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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225356	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Randolph	49 Thomas Patten Drive Randolph, MA 02368

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37183 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had an activated Health Care Proxy (HCP), the Facility failed to ensure nursing immediately notified his/her Health Care Agent (HCA) and physician, when on 09/20/24, Resident #1 was found sitting on the floor after an unwitnessed fall. Resident #1 was noted with a closed, swollen, puffy right eye several hours later and was transferred to the Hospital Emergency Department (ED) for evaluation. Findings include: Review of the Facility's Policy, titled Change in a Resident's Condition or Status, dated as revised February 2021, indicated the following: -our facility promptly notifies the resident's attending physician, the resident representative of change in the resident's medical/mental condition and/or status; -the nurse will notify the resident's attending physician when there has been an accident or incident involving the resident, discovery of injuries of unknown source; -a nurse will notify the resident's representative when the resident is involved in any accident or incident that results in an injury including injuries of unknown source; -the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the Facility Policy, titled Accidents and Incidents - Investigating and Reporting, dated as revised July 2017, indicated the following: -the charge nurse shall promptly initiate and document investigation of the accident or incident; -the following data shall be included in the Accident/Incident form: (continued on next page)

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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NAME OF PROVIDER OR SUPPLIER Care One at Randolph		STREET ADDRESS, CITY, STATE, ZIP CODE 49 Thomas Patten Drive Randolph, MA 02368	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- date and time the accident or incident took place, the nature of the injury, the circumstances surrounding the accident or incident, where the accident took place, the names of the witnesses and their accounts of the accident or incident, the time the resident's attending physician was notified, the date/time the resident's family was notified and by whom, the condition of the resident, including vital signs, the disposition of the resident, and other pertinent data as necessary or required. Resident #1 was admitted to the Facility in March 2022, diagnoses included Alzheimer's disease, failure to thrive, type 2 diabetes mellitus, depression, hypertension, difficulty in walking and muscle weakness. Review of Resident #1's Medical Record indicated Resident #1's Health Care Proxy was permanently invoked on March 11, 2022. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted on 09/22/24, indicated that on 09/21/24 at approximately 6:30 A.M., Resident #1 was found by a CNA with a closed and swollen right eye. The Report indicated that the CNA notified the nurse and Resident #1 was transferred to the ED for evaluation. The Report indicated that on 09/22/24, the facility received a telephone call from the hospital notifying the facility that Resident #1 had a right nasal bone fracture and a right lamina papyracea (paper like lacrimal bone which protects the optic nerve) and an investigation was initiated by the facility. The Report indicated that (on 9/20/24) nursing staff observed Resident #1 sitting on the floor at the end of the roommate's bed at approximately 11:00 P.M. The Report indicated that Resident #1 was without obvious signs of injury, was assisted off the floor, brought to the bathroom and then returned to bed. The Report further indicated that based on the information obtained, Resident #1 ambulated to the bathroom, lost his/her balance, fell , and accidentally struck his/her face on the end of the roommate's bed causing the injuries. Review of Resident #1's Medical Record indicated there was no documentation to support that the physician and Resident #1's HCA were notified of his/her fall that occurred on 09/20/24. During a telephone interview on 10/17/24 at 2:58 P.M., (which included review of her Witness Statement, dated 9/23/24), CNA #1 said that on 09/20/24 at approximately 11:00 P.M., she found Resident #1 sitting on the floor next to his/her roommate's bed. CNA #1 said that she stood Resident #1 up off the floor, walked him/her to the bathroom and then walked him/her back to bed. CNA #1 said that she notified the 3:00 P.M. to 11:00 P.M. nurse (later identified as Nurse #1) that she found Resident #1 on the floor, that she had picked him/her up off the floor, walked him/her to the bathroom and then back to bed. CNA #1 said that at approximately 6:00 A.M. the next morning (09/21/24) she checked on Resident #1 and observed that his/her right eye was shut and swollen and she notified the 11:00 P.M. to 7:00 A.M. nurse (later identified as Nurse #2). However, CNA #1 said that she did not inform Nurse #2 that she had found Resident #1 on the floor earlier in the shift. During an interview on 10/ 09/24 at 2:40 P.M., (which included review of her Witness Statement, undated), Nurse #1 said that she worked the 3:00 P.M. to 11:00 P.M. shift on 09/20/24 and was doing her last set of rounds at approximately 11:20 P.M. when CNA #1 reported to her that she found Resident #1 sitting on the floor in his/her room. Nurse #1 said that CNA #1 told her that she stood Resident #1 up, walked him/her to the bathroom and then walked him/her back to bed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 said that she did not document the incident in the medical record, did not complete an incident report, did not notify the physician or Resident #1's HCA of his/her unwitnessed fall, but said she should have and could not explain why she did not follow the facility's policy. Review of Resident #1's Medical Record indicated that on 9/20/24, there was no documentation from Nurse #1 related to Resident #1's fall. There was no documentation to support Nurse #1 notified the physician or Resident #1's HCA of his/her unwitnessed fall on 09/20/24. This was not consistent with the Facility's Change in a Resident's Condition or Status and Accidents and Incidents - Investigating and Reporting Policies. During an interview on 10/17/24 at 08:50 A.M., (which included a review of her Written Witness Statement, dated 09/23/24), Nurse #2 said that she worked the 11:00 P.M. to 7:00 A.M. shift on 09/20/24. Nurse #2 said that at approximately 6:00 A.M. on 09/21/24, CNA #1 reported to her that Resident #1's right eye was shut and swollen. Nurse #2 said that neither CNA #1 or Nurse #1 had reported to her that Resident #1 had been found sitting on the floor earlier during the start of the overnight shift and said she was unaware that Resident #1 had fallen earlier. Nurse #2 said that Nurse #1 and CNA #1 should have reported to her that Resident #1 had fallen. Nurse #2 said that she did not notify the physician or Resident #1's HCA that Resident #1 had fallen on 09/20/24, because she had been unaware he/she had fallen. Review of a Hospital Discharge Summary Report, dated 09/25/24, indicated that Resident #1 presented to the hospital from a nursing home with edema and erythema on the right side of his/her face around his/her eye and brow. The Summary indicated that a Head and Facial CT scan revealed a right frontal subgaleal hematoma (a collection of blood between the scalp and the skull) with right periorbital (swelling around the eye) soft tissue swelling, an age indeterminate fracture deformity of the right lamina papyracea (paper like lacrimal bone which protects the optic nerve) and age indeterminate right nasal bone fracture. The Summary further indicated that the Nursing Home reported that Resident #1 was found sitting on the floor near his/her bed at 11:20 P.M., that they did not realize he/she was hurt, and the next morning, he/she was noted with his/her right eye swollen and sent him/her to the hospital. During a telephone interview on 10/17/24 at 9:59 A.M., the Director of Nurses (DON) said that she could not find any documentation in Resident #1's Medical Record regarding his/her fall on 09/20/24. The DON said it was her expectation that Nurse #1 should have immediately notified the physician and Resident #1's HCA of his/her fall. The DON said that Nurse #1 did not follow the facilities policies.

