 (F) A considerable number of level2 patients needed to be fed. Trays were observed left at the patients bedside uncovered and food cooling off until staff could return to feed patients. SNF standard for patient nutrition supervision was not met. Refer also to F178.			

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Continuation Sheet	(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED
	0907286	A. BUILDING ______ B. WING ______	11-23-82

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD 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
	150.010 (E) (3) Additional trained rehabilitative nursing staff were not provided to assist with rehabilitative nursing care.			
F256 T76 T77	405.1126 (B) (2); 150.010 (C) Physician orders for physical therapy did not include frequency and goals of treatment.			
	150.006 (C) (1) 4 patients did not have slippers or shoes One patient did not have shoes and could not be ambulated by a physical therapist until she was provided with shoes.			
	150.006 (D) 1 patient had an ear piece to his glasses heavily taped causing a poor fit; he complained they had been like that for sometime.			
T89	249.12 (B) (5) (11) A considerable amount of survey time was spent on the level 2 units. Non-ambulatory and blind patients were observed just sitting, and except for church services were not observed participating in the activities program.			
T143	249.12 (A) (4) (1) (D); 150.013 (D) (7) 2 patients records on the level 2 units did not contain an accurate recording of treatments.			

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Continuation Sheet	(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED
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	249.12 (A) (6); 150.015; 150.017 Sitting rooms on the first floor were not accessible to patients. Both rooms were behind two heavy steel doors, and east one unit had an up-and -down stairwell between the two doors. West one unit room was also not functional due to water leaks.			
	150.015 (A) Patient safety was not assured: the activity room on west one unit had water leaks noted to be coming through an electrical fixture and the electricity had not been shut off. Some call bells did not have cords and others had cords that were too short and/or not accessible to non-ambulatory pts.			
	150.017 (B) (12) (A) Some patient bedroom windows were defective; they could not be closed once they were opened. Signs were posted "keep windows closed". One patient room was cold due to drafty window where drapes were pinned closed.			
F447	405.1135 (E); 150.016 (E) (11) Flies were observed in several patient bedrooms where patients had been incontinent. Pest control was not adequate as cockroaches were observed in patients rooms. SNF standards not met.			

FORM HCFA-2567A (11-79) (FORMERLY SSA-2567A)

1. HEALTH INSURANCE REGIONAL OFFICE OR OFFICE OF LONG-TERM CARE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Continuation Sheet	(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED
	0907286	A. BUILDING ______ B. WING ______	11-23-82

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD 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
	150.016 (E) (1) One patients toilet had feces smeared on toilet bowl and handwash. Pools of urine were noted in 2 patient bedrooms. Overbed table was soiled with spilled milk, and another with nasal excretions. Cockroaches were observed in 2 patient rooms near a handwash, behind cabinet.			

FORM HCFA-2567A (11-75) (FORMERLY SSA-2567A)

1. HEALTH INSURANCE REGIONAL OFFICE OR OFFICE OF LONG-TERM CARE

STATEMENT OF GROUNDS
CANCELLATION OF CERTIFICATION

PROVIDER:

City of Cambridge
Cambridge, Massachusetts

FACILITY:

Mayor Michael J. Neville Manor
650 Concord Avenue
Cambridge, Massachusetts 02138

BEDS AFFECTED:

SNF - 73

AUTHORITY:

This cancellation of certification is pursuant to 42 C.F.R. 442.100 *et seq.* and related provisions of State and Federal laws.

EFFECTIVE DATE:

PROVIDER HISTORY:

The Provider's current certification extends from September 1, 1982 through August 31, 1983 subject to an automatic cancellation clause of December 3, 1982, which has been extended to February 4, 1983 pursuant to 42 CFR 442.16(b).

On June 2, 1982, a survey was completed at the subject facility. A statement of deficiencies was sent to the Provider. A plan of correction for the cited deficiencies, dated August 26, 1982 was submitted to the Department. The plan of correction was acceptable and the facility was certified with an automatic cancellation clause.

On Novemer 23, 1982, a visit was made to determine whether to invoke or rescind the automatic cancellation clause. The visit indicated that not only had the provider failed to correct numerous deficiencies according to the plan of correction, but that serious new deficiencies had been allowed to occur. Consequently, an interim statement of deficiencies was written.

REASONING:

Certification is cancelled for the following reasons:

1) The follow-up survey completed November 23, 1982 indicated that the Provider failed to achieve compliance in implementing the plan of correction dated August 26, 1982.

2) The follow-up survey completed November 23, 1982 indicated that the Provider was not in compliance with the following standard for Skilled Nursing Facilities:

42 CFR 405.1132(6) - Indexes (Medical Records)

3) The follow-up survey completed November 23, 1982 indicated that the Provider allowed new deficiencies to occur which seriously limited the facility's capacity to render adequate care. The Provider was not in compliance with the following Conditions of Participation and Standards for Skilled Nursing Facilities (Citations to 42 CFR.):

A. Condition of Participation

a. 405.1124 - Nursing Services.

