STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225002	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HOLDEN REHABILITATION & NURSING CENTER	32 MAYO ROAD HOLDEN, MA 01520

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 #2), whose plan of care for falls included an intervention not to be left alone in the bathroom, the Facility failed to ensure staff implemented this safety intervention, when on 5/7/20 Certified Nurse Aide (CNA) #2 left Resident #2 unattended in the bathroom, he/she fell and required transfer to the Hospital Emergency Department, where he/she was diagnosed with [REDACTED]. Findings include: Resident #2 was admitted to the Facility in April 2015, [DIAGNOSES REDACTED]. The Policy, titled Fall Prevention Program, dated 12/9/10, indicated the following: - Provide care plan approaches to assist in preventing falls for residents who were assessed to be at high risk for falls. - Once a resident was identified at risk for falls, the resident's risk factors would be assessed and a care plan would be developed to minimize the resident's risk of falling. Review of Resident #2's Plan of Care related to Falls, Risk of Injury, related to unstable gait, history of falls, dated as initiated 9/0718, revised 4/2020, indicated Resident #2 was at risk for falls, and interventions included that staff would not leave Resident #2 in the bathroom unattended. The Plan of Care also indicated Resident #2 required the use of bed and chair alarms at all times. The Fall Risk Assessments, dated 2/05/20 and 5/07/20, indicated Resident #2 was at increased risk for falls, had a history of [REDACTED]. The CNA Care Card, indicated Resident #2 was at risk for falls, and interventions included staff were not to leave Resident #2 unattended in the bathroom and that he/she required the use of bed/chair alarms at all times. The Occurrence Note, dated 5/7/20, indicated Resident #2 had an unwitnessed fall in the bathroom at 3:07 P.M., and was found lying on his/her back and was bleeding a moderate amount of blood from the back of his/her head. The Occurrence Note indicated Resident #2 complained of pain in his/her hip, however was not able to say which side, and was transferred by 911 to the Hospital emergency room . The Hospital Discharge Summary, dated 5/11/20, indicated Resident #2 was transferred to the Hospital Emergency Department on 5/7/20 after an unwitnessed fall at the Facility. The Discharge Summary indicated Resident #2 sustained a laceration to the back of his/her scalp, a right [MEDICAL CONDITION], and a right lateral compression type 1 (front pelvic ring) pelvic fracture. The Discharge Summary indicated Resident #2 required surgery to treat his/her [MEDICAL CONDITION]. During interview on 8/26/20 at 3:00 P.M., CNA #2 said that on 5/7/20 at approximately 3:05 P.M., she transferred Resident #2 from his/her wheelchair to the toilet. CNA #2 said she needed to get some towels to provide care to Resident #2, and left Resident #2 on the toilet unattended to gather supplies. CNA #2 said she then heard Resident #2 yell and when she returned to the bathroom, found Resident #2 lying on the floor in the bathroom, bleeding from the back of his/her head. CNA #2 said she was aware that Resident #2 was at risk for falls, said she knew she should not have left him/her in the bathroom unattended, but said the linen cart was right outside the door to Resident #2 room and thought she could grab towels quickly. During interview on 8/26/20 at 11:01 A.M., Unit Manager #1 said Resident #2 was assessed to be at risk for falls, and his/her plan of care included that staff would not leave him/her unattended in the bathroom. Unit Manager #1 said CNA #2 should not have left Resident #2 unattended in the bathroom. During interview on 8/26/20 at 9:22 A.M., The Director of Nurses (DON) said Resident #2 was known to be at risk for falls, and said CNA #2 should not have left him/her in the bathroom unattended. On 8/26/20 the Facility was found to be in Past Non-Compliance and provided the Surveyor with a plan of correction which addressed the area of concern as evidenced by the following: A) Resident #2 returned to the facility on [DATE], and was referred to Physical Therapy services for transfers. A new fall risk assessment was completed for Resident #2 upon readmission. B) The Staff Education In-service Attendance Sheet, dated 5/7/20, indicated staff were re-educated to not leave residents that are confused or who have pressure sensitive alarms unattended in the bathroom. C) The Facility's Performance Improvement Action Plan (PIP), dated 5/10/20, indicated the Facility performed a root cause analysis of Resident #2's fall on 5/7/20. D) The PIP indicated the Facility would re-educate staff not to leave residents who are confused or unsafe unattended in the bathroom, and indicated falls would be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee for three months E) The QAPI meeting records, dated 5/20/20, 6/17/20, and 7/15/20 indicated falls were monitored by the Interdisciplinary Team, and the PIP was reviewed. F) The QAPI meeting records and PIP indicated the Director of Nurses or designee was responsible for monitoring ongoing 