STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225273	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carleton-Willard Village Retirement & Nursing Ctr	100 Old Billerica Road Bedford, MA 01730

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. 37342 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was assessed by nursing as being at high risk for falls, and whose comprehensive plan of care indicated he/she required the use of monitoring devices (bed and chair alarms) to alert staff when he/she attempted to stand or transfer alone, the Facility failed to ensure staff implemented and followed interventions identified in his/her plan of care, when alarms were not consistently used by staff, and he/she experienced two falls less than 24 hours apart, both of which resulted in an injury. After fall on 5/08/24, Resident #1 sustained a head laceration that required six staples to close, and on 5/09/24, Resident #1 fell again, fractured his/her nose and had a large hematoma (bruise) on his/her forehead. Findings include: The Facility Policy, titled Baseline and Comprehensive Person-Centered Care, dated as revised on 06/15/21, indicated nursing staff would implement a plan of care for each resident to provide effective person-centered care. Resident #1 was admitted to the Facility in May 2024, diagnoses included orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying down and can cause dizziness, lightheadedness, fainting, and other problems), chronic atrial fibrillation, stroke, macular degeneration, and was legally blind. Review of Resident #1's Fall Risk Assessment, dated 05/02/24, indicated he/she was assessed by nursing as being at high risk for falls. Review of Resident #1's Fall Risk Care Plan, dated 05/02/24, (which was provided by the facility in the Report they submitted to the Department of Public Health via the Health Care Facility Reporting System (HCFRS), dated 05/13/24), indicated that his/her interventions included for staff to equip Resident #1 with a device that monitored rising (clarified during the survey by the Director of Nursing to mean bed and chair alarms). However, despite the Fall Risk Care Plan indicating Resident #1 required alarms, review of Resident #1's medical record, dated 5/02/4 through 5/08/24, indicated there was no nursing or CNA documentation to support any type of monitoring device was in place and being monitored by staff, in an effort to maintain Resident #1's safety. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	Review of Resident #1's Nurse Progress Note, dated 05/08/24, indicated that at 05:00 P.M., Resident #1 was found on the floor in his/her room, was bleeding from a laceration on the left side of his/her head, and was transferred to the Hospital Emergency Department. Review of Resident #1's Hospital Emergency Department Discharge Summary, dated 05/08/24, indicated he/she was assessed and treated for a 4 centimeter (cm) laceration to the left side of his/her head as a result of a fall at the Facility, and required 6 staples to close the wound. During an interview on 05/29/24 at 12:39 P.M., Certified Nurse Aide (CNA) #1 said that on 05/08/24 at 5:00 P. M., she saw Resident #1 standing alone in his/her room, and witnessed Resident #1 fall. CNA #1 said Resident #1 did not have any alarms in place or sounding at the time. During an interview on 05/29/24 at 03:09 P.M., CNA #4 said that on 05/08/24 she was the CNA assigned to care for Resident #1 on 05/08/24, and at 05:00 P.M., she was called over by CNA #1 because Resident #1 had fallen, and was bleeding. CNA #1 said Resident #1 did not have any alarms in place at that time. During an interview on 05/29/24 at 02:57 P.M., Nurse #1 said that on 05/08/24 at 05:00 P.M., he was told by CNA #4 that Resident #1 had fallen. Nurse #1 said Resident #1 was bleeding from a laceration on the left side of his/her head and was transferred to the Hospital Emergency Department. Nurse#1 said prior to this incident, Resident #1 did not not have bed or chair alarms in place. Nurse #1 said that when Resident #1 returned to the Facility that night at 9:45 P.M., he implemented bed and chair alarms for Resident #1 as a measure to prevent falls. Review of Resident #1's Nurse Progress Note, dated 05/09/24, indicated that he/she had an unwitnessed fall when CNA #1 left him/her (unattended in the bathroom) on the toilet seat to get linen. The Note indicated CNA #1 said she heard a loud bang, and upon returning to Resident #1's room, found him/her lying on the bathroom floor, was bleeding from his/her nose, had swelling to his/her forehead, and was transferred to the Hospital Emergency Department. Review of Resident #1's Hospital emergency room Discharge Summary, dated 05/09/24, indicated he/she was diagnosed with a closed fracture of the nasal bone as a result of a fall at the Facility. During a telephone interview on 05/29/24 at 11:42 A.M., Certified Nurse Aide (CNA) #2 said that on 05/09/24 at 5:40 A.M., she assisted Resident #1 to the bathroom, and left him/her on the toilet while she went to the linen cart, which was located outside Resident #1's room and a few doors down the hall, to get linen. CNA #2 said when she transferred Resident #1 from his/her bed, there was a bed alarm in place and functioning which she disabled in order to help Resident #1 up from the bed. CNA #2 said she should not have left Resident #1 alone in the bathroom without an alarm in place. CNA #2 said after going to get the linens, she heard a loud bang, and upon returning to the Resident #1's room, found him/her on his/her stomach on the bathroom floor and he/she was bleeding from the laceration on the left side of his/her head he/she had gotten from the fall on 05/08/24. CNA #2 said she could not see if Resident #1 was bleeding from his/her nose. (continued on next page)