B. Standards

1. 405.1121 (E) - Administrator
2. 405.1124 (E) - Rehabilitative Nursing Care
3. 405.1124 (C) - Twenty Four Hour Nursing Service
4. 405.1124 (F) - Supervision of Patient Nutrition
5. 405.1135 (E) - Pest Control

SUPPORTING DOCUMENTATION:

EXHIBIT A:

A copy of Statement of Deficiencies and Plan of Correction for survey completed June 2, 1982.

EXHIBIT B:

A copy of Statement of Deficiencies for follow-up survey completed November 23, 1982.

EXHIBIT C:

A copy of the Interim Statement of Deficiencies dated November 23, 1982.

BY:
Marilyn D. Ballivan
Assistant Director Survey Operations

DATE: Jan 25, 1982

MDG/mk

STATEMENT OF GROUNDS
CANCELLATION OF CERTIFICATION

PROVIDER:

City of Cambridge
Cambridge, Massachusetts

FACILITY:

Mayor Michael J. Neville Manor
650 Concord Avenue
Cambridge, Massachusetts 02138

BEDS AFFECTED:

SNF - 73

AUTHORITY:

This cancellation of certification is pursuant to 42 C.F.R. 442.100 *et seq.* and related provisions of State and Federal laws.

EFFECTIVE DATE:

PROVIDER HISTORY:

The Provider's current certification extends from September 1, 1982 through August 31, 1983 subject to an automatic cancellation clause of December 3, 1982, which has been extended to February 4, 1983 pursuant to 42 CFR 442.16(b).

On June 2, 1982, a survey was completed at the subject facility. A statement of deficiencies was sent to the Provider. A plan of correction for the cited deficiencies, dated August 26, 1982 was submitted to the Department. The plan of correction was acceptable and the facility was certified with an automatic cancellation clause.

On November 23, 1982, a visit was made to determine whether to invoke or rescind the automatic cancellation clause. The visit indicated that not only had the provider failed to correct numerous deficiencies according to the plan of correction, but that serious new deficiencies had been allowed to occur. Consequently, an interim statement of deficiencies was written.

REASONING:

Certification is cancelled for the following reasons:

1) The follow-up survey completed November 23, 1982 indicated that the Provider failed to achieve compliance in implementing the plan of correction dated August 26, 1982.

2) The follow-up survey completed November 23, 1982 indicated that the Provider was not in compliance with the following standard for Skilled Nursing Facilities:

The following sections of this letter describe your right to informal reconsideration and your right to a full adjudicatory hearing.

I. Informal Reconsideration

Pursuant to the requirements of federal regulations governing provider appeals (42 C.F.R. 431 151 et seq.) this Department will provide informal reconsideration prior to effective date of cancellation, according to the procedures set forth in this paragraph. If you wish to request informal reconsideration, you must state in writing why you disagree with the findings of the Department. This written statement must be received on or before January 31, 1983, in the office of the Director, Health Care Quality, Room 1125, 80 Boylston Street, Boston, Massachusetts 02116. If your written statement has not been received by the above date, no informal reconsideration will be provided. If your statement is received in timely fashion the Program Director will review it and inform you in writing whether the cancellation of certification is affirmed or reversed.

If upon reconsideration the cancellation action is reversed, you will be advised in writing that your automatic cancellation clause has been rescinded and that this Notice of Agency action has been withdrawn. Reversal will prevent termination of your provider agreement with the Department of Public Health.

II. Rights to Administrative Review

If you do not request informal reconsideration, or if, upon reconsideration the Program Director informs you in writing that cancellation is affirmed, you will have the right to a full adjudicatory hearing under the Standard Adjudicatory Rules of Procedure, 801 CMR 1.01 et seq. The Department will inform you be letter how you may obtain a full adjudicatory hearing.

The federal regulations referred to above provide that if you request a hearing, a hearing will be held and a decision rendered within one hundred twenty (120) days of the expiration date of your current certification.

I am being represented by Donna Levin, Esq. General Counsel, Room 218A, 600 Washington Street, Boston, Massachusetts 02111 (617-727-2665).

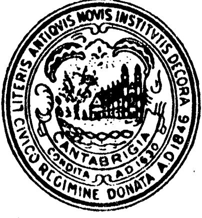
Very truly yours,

Marilyn D. Gallivan
Assistant Director Survey Operations

MDG/mk

cc: City of Cambridge
City Hall
Massachusetts Avenue
Cambridge, Ma. 02139
Att: Health Policy Board

ATTACHMENT C



CITY OF CAMBRIDGE
DEPARTMENT OF HEALTH, HOSPITAL AND WELFARE
1493 CAMBRIDGE STREET CAMBRIDGE, MASSACHUSETTS 02139
Telephone 354-2020

February 4, 1983

All Neville Manor Personnel
650 Concord Avenue
Cambridge, MA 02138

This letter is to inform you that effective immediately Mrs. Beverly Gorvine is appointed Acting Director of Nursing at Neville Manor, and that Miss Penny Woody is appointed Acting Assistant Director of Nursing at Neville Manor.