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #2), who was confused and assessed as being at increased risk for falls, the Facility failed to ensure staff provided necessary supervision to prevent a fall. On 5/7/20 Certified Nurse Aide (CNA) #2 left Resident #2 unattended in the bathroom, he/she fell and required transfer to the Hospital Emergency Department, where he/she was diagnosed with [REDACTED]. Resident #2 was admitted and required surgical intervention of the right [MEDICAL CONDITION]. Findings include: Resident #2 was admitted to the Facility in April 2015, [DIAGNOSES REDACTED]. Review of Resident #2's Plan of Care related to Falls, Risk of Injury, related to unstable gait, history of falls, dated as initiated 9/0718, revised 4/2020, indicated Resident #2 was at risk for falls, and interventions included that staff would not leave Resident #2 in the bathroom unattended. The Plan of Care also indicated Resident #2 required the use of bed and chair alarms at all times. The Fall Risk Assessments, dated 2/05/20 and 5/07/20, indicated Resident #2 was at increased risk for falls, had a history of [REDACTED]. The CNA Care Card, indicated Resident #2 was at risk for falls, and interventions included staff were not to leave Resident #2 unattended in the bathroom and that he/she required the use of bed/chair alarms at all times. The Policy, titled Fall Prevention Program, dated 12/9/10, indicated that once a resident was identified at risk for falls, the resident's risk factors would be assessed and a care plan would be developed to minimize the resident's risk of falling. The Occurrence Note, dated 5/7/20, indicated Resident #2 had an unwitnessed fall in the bathroom at 3:07 P.M., and was found lying on his/her back and was bleeding a moderate amount of blood from the back of his/her head. The Occurrence Note indicated Resident #2 complained of pain in his/her hip, however was not able to say which side, and was transferred by 911 to the Hospital emergency room . The Hospital Discharge Summary, dated 5/11/20, indicated Resident #2 was transferred to the Hospital Emergency Department on 5/7/20 after an unwitnessed fall at the Facility. The Discharge Summary indicated Resident #2 sustained a laceration to the back of his/her scalp, a right [MEDICAL CONDITION], and a right lateral compression type 1 (front pelvic ring) pelvic fracture. The Discharge Summary indicated Resident #2 required surgery to treat his/her [MEDICAL CONDITION]. During interview on 8/26/20 at 3:00 P.M., CNA #2 said that on 5/7/20 at approximately 3:05 P.M., she transferred Resident #2 from

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) his/her wheelchair to the toilet. CNA #2 said she needed to get some towels to provide care to Resident #2, and left Resident #2 on the toilet unattended to gather supplies. CNA #2 said she then heard Resident #2 yell and when she returned to the bathroom, found Resident #2 lying on the floor in the bathroom, bleeding from the back of his/her head. CNA #2 said she was aware that Resident #2 was at risk for falls, said she knew she should not have left him/her in the bathroom unattended, but said the linen cart was right outside the door to Resident #2 room and thought she could grab towels quickly. During interview on 8/26/20 at 11:01 A.M., Unit Manager #1 said Resident #2 was assessed to be at risk for falls, and his/her plan of care included that staff would not leave him/her unattended in the bathroom. Unit Manager #1 said CNA #2 should not have left Resident #2 unattended in the bathroom. During interview on 8/26/20 at 9:22 A.M., The Director Of Nurses (DON) said Resident #2 was known to be at risk for falls, and said CNA #2 should not have left him/her in the bathroom unattended. As a result of this survey, the Department determined that at a point in time prior to the date of our visit, you were not in substantial compliance with the Federal Regulations applicable to long-term care. On 8/26/20 the Facility was found to be in Past Non-Compliance and provided the Surveyor with a plan of correction which addressed the area of concern as evidenced by the following: A) Resident #2 returned to the facility on [DATE], and was referred to Physical Therapy services for transfers. A new fall risk assessment was completed for Resident #2 upon readmission. B) The Staff Education In-sensitive Attendance Sheet, dated 5/7/20, indicated staff were re-educated to not leave residents that are confused or who have pressure sensitive alarms unattended in the bathroom. C) The Facility's Performance Improvement Action Plan (PIP), dated 5/10/20, indicated the Facility performed a root cause analysis of Resident #2's fall on 5/7/20. D) The PIP indicated the Facility would re-educate staff not to leave residents who are confused or unsafe unattended in the bathroom, and indicated falls would be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee for three months E) The QAPI meeting records, dated 5/20/20, 6/17/20, and 7/15/20 indicated falls were monitored by the Interdisciplinary Team, and the PIP was reviewed. F) The QAPI meeting records and PIP indicated the Director of Nurses or designee was responsible for monitoring ongoing compliance.