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(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	During an interview on 05/29/24 at 03:55 P.M., Nurse #4 said she worked the 11:00 P.M., (05/08/24) to 7:00 A.M., (05/09/24) shift. Nurse #4 said it was reported to her during shift report (from Nurse #1) that Resident #1 had fallen, was transferred to the Hospital Emergency Department where he/she was treated for a laceration to the left side of his/her head. Nurse #4 said Nurse #1 shared in report that he had implemented bed and chair alarms for Resident #1 for safety. Nurse #4 said she checked on Resident #1 throughout her shift and the bed alarm was in place and functioning. Nurse #4 said that on 05/09/24 at 5:40 A.M., CNA #2 informed her that Resident #1 was on the floor in the bathroom. Nurse #4 said Resident #1 was found in the bathroom, lying on the floor on his/her stomach with his/her face on the floor, was bleeding from his/her nose and the laceration at the left side of his/her head, and was transferred to the Hospital emergency room . During an interview on 05/29/24 at 9:03 A.M., The Director of Nurses (DON) said staff should implement alarms when they are identified on a resident's care plan, and said residents who have bed and chair alarms implemented should not be left alone without an alarm in place.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37342 Based on records reviewed and interviews, for one of three sampled residents (Resident #2), who had a history of having sustained a subdural hematoma (pool of blood between the brain and it;s outer covering), the Facility failed to ensure staff provided quality of care consistent with professional standards of practice, when on 5/19/24 after finding Resident #2 on the floor after an unwitnessed fall, two Certified Nurse Aides (CNAs) picked him/her up off the floor and put him/her in bed before informing and having nursing assess him/her for the potential for injury, and as a result, his/her neurological signs were not measured or documented per facility policy in the event of an unwitnessed fall, by nursing. Findings include: The Facility Policy, titled Actual Fall Protocol, dated as revised on 05/03/18, indicated a fall was defined as a problem characterized by the failure to maintain an appropriate lying or sitting position, resulting in an individual's abrupt, undesired relocation to the ground. The Policy indicated that all falls were to be assessed and treated immediately to provide comfort and prevent further injury, the resident should never be moved until the licensed nurse assesses him/her, and any neurological changes. The Facility Policy, titled Neurological Signs for Suspected Head Injury, dated as revised 03/16/19, indicated neurological signs would be assessed on a resident who had sustained or was suspected to have sustained a head injury. The Policy indicated neurological signs would be assessed every two hours for the first 24 hours, then every shift for 48 hours. Resident #2 was admitted to the Facility in July 2019, diagnoses included sepsis, hypertension, history of subdural hematoma, cognitive impairment, and anxiety. Review of Resident #2's Nurse Progress Note, dated 05/19/24, indicated he/she had a skin tear on his/her elbow. The Progress Note indicated he/she denied falling, but was unable to explain how he/she got the skin tear. During an interview on 05/29/24 at 12:39 P.M., Certified Nurse Aide (CNA) #1 said that on 05/19/24 at 10:20 P.M., she found Resident #2 lying on the floor in his/her room. CNA #1 said she got CNA #5, who was assigned to Resident #2, and they lifted Resident #2 up off the floor and put him/her in bed. CNA #1 said when they removed his/her shirt they discovered the skin tear on his/her left arm. CNA #1 said she stayed with Resident #2 and that CNA #5 went to tell Nurse #3 about the incident, and that she (CNA #1) left the room when CNA #5 returned. Review of CNA #5's Written Witness Statement, dated 05/19/24, indicated Resident #2 was sitting on his/her bed and she noticed he/she had a skin tear on his/her left arm. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CNA #5's additional Witness Statement, emailed by CNA #5 to the facility, dated 05/24/24, indicated that on 05/19/24 at 10:20 P.M., CNA #1 told her that Resident #1 was found on the floor in his/her room. The Statement indicated that she (CNA #5) and CNA #1 picked Resident #2 up from the floor and put him/her onto the bed, and when they removed his/her shirt they discovered the skin tear on his/her left arm. The Statement indicated she (CNA #5) reported to Nurse #3 that Resident #2 had a skin tear. However, there was no documentation in either one of CNA #5's statements that indicated she notified Nurse #3 about Resident #2's being found on the floor (after an unwitnessed fall). During a telephone interview on 06/03/24 at 11:34 A.M., Nurse #3 said that on 05/19/24 at 10:30 P.M., Certified Nurse Aide #5 told him that Resident #2 had a new skin tear on his/her left arm. Nurse #3 said when he went to assess Resident #2, he/she was seated on his/her bed and had a skin tear on his/her left elbow that measured 4 centimeters (cm) by 2 cm. Nurse #3 said he asked Resident #2 if he/she fell , and he/she said no. Nurse #3 said he asked CNA #5 if Resident #2 fell , and she said no. Nurse #3 said he did not ask any other staff if they knew what happened to Resident #2 that caused the skin tear, and said he was informed several days later that Resident #2 told Unit Manager #1 that he/she had fallen. During an interview on 05/29/24 at 1:22 P.M., Unit Manager #1 said that on 05/20/24 she read the skin tear report regarding Resident #2's skin tear, and said she did not understand how he/she got the skin tear. Unit Manager #1 said she tried calling Nurse #3, but was unable to reach him. Unit Manager #1 said that on 05/21/24 (two days after the unwitnessed fall) Resident #2 told her that he/she had fallen, and that was how he/she got the skin tear. Unit Manager #1 said CNA #1 and CNA #5 should have told Nurse #3 that Resident #2 was found on the floor (after an unwitnessed fall). Unit Manager #1 said Nurse #3 should have collected statements from staff other than CNA #5's in an effort to learn what had happened to Resident #2. Unit Manager #1 said that due to the delay in nursing staff knowing that Resident #2 had fallen, nursing staff did not initiate neurological signs for Resident #2 following an unwitnessed fall, but should have. During an interview on 05/29/24 at 4:09 P.M., the Director of Nurses (DON) said the Facility's policy is that with any unwitnessed fall, a licensed nurse assesses the resident before he/she is moved, and neurological signs would be initiated immediately after the fall and monitored. The DON said Resident #2 should have been assessed by the nurse before being moved, and neurological signs should have been initiated and monitored immediately following the fall, but were not.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 37342 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was assessed by nursing as being at high risk for falls, had a fall on 5/08/24 with an injury, was known to be impulsive and whose fall risk interventions included the use of monitoring devices (bed and chair alarms) to alert staff when he/she rose from a sitting or lying position, the Facility failed to ensure he/she was provided with the necessary safety devices and level of staff supervision to maintain his/her safety, when on 05/09/24 Certified Nurse Aide #1 assisted Resident #1 to the toilet, removed his/her alarm and left him/her unattended in the bathroom to go get supplies. Resident #1 fell in the bathroom, struck his/her face on the floor, and as a result, was transferred to the Hospital Emergency Department where he/she was diagnosed with a nasal bone fracture and large forehead hematoma (bruise). Findings include: The Facility Policy, titled Fall Prevention Protocol, dated 11/13/17, indicated staff would provide an environment of safety, prioritize and assist with the prevention of resident falls, and through the use of assessments tools, all residents would be assessed for risks of falling and programs would be initiated as a result of the assessment. The Policy indicated residents that were assessed as being at risk to fall would have interventions initiated as indicated through the assessment and Interdisciplinary Team Plan of Care. The Facility Policy, titled Bed and Chair Alarms, dated 07/14/08, indicated the Facility would use bed and chair alarms to help assure resident safety from falls. The alarms would not replace clinical judgement, and staff would monitor residents closely to avoid fall situations. The Facility Policy, titled Baseline and Comprehensive Person-Centered Care, dated as revised on 06/15/21, indicated nursing staff would implement a plan of care for each resident to provide effective person-centered care. Resident #1 was admitted to the Facility in May 2024, diagnoses included orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying down and can cause dizziness, lightheadedness, fainting, and other problems), chronic atrial fibrillation, stroke, macular degeneration, and was legally blind. Review of Resident #1's Fall Risk Assessment, dated 05/02/24, indicated he/she was assessed by nursing as being at high risk for falls. Review of Resident #1's Fall Risk Care Plan, dated 05/02/24, (which was provided by the facility in the Report they submitted to the Department of Public Health via the Health Care Facility Reporting System (HCFRS), dated 05/13/24), indicated that his/her interventions included for staff to equip Resident #1 with a device that monitored rising (clarified during the survey by the Director of Nursing to mean bed and chair alarms). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	However, despite the Fall Risk Care Plan indicating Resident #1 required alarms, review of Resident #1's medical record, dated 5/02/4 through 5/08/24, indicated there was no nursing or CNA documentation to support any type of monitoring device was in place and being monitored by staff, in an effort to maintain Resident #1's safety. Review of Resident #1's Nurse Progress Note, dated 05/08/24, indicated that at 05:00 P.M., Resident #1 was found on the floor in his/her room, was bleeding from a laceration on the left side of his/her head, and was transferred to the Hospital Emergency Department. During an interview on 05/29/24 at 02:57 P.M., Nurse #1 said that on 05/08/24 at 05:00 P.M., he was told by CNA #4 that Resident #1 had fallen. Nurse #1 said Resident #1 was bleeding from a laceration on the left side of his/her head and was transferred to the Hospital Emergency Department. Nurse#1 said prior to this incident, Resident #1 did not not have bed or chair alarms in place. Nurse #1 said that when Resident #1 returned to the Facility at 9:45 P.M., he implemented bed and chair alarms for Resident #1 as a measure to prevent falls. Review of Resident #1's Hospital Emergency Department Discharge Summary, dated 05/08/24, indicated he/she was assessed and treated for a 4-centimeter (cm) laceration to the left side of his/her head as a result of a fall at the Facility, and required 6 staples to close the wound. During an interview on 05/29/24 at 12:39 P.M., Certified Nurse Aide (CNA) #1 said that on 05/08/24 at 5:00 P.M., she saw Resident #1 standing alone in his/her room, and witnessed Resident #1 fall. CNA #1 said Resident #1 did not have any alarms in place or sounding at the time. During an interview on 05/29/24 at 03:09 P.M., CNA #4 said she was assigned to care for Resident #1 on 05/08/24 during the evening shift (3:00 P.M to 11:00 P.M.), and said Resident #1 did not have any alarms in place at that time. During an interview on 05/29/24 at 03:55 P.M., Nurse #4 said she worked the 11:00 P.M., (05/08/24) to 7:00 A.M., (05/09/24) shift. Nurse #4 said it was reported to her during change of shift report that Resident #1 had fallen, was transferred to the Hospital Emergency Department where he/she was treated for a laceration to the left side of his/her head. Nurse #4 said Nurse #1 had implemented bed and chair alarms for Resident #1 for safety. Nurse #4 said she checked on Resident #1 throughout her shift and the bed alarm was in place and functioning. Nurse #4 said that on 05/09/24 at 5:40 A.M., CNA #2 informed her that Resident #1 was on the floor. Nurse #4 said Resident #1 was found in the bathroom, lying on the floor on his/her stomach with his/her face on the floor and he/she was bleeding from his/her nose and laceration at the left side of his/her head, and was transferred to the Hospital emergency room . Review of Resident #1's Nurse Progress Note, dated 05/09/24, (written by Nurse #4 during the 11:00 P.M. to 7:00 A.M. shift) indicated that at 5:40 A.M., Resident #1 had an unwitnessed fall when CNA #1 left him/her on the toilet seat [and left the bathroom] to get linens. The Note indicated CNA #1 said she heard a loud bang, and upon returning to Resident #1's room, found him/her lying on the bathroom floor, he/she was bleeding from his/her nose, had swelling to his/her forehead, and was transferred to the Hospital Emergency Department. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Hospital emergency room Discharge Summary, dated 05/09/24, indicated he/she was diagnosed with a closed fracture of the nasal bone as a result of a fall at the Facility. During a telephone interview on 05/29/24 at 11:42 A.M., Certified Nurse Aide (CNA) #2 said that on 05/09/24 at 5:40 A.M., she assisted Resident #1 to the bathroom, and left him/her on the toilet while she went to the linen cart, which was located outside Resident #1's room and a few doors down the hall, to get linen. CNA #2 said she heard a loud bang, and upon returning to the Resident #1's room, found him/her on his/her stomach on the bathroom floor and he/she was bleeding from the left head laceration he/she had gotten from the fall on 05/08/24. CNA #2 said she could not see if Resident #1 was bleeding from his/her nose. CNA #2 said when she assisted Resident #1 to transfer from his/her bed, there was a bed alarm in place and functioning which she disabled in order to help Resident #1 up from the bed. CNA #2 said she should not have left Resident #1 alone in the bathroom without an alarm in place. During an interview on 05/29/24 at 9:03 A.M., The Director of Nurses (DON) said staff should implement alarms when they are identified on a resident's care plan, and said residents who have bed and chair alarms implemented should not be left alone without an alarm in place.