Sincerely,

Robert W. Healy
City Manager

RWH:bkm

ATTACHMENT D

THE CAMBRIDGE HOSPITAL
DEPARTMENT OF NURSING

STATUS REPORT ON NURSING: WEEK ONE
NEVILLE MANOR NURSING HOME

I. Supervision

A. Met with day supervisors to discuss expectations.

1. Time Schedules - to be done in four-week blocks, with requests to be in two weeks prior to posting. To begin with February 28th time sheet.
2. Evaluations to be done on all charge nurses within two weeks.
3. Review of documentation on problem employees.
4. Requested they describe their role, functions and responsibilities.

B. Scheduled off-shift supervision with coverage from The Cambridge Hospital.

II. Communication

A. Hold meetings with: nursing assistants, charge nurses, occupational and physical therapy, Social Service and recreational activities.

1. Will hold weekly meetings to discuss issues and coordinate activities.
2. Patient care rounds on each unit to include nursing personnel and staff development.

B. Developed guidelines for change of shift report on all shifts.

C. Met with LPN regarding 40-hour work week.

III. Staff Issues

A. Prepared Staffing Guidelines and made proposal for additional supervisors, registered nurses and nursing assistant's, with necessary conversions.

B. Reviewed Manpower sheets and set-up meeting to confirm position control status.

C. Terminated nurse aide in probationary period.

D. Implemented system for Licensure Verification.

E. Developed evaluation tool for nursing assistant's, to be completed on all within two weeks.

IV. <u>Staff Development/Inservice</u>

A. Personnel from The Cambridg Hospital recruited.

B. Assessment of deficiencies and plan of action developed (See attached).

C. All new orientees to attend Cambridge Hospital Orientation.

D. Developing methods for reporting and documenting patient care activities.

B. Garvine

BG/mms
2/14/83
cc: Robert Healy, City Manager
    Richard Rossi, Deputy City Manager

INSERVICE PROGRAMS

14th to 18th - Safety Week

- --16th Classes, 2-3pm and 3-4pm
- Review of Fire & Safety
- Procedures, assessment tool for all nursing employee's.
- To be filed in personnel records

21st to 27th - Activity Week

- Classes: 2-3pm and 3-4pm
- 22nd - positioning and transferring
- 23rd - range of motion
- 24th - ambulation

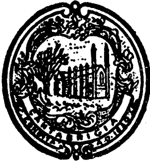
28th to 4th - Personal Hygiene

- Classes: 2-3pm and 3-4pm
- 1st - grooming.toileting
- 2nd - Decubitus care and prevention of

7th to 13th - Nutrition Week

- Classes - 2-3pm and 3-4pm
- How to feed problem eaters
- Nutritional assessment

ATTACHMENT D



CITY OF CAMBRIDGE

INTEROFFICE CORRESPONDENCE

To Mr. Robert W. Healy, City Manager **Date** February 23, 1983

From Richard Sullivan, Assistant Plant Engineer **Reference** Neville Manor

Subject Deficiency Status Report

Item I - Dumpster Covers: The solution to this problem was effected by leasing a 6 yard rubbish compactor. The City Electrician is in the process of installing electrical service to this compactor. This should be functional by Friday, 2/25/83.

Item II - Plate Warmers: In order to improve the method of serving hot meals more effectively, the Dietary Department has purchased four (4) plate warmers. I met with Mr. Crocker, the City Electrician, to expedite the wiring needs of the new equipment. A P.O. has been cut for electrical supplies and Mr. Crocker has assured me that this is a top priority job.

Item III - Broken Window Guides: Mr. Mulcahy and I looked at the windows in question and found the need for purchasing new guides was essential to allevate the above condition. I also felt that the repairs could be handled in house when these parts become available. Mr. Mulcahy assured me he would contact Spillane Window Co. and procure the above items as quickly as possible.

Item IV - Drain Back-ups: All plumbing codes relative to pipe size and installation have been compiled with. The primary problem that exists is that patients and/or employees are improperly disposing of clothing or other materials. I recommend that the purchase of paper towel materials be upgraded to begin acquiring softer, more water soluable and degradable materials.

The Hospital loaned its industrial duty drain snake to clear the drains. The purchase of a similar machine by the Neville Manor is no guarantee that back-ups will never occur. However, the initiation of the regularly scheduled use of an industrial duty drain snake in connection with a policing policy and mechanism on the patient units to prevent the introduction of inappropriate materials into the drain system should solve the problem.

