

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Charlwell House Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Walpole Street Norwood, MA 02062	

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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>40702</p> <p>Based on records reviewed and interviews for three of three sampled residents (Resident #1, #2, and #3), the Facility failed to ensure they maintained complete and accurate medical records, related to Certified Nurse Aide (CNA) Activity of Daily Living (ADL) Flow Sheets, when daily documentation by CNA's were not consistently completed, with ADL Flow Sheets often left completely blank.</p> <p>Findings Include:</p> <p>Review of the Facility's Policy titled Charting and Documentation, dated as last revised July 2017, indicated all services provided to the resident, progress towards care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The Policy further indicated documentation in the medical record will be complete and accurate.</p> <p>Review of the Facility's documentation for care and services provided by CNA's is recorded on the Facility's document titled Documentation Survey Report v2, going forward in this deficiency the document will be referred as the Resident's ADL Flow Sheet.</p> <p>1) Resident #1 was admitted to the Facility in June 2023, diagnoses included adult failure to thrive, dysphagia (difficulty swallowing), Alzheimer's, dementia, and contracture of right lower leg (shortening and hardening of muscles and tendons).</p> <p>Review of Resident #1's ADL Flow Sheets, dated 04/01/24 through 04/30/24, indicated that for the following shifts, documentation on the flow sheets was incomplete.</p> <p>-7:00 A.M. to 3:00 P.M.- 26 days (out of 30) all care areas were left blank</p> <p>-3:00 P.M. to 11:00 P.M.- 11 days (out of 30) all care areas were left blank</p> <p>-11:00 P.M. to 7:00 A.M.- 24 days (out of 30) all care areas were left blank</p> <p>Review of Resident #1's ADL Flow Sheets, dated 05/01/24 through 05/31/24, indicated that for the following shifts, documentation on the flow sheets was incomplete.</p> <p>-7:00 A.M. to 3:00 P.M.- 13 days (out of 24) all care areas were left blank</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-3:00 P.M. to 11:00 P.M.- 3 days (out of 24) all care areas were left blank</p> <p>-11:00 P.M. to 7:00 A.M.- 18 days (out of 24) all care areas were left blank</p> <p>This does not include dates and shifts when Resident #1 was Medical Leave of Absence (MLOA) 05/09/24 through 05/15/24.</p> <p>Review of Resident #1's ADL Flow Sheets, dated 06/01/24 through 06/05/24, indicated for the following shifts, documentation on the flow sheets was incomplete.</p> <p>-7:00 A.M. to 3:00 P.M.- 3 days (out of 5) all care areas were left blank</p> <p>-11:00 P.M. to 7:00 A.M.- 3 days (out of 5) all care areas were left blank</p> <p>2) Resident #2 was admitted to the Facility in October 2023, diagnoses included polyneuropathy (decreased ability to move or feel sensation), essential tremor (involuntary shaking of body parts), cervical disc disorder at C5-C6 level with myelopathy (injury to spinal cord caused by compression), and hypertensive heart disease without heart failure.</p> <p>Review of Resident #2's ADL Flow Sheets, dated 08/01/24 through 08/12/24, indicated that for the following shifts, documentation on the flow sheets was incomplete.</p> <p>-7:00 A.M. to 3:00 P.M.- 6 to 7 days (out of 12) all care areas were left blank</p> <p>-3:00 P.M. to 11:00 P.M.- 1 day (out of 12) all care areas were left blank</p> <p>-11:00 P.M. to 7:00 A.M.- 7 to 8 days (out of 12) all care areas were left blank</p> <p>3) Resident #3 was admitted to the Facility in May 2024, diagnoses included muscle wasting and atrophy (thinning of muscle mass), Alzheimer's disease, muscle weakness, and adult failure to thrive.</p> <p>Review of Resident #3's ADL Flow Sheets, dated 08/01/24 through 08/12/24, indicated that for the following shifts, documentation on the flow sheets was incomplete.</p> <p>-7:00 A.M. to 3:00 P.M.- 9 days (out of 12) all care areas were left blank</p> <p>-11:00 P.M. to 7:00 A.M.- 8 to 9 days (out of 12) all care areas were left blank</p> <p>During an interview on 08/13/24 at 1:28 P.M., CNA #1 said they are supposed to do their documentation of care provided to residents every day before the end of their shift. CNA #1 said she was not always able to do her documentation because she is so busy, and just does not have time someday's to document the care she provided to the residents.</p> <p>During an interview on 08/13/24 at 2:03 P.M., CNA #2 said they document resident's care in the Point of Care (POC) system on the computer and that it has to be done by the end of the shift. CNA #2 said she does not have time to do her documentation some days because it is very busy and someday's are harder than others to get her work done.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/19/24 at 1:21 P.M., the Former Director of Nursing (DON) said she was aware that the CNA's were not doing ADL documentation daily, that it was a big issue and always a struggle to get them to do their documentation. The Former DON said that the CNA's should have been documenting daily all care that was provided to residents before the end of their shift.</p> <p>During an interview on 08/13/24 at 4:17 P.M., the Interim Director of Nursing (DON) said she was not aware that the CNA ADL Flow sheets were incomplete and said that the CNAs should be doing their daily documentation by the end of their shift. The Interim DON said she expects the CNAs to complete all documentation on care provided to residents daily and that ADL Flow Sheets should not be left blank.</p>		