STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225476	A. BUILDING _____ B. WING _____	**10/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLES REHABILITATION & NURSING CENTER	**90 TAUNTON STREET WRENTHAM, MA 02093**

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review and facility policy review the facility failed to investigate a bruise of unknown origin for Resident #1 from a total sample of 3 residents. Findings include: Review of the facility policy titled Incident Reporting dated 10/17/19, indicated the following: Policy- An incident is defined as any event that occurs, involving residents, visitors or staff, that is not consistent with the desired outcomes of care provided by the facility, whether or not injury results. Procedure- *All incidents involving residents and/or their care will be reported to the Nurse Manger/Nursing Supervisor immediately at the time of the incident. *When an incident involving a resident occurs, the nurse will document the incident or accident in the nursing progress notes and complete an incident report, at the time the incident occurred, after the resident is cared for. The report will contain information that is complete, pertinent, factual, accurate, objective and concise. The individual completing the report should sign the incident report. The nurse must contact the family and physician. *The nurse begins an investigation for any fall resulting in injury any finding of injury (bruise, skin tear, and abrasion) that is not witnessed and the resident cannot state what happened. This documentation must be completed and kept with the incident report. The nurse will obtain employee statements from all staff working at the time of the incident. *The Nurse Manager or Supervisor is responsible for the ongoing investigation of any accidents/incidents not witnessed. *Any findings of injury (bruise, skin tear, and abrasion) that is not witnessed and the resident cannot state what happened are reviewed by the Nurse Manager or Supervisor as potential for abuse. Resident #1 was admitted to the facility in August 2014 with [DIAGNOSES REDACTED]. Review of Resident #1's medical record indicated a quarterly Minimum (MDS) data set [DATE], which indicated that Resident #1 scored 3 out of 10 on the Brief Interview for Mental Status indicating that Resident #1 had severe cognitive loss. The Minimum Data Set further indicated that Resident #1 was independent with eating, did not ambulate, used a wheel chair, required extensive assistance with locomotion, dressing and hygiene, was dependent with toileting and required help with part of bathing. On 10/5/20 at 10:25 A.M., The surveyor observed Resident #1 sitting in his/her wheelchair in the hallway. The surveyor observed that Resident #1's entire ring finger on his/her right hand was purple. Review of Resident #1's Nurses's notes dated 9/1/20 through 10/4/20 failed to indicate any notes regarding Resident #1's right ring finger. Review of Resident #1's Weekly Skin Checks failed to indicate any documentation regarding Resident #1's right ring finger. Weekly skin checks indicated the following: 9/3/20-Dry scab to the back of neck, area treated as ordered. 9/10/20-Dry scab to the back of neck, area treated as ordered. 9/17/20-Dry scab to the back of neck, area treated as ordered. 9/24/20-Dry scab to the back of neck, area treated as ordered. 10/1/20 -Dry area to the back of the neck. During an interview on 10/5/20, at 10:30 A.M., Nurse #1 said that she knew nothing about Resident #1's right ring finger being purple, she said that maybe it was an old bruise. Nurse #1 further said that it wasn't reported to her by the nurse who gave her report or Resident #1's Nurse's Aide who provided his/her morning care. During an interview on 10/5/20, at 10:42 A.M., Nurse #1 said that she couldn't find any mention of Resident #1's right ring finger being purple in Resident #1's medical record. She further said that she would follow the facility policy and investigate and complete an incident report. During an interview on 10/5/20, at 12:30 P.M., Certified Nurse's Aide #1 said that she provided care to Resident #1 around 9:30 A.M., and she did not notice the purple bruise to the right ring finger until later on when Nurse#1 showed her Resident #1's right ring finger. During an interview on 10/5/20, at 1:16 P.M., Coordinator of Educator #1 confirmed that an incident report or investigation had not been started for Resident #1's right ring finger prior to the surveyor mentioning the purple right ring finger to the nursing staff. She further said that the policy is to start an investigation, incident report and to notify the doctor and responsible party.

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