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Y MANAGE

Item V - Maintenance Forms and Procedures & Logging of Outside Vendors: A copy of the maintenance form now in effect at the hospital has been forwarded to Mr. Mulcahy. By implementing the use of this form a more controlled maintenance system can be established. The form is triplicate in nature, one copy for the person requesting the repair, one copy for the man making the repair, and one for the maintenance department for costs or record keeping. This form should always be signed by the requestee as well as by the man making the repair. Only emergency maintenance situations should be handled over the phone.

I also feel a log book procedure should be established for any and all vendors, repairman or people who are doing business of any nature sign, such as: Company name, person's name, nature of business, and date and time.

Item VI - Epoxy Floors: I am obtaining a copy of the specifications from Mr. Feloney to see what material and method of applying this material was used. At that time we will institute guidelines as to how these areas may be repaired and improved.

Item VII - Maintenance and Painting Conditions: I think that a genuine need exists for an additional semi-skilled maintenance man with a background leaning toward carpentry and painting skills. The use of a man with these abilities would greatly improve the down time of equipment, improve the potential to complete maintenance tasks expeditiously and improve appearances by painting areas on a more controlled basis.

Item VIII - Leaky Roofs: I feel that the two areas in question should be evaluated as quickly as possible and prices as well as specifications should be obtained and processed for bid. It is further recommended that the spot leaks throughout the building be included in the roof specifications for bid.

sal

cc: Alfred P. Vellicci

ATTACHMENT D

CITY OF CAMBRIDGE

INTEROFFICE CORRESPONDENCE

To Mr. Robert W. Healy, City Manager **Date** February 23, 1983

From Paul McCann, Housekeeping Manager **Reference** Neville Manor

Subject Housekeeping & Laundry Status Report

Housekeeping & Laundry Department, Neville Manor Status Report 2/18/83.

- Current Staffing:

  14 Laborers
  8 Hospital Workers
  1 Laundress
  1 Working Foreman

- Shifts:

  Currently the entire housekeeping staff works a 7 a.m. - 3:30 p.m. shift, except for 2 individuals who work odd shifts (one laborer-porter works 8 p.m. - 4:30 a.m. and one laborer-porter/watchman works 10 p.m. - 5:30 a.m.) There is a glaring need for housekeeping shifts to coincide with other in-house shifts, and an obvious need for adding on a regular 3-11 housekeeping shift. The odd hour shifts should be converted to a 3-11 shift to provide specifically assigned services such as cleaning vacated areas (administrative area, dining room, and recreation area), regular laundry and trash pick-up, floor refinishing and cleaning of wheelchairs and gerichairs, as well as emergency services on the units as needed.

- Supervisor:

  There is one working foreman for housekeeping and laundry. The foreman's messenger duties have been curtailed. The foreman should assume responsibility for storeroom inventories, distribution and control of supplies & materials, assignment of regular duties to his staff, the inspection reporting system recently implemented, and assignment of employees to special details or emergency details.

- Uniforms

  Housekeeping employees have not been required to be uniformly dressed even though they get the contractual clothing allowance. They have been instructed to choose uniform colors by 2/23/83 and to purchase and begin wearing uniforms by 3/15/83.

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CITY MANAGER

- Equipment:

Minor equipment purchases would be advisable at this time. Much of the current equipment is old or not fully usable.

- 6 floor buckets - $75.00/per - $450.00 total
- 5 Maid Carts - 75.00/per - 375.00 total
- Wet/Dry Vacuum - 600.00 (1) - 600.00 total
- Mattresses (20) - 70.00/per -1,400.00 total
- Clothes Hampers (20)-10 - 30.00/per - 600.00 total

This list constitutes a minimum amount of necessary capital equipment and it would help in solving a number of small problems.

- Disciplinary Action:

Three disciplinary warnings have been issued to people with chronic absenteeism problems for 1982. Another look at their 1983 usage may necessiate further action to control this problem.

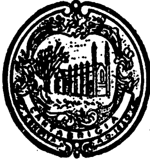
- Cleaning Procedures and Products:

Minor product changes seem necessary to control odor problems and make cleaning assignments more manageable and thorough. I suggest a change from general type cleaners to more hospital grade products. Current implementation of automatic scrubber usage will free laborers to perform duties such as cleaning stairs, floor refinishing and special tasks.

The interior plant is basically new and with a change in work techniques and shifts to accomodate floor refinishing coupled with more supervision and inspection reports the Manor should have a manageable, predictable and well run Housekeeping & Laundry Department. I will attempt to accomodate Mr.Mulcahy with frequent visits over the next 8 weeks to insure the deficiencies noted by Inspectors and the City Adminsitration are corrected and that employees are instructed in techniques and methodology.

sal

cc: Alfred P. Vellucci



ATTACHMENT D

CITY OF CAMBRIDGE

INTEROFFICE CORRESPONDENCE

To Mr. Robert W. Healy, City Manager **Date** February 23, 1983

From Sgt. James A. Roscoe, Director of Security **Reference** Neville Manor

Subject Security Status Report

On February 18, 1983 a meeting at the Neville Manor was held and it was agreed to implement the following plan for the security system.

