STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225720	A. BUILDING _____ B. WING _____	09/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE ONE AT MILLBURY	312 MILLBURY AVENUE MILLBURY, MA 01527

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 0656 **Level of harm -** 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), who required the assistance of two staff members for positioning and personal care while in bed, the Facility failed to ensure that Resident #1's care plan interventions were implemented by staff, when Certified Nurse Aide (CNA) #3, provided personal care which included repositioning Resident #1, without another staff member present to help. CNA #3 rolled Resident #1 onto his/her side, Resident #1's legs than began to slide off the lower end of the bed, CNA #3 was unable to stop Resident #1 from sliding completely off the bed, and lowered Resident #1's upper body to the floor. Resident #1 was transferred to the Hospital Emergency Department where his/her [DIAGNOSES REDACTED]. Findings Include: A Facility Policy titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each Resident. An Activity of Daily Living (ADL) Self Care and Mobility Deficit Care Plan, dated as reviewed and revised on 5/28/20, indicated that Resident #1 required assistance with bed mobility, incontinence care, bathing, dressing related to pain, weakness, and physical limitations. The Care Plan interventions that indicated Resident #1 required the physical assistance of two staff members for side to side positioning in bed while providing personal care. A Quarterly Minimum Data Set (MDS), dated [DATE], indicated that Resident #1's [DIAGNOSES REDACTED]. The MDS indicated that Resident #1 required the assistance of two staff members for bed mobility and personal hygiene. An Incident and Accident Report, dated 7/08/20, indicated that, at 4:00 A.M., Certified Nurse Aide (CNA) #3, while providing care to Resident #1, Resident #1 grabbed the 1/4 siderails to help with rolling over in bed, as Resident #1 rolled over towards CNA #3, Resident #1's legs began to slide off the bed and CNA #3 was able to lower Resident #1's upper body to the floor. The Report indicated that Nurse #1 went into Resident #1's room and observed him/her lying on the floor on his/her right side, bleeding from his/her left leg. The Report indicated 911 was called and Resident #1 was transferred to the Hospital Emergency Department for evaluation. A Hospital Transfer Form, dated 7/08/20, indicated that Resident #1 was transferred to the Hospital with complaints of left leg and back pain after he/she sustained a fall. A Written Witness Statement, dated 7/08/20 and signed by CNA #3, indicated that Resident #1 asked him (CNA #3) to change him/her because he/she was wet. The Statement indicated that he (CNA #3) attempted to find another staff member to assist him, however other staff members were busy at the time. The Statement indicated Resident #1 was irritated, that Resident #1 insisted on being changed, and that he (CNA #3) provided care to Resident #1 in bed without assistance of another staff member. The Statement indicated that as he (CNA #3) was about to finish up with the care for Resident #1, as he rolled Resident #1 towards him, Resident #1 over-pulled on the side rail which caused his/her legs to slip off the wet air mattress and his/her whole body followed. The Statement indicated that Resident #1 fell to the floor and that he (CNA #3) was unable to stop the fall due to the height of the bed. The Statement indicated Resident #1 had refused to let him (CNA #3) place into a lower position. During an interview on 9/4/20 at 1:33 P.M., CNA #3 said that at the time of the incident he was aware Resident #1 required the assistance of two staff members for care provided in bed. CNA #3 said he looked for another staff member to assist him but the other CNA was on a break, one of the nurses had to leave the unit and the other nurse was in another resident's room, so he went back