A part-time arrangement of employment of four security personnel will be implemented, involving a total of 128 hours covering the week-ends and nights. These positions, all being City of Cambridge positions, will be filled by advertising and posting, and subsequent interviews relating to security requirements.

Northeastern University's Co-op plan was discussed and it was agreed that this plan should be terminated so that we could establish our own security force in order to try to improve the security setting. The shift assignments will be 7-3 on weekends, 3-11, 11-7 every night so as to coincide with the other departments employed at this facility. While the above manpower will enable us to handle these shifts we will have no back-up for sick or vacation conditions.

A walkie-talkie radio set-up on Cambridge Police Channel #5, will be provided by the Cambridge Police Department and instant communications can be maintained during the patrolling of the grounds.

All entrance and exit doors will be provided with a annunciator system alarm which will alert the guard as to what area to respond to. This is subject to availability of funds and approval of the Commissioner of Health & Hospitals and the City Manager.

The security guards will be provided with uniforms and equipment including a badge. All guards will be trained in the fundamentals of security and the use of the walkie talkie. The Nursing Supervisor will supervise security for all of the 3-11 and 11-7 shifts, with back-up provided by the Hospital Director of Security. The administrator will be responsible for security related matters for the Monday-Friday day shifts.

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CITY MANAGER

A suggestion for closed circuit television was submitted and will be looked into for future consideration.

Identification photos will be started in March and all employees at Neville Manor will be done during the month.

A schedule including days worked and days off totalling 32 hours for each shift has been attached.

The new schedule will start on Sunday, April 3, 1983.

attachment

sal

cc: Alfred P. Vellucci

ATTACHMENT D

CITY OF CAMBRIDGE

INTEROFFICE CORRESPONDENCE

To Mr. Robert W. Healy, City Manager **Date** February 24, 1983

From Jeffrey A. Collins, Financial Manager **Reference**

JAC

Subject Neville Manor Cost Report Completion

Mr. John O'Brien and I met with Mr. Talarico at the Neville Manor regarding their RSC-1 Cost Report on February 11. At that time we reviewed the various regulations to first determine the correct report and filing date. We then reviewed the forms to determine what information was needed and who could best handle the various segments and assignments were made by Mr. O'Brien.

At our second meeting on February 15, 1983, Mr. Talarico provided us with his completed workpapers for utilization (patient days) and revenue. In addition we now have in our possession much of the expense data that is needed, some of which was obtained from Mr. Talarico and the remainder from John Flynn at City Hall.

The next step is to pick-up today, the payroll registers, etc. from Mr. Carney at Neville and to obtain from City Hall records the pension and fringe benefit figures from former Neville Manor employees.

The aforementioned information together with our workpapers from last years filing should enable us to complete the report by early next week.

Thank you.

sal

cc: Alfred P. Vellucci

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OFFICE OF THE
CITY MANAGER

Dick Vowles
ATTACHMENT D

CITY OF CAMBRIDGE

THE CAMBRIDGE INFIRMARY

650 CONCORD AVENUE CAMBRIDGE, MASSACHUSETTS 02138

February 22, 1983

To: Mr. Robert Healy, City Manager

From: Bobbye Boccadori, Food Service Director of Neville Manor

Re: Dietary Department Update

Item 1: Drainage Back-ups

Continue to be a problem, with sewerage backing up from the three drains located within the department (dishroom, food preparation, and serving areas) as well as from other drains located in employee restrooms and in hallways on the ground floor. A larger-size "snake" was borrowed from Cambridge Hospital on February 15, 1983 and used to thoroughly clean out the lines. Approximately two hours later a back-up occurred.

Mr. Sullivan has written up the speculations to purchase an industrial size "snake" for our use. Posted throughout the Dietary Department are Safety and Sanitation procedures to be taken in the event that a back-up does occur. Attached you will find a copy of the procedure.

Item 2 : Painting of the Department

The areas that need to be painted are as follows: Kitchen walls & floor, Dishroom walls & floor, Daily Storage Room Walls and floor, and Main Storeroom Walls and floor. The Dining Room ceiling was painted in November, 1982, therefore it does not need to be painted at this time.

Item 3 : Replacement of Lowerators

Loweratore are heated mobile cabinets used to store plates and stainless steel underliners in order to retain the maximum temperature during transport of food to the floors and the dining room. The department has 2, one which does not work at all and one which operates at only minimal capacity. Cambridge Hospital loaned one to us, however we do not have the wiring sufficient to handle the necessary voltage. Through Cambridge Hospital we have ordered four new lowerators

CITY OF CAMBRIDGE

THE CAMBRIDGE INFIRMARY

650 CONCORD AVENUE CAMBRIDGE, MASSACHUSETTS 02138

Item 3: (cont.)

as Mr. Sullivan has deemed our old lowerators no longer able to be repaired. The city electrician was in on Thursday, February 17, 1983 to check on our wiring needs to handle the additional voltage. Both the lowerators and wiring should be in place by the time you read this report.

Item 4: Dry Cleaning of Dining Room Draperies

Frank Riley has informed me that the draperies will be taken down on Tuesday, February 22, 1983 and sent out to our laundry service for dry cleaning. They should be returned and re-hung within three days.

Item 5: Remedy of State Health Department Deficiency

This refers to the deficiency received from the last survey pertaining to insufficient drying of plastic serving items once they come out of the dishmachine. A drying agent has always been used in the rinse cycle and this dries all of the china completely but moisture remains on plate covers, mugs, trays, and coffee pitchers (all plastic).

A representative from the dishmachine manufacturer, Vulcan Co., was contacted. He notified us that there was no blow /dryer attachment made for that particular model. Currently in force are various stop-gap measures to allow air-drying of all plastic items. Although cumbersome and not the ideal they do seem to be alleviating the situation. I would like to add that insufficient drying of plastic trays, mugs, etc. is a universal problem and not one peculiar to this institution. Also, most hospitals do not have a blow/dryer attachment on their dishmachines either.

Attached you will find copies of the procedure we are now using to air-dry all plastics. These are posted in strategic locations throughout the department.

CITY OF CAMBRIDGE

THE CAMBRIDGE INFIRMARY

650 CONCORD AVENUE CAMBRIDGE, MASSACHUSETTS 02138

Item 6: Personnel Problems

Sick-time abuse is not a problem in the Dietary Department. There were three legitimate Medical LOA's in 1982 resulting in those people being out more than 15 days. Those people are Pat Driscoll, Bob Masterson, and Ana Maria Goncalves, the last being out on Workman's Compensation since August, 1982.

The foremost employee discipline problem has been written up in report form complete with documentation of all incidents and given to the City Manager as well as to Alan Cherish. It is my understanding that a severe written warning will be issued to [redacted] with the understanding that should any incident re-occur, termination proceedings will commence.

CITY OF CAMBRIDGE

MAYOR MICHAEL J. NEVILLE MANOR

650 CONCORD AVENUE CAMBRIDGE, MASSACHUSETTS 02138

February 1, 1981

Emergency Sanitation Procedure

In the event of a drainage back-up:

1) Stop all food production and close off the department.
2) Cover and store all foodstuffs in walk-in.
3) Immediately put up "Wet Floor - Caution" signs.
4) Notify the following administrative personnel:

Mr. ~~Lynskey~~ Mulcahy	Page # 781-0942 / or ext. 12	If on off hours notify East II that Mr. Lynskey has been called.
Mr. Stevens	864-2696 or ext. 30	
Mr. Mulcahy	ext. 10	
Ms. Boccadori	846-5366	

5) Call all units to stop use of plumbing facilities.
6) Siphon, mop, and squeegie water.
7) When all water has drained saitize floor with Mikroklene solution.
8) Sanitize all food contact surfaces.
9) All employees are to thoroughly scrub their hands with Surgi-Bac.

Reviewed 2-5-82 BLB
Reviewed 1-11-83, BLB

CITY OF CAMBRIDGE

THE CAMBRIDGE INFIRMARY

650 CONCORD AVENUE CAMBRIDGE, MASSACHUSETTS 02138

PROCEDURE FOR AIR-DRYING PLASTIC ITEMS*

1) All pitchers are to be stored upright without lids.

2) All plate covers are to be run through the dishmachine last and left in racks, not stacked. They will remain in these racks until it is time for the next meal to be served. Five minutes before the trayline is to start, the porter on dishroom duty will collect the covers and take them to the serving area.

3) All mugs are to be left in racks until just prior to meal serving times ofr lunch and supper. After supper when the breakfast trays are being set up, mugs are put on the trays upright to allow them to air-dry further overnight.

4) All trays will be air-dried by setting them upright in racks after being run through the dishmachine. They will remain this way for 1 hour after breakfast and lunch, and overnight after supper.

*All surfaces used for airdrying are sanitized right before each usage period with a mikroklene solution.