into Resident #1's room and proceeded to change him/her. During an interview, on 9/03/20 at 12:39 P.M., the Unit Manager said that the day after Resident #1 fell , she and the Director of Nursing (DON) met with CNA #3 so he could explain how Resident #1's fall occurred. The Unit Manager said that Resident #1's care plan indicated that he/she required two staff members to provide care while in bed. The Unit Manager said CNA #3 said he was aware that Resident #1 required two people for care in bed, and said he had looked for another staff member for assistance. The Unit Manager said that CNA #3 told her the height of the bed was raised to approximately four feet in height, and that CNA #3 said Resident #1 didn't want him to lower the bed. During an interview on 9/16/20 at 1:17 P.M., Nurse #1 said that on 7/08/20, at the time of Resident #1's fall, she was in another resident's room and heard CNA #3 yelling that there was an emergency. Nurse #1 said she went into Resident #1's room, observed him/her on the floor bleeding and said he/she complained of pain. Nurse #1 said 911 was called and Resident #1 was transferred to the Hospital. An Emergency Department Note, dated 7/8/20, indicated that Resident #1 sustained bilateral femoral fractures (bone that runs from hip to knee), bilateral tibia-fibula fractures (bones in lower legs), and that there were concerns with Resident #1 maintaining his/her blood pressure. A Hospital Consultation Note, dated 7/8/20, indicated that Resident #1's injuries were deemed non-operative and his/her wounds were treated and dressings were applied. During an interview on 9/3/20 at 1:35 P.M., the Assistant Director of Nursing (ADON) said that if a resident required two staff members for assistance with care, staff should wait for a second person to come help before care is provided. During an interview on 9/16/20 at 12:09 P.M., the Director of Nurses (DON) said Resident #1 required assistance of two staff members for care and said although Resident #1 wanted something done and wanted it done right away, the DON said CNA #3 should have followed Resident #1's care plan and should have waited for the nurse's assistance. As the cited deficiency was determined to be corrected at the time of our visit, no plan of correction is required. On 9/3/20, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction which addressed the area of concern as evidenced by: A. Resident #1 no longer resides at the Facility. B. The Unit Managers, ADON, and DON conducted Medical Record audits on all residents to ensure residents, who required air mattresses and assistance of two staff members while in bed, had an updated CNA Kardex and that Care Plan interventions reflected two staff member assistance. Audits were completed by 7/11/20. C. The Unit Managers, ADON, and DON conducted Audits for the use of Air Mattress Audit to determine the need for side bolster inflation for additional safety. Audits were completed by 7/11/20. D. The DON in-serviced Nursing Staff with mandatory education about how to handle residents insistent on unsafe care that is not consistent with their Care Plan, air mattress safety, ensuring kardex is reviewed with agency staff. Mandatory nursing staff education was completed by 7/13/20. E. The Unit Managers, ADON, and DON conducted random observations weekly (10% of resident census weekly) to ensure that Certified Nurse Aides provided bed mobility in accordance with resident care plans. Random operations were completed from 7/16/20-8/21/20. F. The Unit Managers, ADON, and DON conducted random weekly staff interviews to ensure that staff provided appropriate level of assistance with mobility, positioning and air mattress safety. Random staff interviews were completed from 7/16/20-8/21/20. G. Quality Assurance Performance Improvement (QAPI) Meeting conducted 7/8/20 and area of concerns discussed with committee and will continue for next two months (at a minimum). H. The DON and his/her designee is responsible for overall compliance.