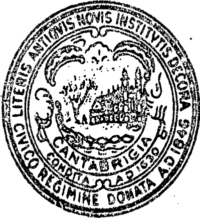
CITY OF CAMBRIDGE

THE CAMBRIDGE INFIRMARY

650 CONCORD AVENUE CAMBRIDGE, MASSACHUSETTS 02138

Synopsis of Dietary Department Programs

- Enforced uniform policy including proper hair coverings and footwear.
- Established Safety Program including Safety Committee, safety inspection tags on equipment, and monthly Safety Inspections. Safety Board on display.
- Quality Assurance Program in effect including weekly tray evaluations and temperature tests, and total sanitation inspections performed monthly.
- Patient Satisfaction Surveys conducted twice per year, in May and November with results and suggestions utilized in revision of menus.
- Posted daily work schedules for each position within the department.
- Posted Emergency and Fire Procedure; Emergency numbers posted on the outsides of all department doors and next to all phones.
- Monthly inservices scheduled one year in advance, covering such topics as safety, review of fire procedure, sanitation, personal hygiene, portion control, therapeutic diets, nutritional principles, and courtesy, to name a few.
- Department meetings and Patient Visitation held on a regular basis.
- Temperature logs maintained daily for dishmachine, reachins, and walkins.
- Policy & Procedure Manual written specifically for this facility, updated annually. Contains all policies pertaining to every facet of running the Dietary Department.
- Special events held once per month in conjunction with the Recreation Department. Other pace changers include monthly birthday parties, holiday feasts, and family night.
- Job descriptions current for all positions.
- Orientation program for all new employees which includes tour of building, review of policy and procedure manual, and signing off of "Safety Rules" Sheet.
- Weekly inventories conducted by Food Service Manager.
- Perpetual maintenance program for all equipment.
- Quality Assurance Audits conducted twice per year by Food Service Director and Food Service Manager.
- Personnel files maintained for all employees including appraisals and documentation of disciplinary action.



ATTACHMENT E

CITY OF CAMBRIDGE

CAMBRIDGE, MASSACHUSETTS 02139
Tel. 498-9011

EXECUTIVE DEPARTMENT
ROBERT W. HEALY
City Manager

February 9, 1983

In order to relieve any concerns that the families of the patients at Mayor Michael J. Neville Manor may have as a result of recent newspaper articles about the Nursing Home, we are writing to all of you to inform you of the current status.

During a recent routine Massachusetts Department of Public Health inspection of the facility, deficiencies were noted. The majority of these have already been addressed. The remaining deficiencies are in the process of correction by a multi-disciplinary team of health care experts from the City's Department of Health and Hospitals.

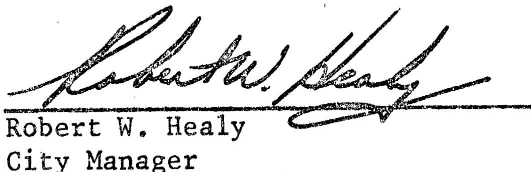
Additionally, the Administrator and Director of Nursing have resigned. While a search for well-qualified people to fill these positions proceeds, Beverly Gorvine, R. N., Director of Nursing at Cambridge Hospital has been appointed Acting Director of Nursing at Neville Manor. To further improve patient care, Penny Woody, R. N., Assistant Director for Nursing Operations at Cambridge Hospital has been appointed Acting Assistant Director of Nursing at Neville Manor. James Mulcahy, Assistant Administrator at Neville Manor for over ten years has been appointed Acting Administrator during this interim period.

The Mayor, the City Council, the City Manager and the Commissioner of Health and Hospitals want to assure you that we are all working together in a continuing effort to provide quality care to the patients at Neville Manor.

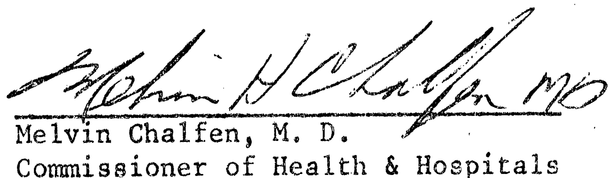
Should you have any questions, please contact James Mulcahy at 492-6310 or Melvin Chalfen, M. D. at 498-1486.

Again, we repeat that quality care will continue to be provided at the City's Nursing Home.

Very truly yours,



Robert W. Healy
City Manager



Melvin Chalfen, M. D.
Commissioner of Health & Hospitals

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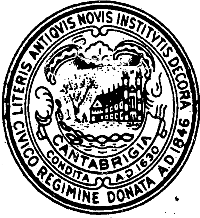


CITY OF CAMBRIDGE

CAMBRIDGE, MASSACHUSETTS 02139
Tel. 498-9011

EXECUTIVE DEPARTMENT
ROBERT W. HEALY
City Manager

February 28, 1983

To the Honorable, the City Council:

The following is a report on the conditions which have existed at Neville Manor and which have led to the recent action by the Massachusetts Department of Public Health, whereby the City has been placed on notice that the Department is commencing actions to decertify our 73 Level II beds. In addition, I have included my plan of action for correcting all outstanding deficiencies and provisions for strong leadership and management in order to provide a high level of long-term care necessary to meet and/or exceed all State standards.

Enclosed (Attachment A) you will find copies of the State surveyor's comments and deficiencies from the survey inspection conducted in June of 1982 and the plan for corrective action as submitted by Mr. Lynskey at that time. After the June, 1982 inspection, a subsequent follow-up inspection took place in November of 1982 (Attachment B). In both instances, exit interviews were conducted by the State surveyor with Mr. Lynskey. The result of the November, 1982 inspection showed that not only did some of the June, 1982 deficiencies remain uncorrected, but, in fact, several additional deficiencies were cited. These new deficiencies were of a very serious nature and indicated severe problems with Administration and Nursing services.

When I learned that additional deficiencies had developed from June to November, I instructed Dr. Chalfen to obtain from Mr. Lynskey his plan for corrective action against all deficiencies as well as devote more of hiw own (Dr. Chalfen) time to Neville Manor. At a meeting on January 7, 1982 I placed Mr. Lynskey on probation due to his performance as indicated by the surveyor's comments in the June and November, 1982 deficiency reports, and he was to file his plan for corrective action to Dr. Chalfen and to me.

It was not until January 28, 1982, when Mr. Rossi and Dr. Chalfen attended a meeting with Attorney Kenneth Behar, that a full report was given to me outlining the seriousness of this action by the State and the meaning of the timetable of 120 days for either total corrective action or decertification became fully clear.

On Tuesday, February 1, 1983, Mr. Rossi and I conducted an unannounced inspection of our own and noted several deficiencies, many of the same, as noted by the State, still clearly uncorrected.

On Thursday, February 3, 1983, a meeting was scheduled with several officials of the Department of Public Health, Mr. Rossi, Dr. Chalfen and myself, where we asked the State for informal reconsideration of their 120-day automatic cancellation period, and the City also submitted its plan for corrective action at this time. Although the State denied reconsideration, they did comment favorably on my plan for corrective action and indicated that another inspection could take place sixty (60) days from February 4, 1983 and if, in fact, the deficiencies were corrected, then the process to decertify the 73 Level II beds would cease, and Neville Manor would once again be in good standing.

On Friday, February 4, 1983, I received the resignations of Mr. Lynskey, the Administrator, and Mrs. Renzi, the Director of Nursing. That evening, Mr. Rossi and I conducted a meeting at Neville Manor with Dr. Chalfen, Mr. Mulcahy, Beverly Gorvine (Director of Nursing at the Cambridge Hospital), and Penny Woody (Assistant Director of Nursing at the Cambridge Hospital). Effective at 5:00 P. M. on February 4, 1983, Mr. Mulcahy was appointed the Acting Administrator, Beverly Gorvine was appointed the Acting Director of Nursing, and Penny Woody was appointed the Acting Assistant Director of Nursing, Neville Manor. (See Attachment C).

The next phase of my plan for corrective action was to instruct Dr. Chalfen to have the senior management staff at the Hospital become familiar with all deficiencies at Neville Manor and to assist in the implementation of the plan for corrective action. On a regular basis, Dr. Chalfen, Mr. Rossi, and I have met at Neville Manor and reviewed progress towards our goal. To date, I am well satisfied with the actions taken, and feel confident that we will meet our 60-day goal and be ready for another inspection. Summary reports for corrective action have been enclosed (See Attch.D).

In addition to the City support, I have engaged the services of Suzanne Hamlett, a long-term care consultant and former surveyor for the State Department of Public Health, to give us proper guidance towards our goal. Ms. Hamlett has an excellent reputation with the Department of Public Health and will be particularly valuable with her in-depth knowledge of the public health regulations and the manner in which to correct deficiencies. Ms. Hamlett's expertise is in dealing with nursing homes in receivership or under the decertification process.

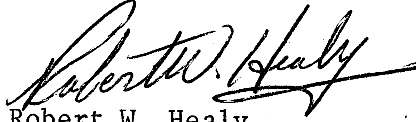
Of serious concern are issues related to personnel, especially staffing of nurses and nurses' aides. The advertisements for the Administrator and Director of Nursing were placed in the Boston Globe on Sunday, February 20, 1983. The Hospital's nurse recruiter, Ellen Costello, has identified the vacant nursing and nursing aide positions which we are now in the process of filling.

Disciplinary actions have been taken where warranted. In-service training and orientation, which was minimal, is now being instituted in professional as well as non-professional positions. Discussions have taken place with union representatives and their commitment to support any actions to improve the level of service to patients at Neville Manor has been most helpful.

Each family of patients at Neville Manor has received a letter from the City (Attachment E) which insures the safety and well-being of the patients and states the City's commitment towards providing a high level of patient care.

Please be assured that I have considered this situation a top priority matter for the City Manager's Office and I will continue to see to it that all the proper resources needed to provide proper patient care and reverse the decertification process will be committed by me and my staff. Furthermore, the actions which are currently being undertaken will provide stronger leadership, better management for the future, and more effective communication, all leading to quality patient care. I am well aware of the degree of importance placed on this matter by the City Council and will work extremely hard to insure a favorable resolution of the problems.

Very truly yours,



Robert W. Healy
City Manager

RWH/mbf
Encs. 5

Agenda Item Number Thirteen 5-109

Re: report on conditions at the Neville Manor and a plan of action ot correct all outstanding deficiencies in order to meet or exceed State standards.

In City Council,

February 28, 1983

2/28/83

Placed on File