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**

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

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.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), who required the assistance of two staff members for side to side positioning and personal care while in bed, the Facility failed to ensure the appropriate level of staff assistance was provided during care to ensure safety and prevent injury when, on 7/08/20, Resident #1 fell out of bed while Certified Nurse Aide #3 positioned him/her onto his/her side when he provided personal care without the assistance of another staff member. Resident #1 was transferred to the Hospital Emergency Department where his/her [DIAGNOSES REDACTED]. Findings Include: An Activity of Daily Living (ADL) Self Care and Mobility Deficit Care Plan, dated as reviewed and revised on 5/28/20, indicated that Resident #1 required assistance with bed mobility, incontinence care, bathing, dressing related to pain, weakness, and physical limitations. The Care Plan interventions that indicated Resident #1 required the physical assistance of two staff members for side to side positioning in bed while providing personal care. A Quarterly Minimum Data Set (MDS), dated [DATE], indicated that Resident #1's [DIAGNOSES REDACTED]. The MDS indicated that Resident #1 required the assistance of two staff members for bed mobility and personal hygiene. An Incident and Accident Report, dated 7/08/20, indicated that, at 4:00 A.M., Certified Nurse Aide (CNA) #3, while providing care to Resident #1, Resident #1 grabbed the 1/4 siderails to help with rolling over in bed, as Resident #1 rolled over towards CNA #3, Resident #1's legs began to slide off the bed and CNA #3 was able to lower Resident #1's upper body to the floor. The Report indicated that Nurse #1 went into Resident #1's room and observed him/her lying on the floor on his/her right side, bleeding from his/her left leg. The Report indicated 911 was called and Resident #1 was transferred to the Hospital for evaluation. A Hospital Transfer Form, dated 7/08/20, indicated that Resident #1 was transferred to the Hospital with complaints of left leg and back pain after he/she sustained a fall. A Written Witness Statement, dated 7/08/20 and signed by CNA #3, indicated that Resident #1 asked him (CNA #3) to change him/her because he/she was wet. The Statement indicated that he (CNA #3) attempted to find another staff member to assist him, however other staff members on the unit were busy at the time. The Statement indicated Resident #1 was irritated, that Resident #1 insisted on being changed, and that he (CNA #3) provided care to Resident #1 in bed without assistance of another staff member. The Statement indicated that as he (CNA #3) was about to finish up with the care for Resident #1, as he rolled Resident #1 towards him, Resident #1 over-pulled on the side rail which caused his/her legs to slip off the wet air mattress and his/her whole body followed. The Statement indicated that Resident #1 fell to the floor and that he (CNA #3) was unable to stop the fall due to the height of the bed. The Statement indicated Resident #1 had refused to let him (CNA #3) place into a lower position. During an interview on 9/4/20 at 1:33 P.M., CNA #3 said he worked on the night shift (11:00 P.M. to 7:00 A.M.) on the morning that Resident #1 fell out of bed. CNA #3 said that at the time of the incident he was aware Resident #1 required the assistance of two staff members for care provided in bed. CNA #3 said he looked for another staff member to assist him, and said the other CNA was on a break, one of the nurses had to leave the unit for something, and the other nurse was in another resident's room, so he went back into Resident #1's room and proceeded to change him/her. CNA #3 said the two upper side rails on Resident #1's bed were raised, the air mattress was inflated, and the bed was raised to approximately the height of his waist which he said was approximately three and a half feet. CNA #3 said Resident #1 was lying on his/her left side facing him, he provided incontinence care, walked over to the other side of the bed and then asked Resident #1 to roll from his/her left side onto his/her back. CNA #3 said he continued to provide care, then asked Resident #1 to hold onto the side rail so he/she could roll onto his/her right side towards him (CNA #3). CNA #3 said he placed a hand on Resident #1's left shoulder and hip and pulled Resident #1 to guide him/her while Resident #1 simultaneously shifted his/her body. CNA #3 said Resident #1 moved his/her legs and with that momentum, Resident #1's legs went over the edge of the bed and gravity took over. CNA #3 said although he attempted to push Resident #1's legs back onto the bed, his/her whole body followed and he was unable to stop Resident #1 from falling out of the bed and said Resident #1 landed on his/her knees on the floor. During an interview, on 9/03/20 at 12:39 P.M., the Unit Manager said that the day after Resident #1 fell , she and the Director of Nursing (DON) met with CNA #3 so he could explain how Resident #1's fall occurred. The Unit Manager said that Resident #1's care plan indicated that he/she required two staff members to provide care while in bed. The Unit Manager said CNA #3 said he was aware that Resident #1 required two people for care in bed, and said he had looked for another staff member for assistance. The Unit Manager said that CNA #3 told her the height of the bed was raised to approximately four feet in height, and that CNA #3 said Resident #1 didn't want him to lower the bed. During an interview on 9/16/20 at 1:17 P.M., Nurse #1 said that on 7/08/20, at the time of Resident #1's fall, she was in another resident's room and heard CNA #3 yelling that there was an emergency. 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