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F 0656 Level of Harm - Minimal harm or potential for 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. 37183 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), whose Plans of Care indicated that he/she required the physical assistance of one staff member with transfers and ambulation, the Facility failed to ensure nursing staff consistently implemented and followed interventions identified in their Plans of Care, when on 09/20/24, a short time after Resident #1 had been found on the floor by staff after an unwitnessed fall, Nurse #1 witnessed Resident #1 walking in his/her room, unassisted, and did not intervene to assist him/her, did not notify a staff member that he/she was ambulating in his/her room without assistance and proceeded to leave the facility and go home. Findings include: Review of the Facility's Policy, titled Comprehensive Person-Centered Care Plans, dated as revised December 2016, indicated the following: -an 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; -the Facility's Care Planning/Interdisciplinary Team (IDT) in conjunction with the resident, his/her family or representative, develops and implements a comprehensive, person-centered care plan for each resident; -the comprehensive, person-centered care plan will: -describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; - incorporate identified problem areas; incorporate risk factors associated with identified problems; -build on the resident's strengths, aid in preventing or reducing decline the resident's functional status and/or functional levels; -reflect currently recognized standard of practice for problem areas; -when possible, interventions address the underlying soured(s) of the problem area(s); -assessments of residents are ongoing and care plans are revised as information about the resident and the residents conditions change. Resident #1 was admitted to the Facility in March 2022, diagnoses included Alzheimer's disease, failure to thrive, type 2 diabetes mellitus, depression, hypertension, difficulty in walking and muscle weakness. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 08/27/24, indicated that Resident #1 was severely cognitively impaired, required supervision or touching assistance from a staff member with ambulation and substantial to maximal assistance from a staff member with transfers and sit to stand. Review of Resident #'s Care Plan related to Physical Limitations - ADL Self Care Deficit, renewed and reviewed with his/her August 2024 MDS, indicated that he/she required the physical assist of one staff member with ambulation, transfers and toileting. Review of Resident #1's Fall Risk Assessment, dated 08/19/24, indicated that he/she was assessed by nursing as being at high risk for falls. During an interview on 10/ 09/24 at 2:40 P.M., (which included review of her Witness Statement, undated), Nurse #1 said that she worked the 3:00 P.M. to 11:00 P.M. shift on 09/20/24 and was doing her last set of rounds at approximately 11:20 P.M. when CNA #1 reported to her that she found Resident #1 sitting on the floor in his/her room. Nurse #1 said that CNA #1 said that she stood Resident #1 up, walked him/her to the bathroom and then walked him/her back to bed. Nurse #1 said that she observed Resident #1 quietly lying in bed and assumed that he/she was alright. Nurse #1 said (since it was the end of the shift) that she went to the nurse's station to get her personal belongings and when she went by Resident #1's room, on her way home, she saw Resident #1 walking to the bathroom. Nurse #1 said she did not notify any staff member that Resident #1 was walking in his/her room without assistance and said she went home. Nurse #1 said that Resident #1 is at high risk for falls and said Resident #1 requires supervision and physical assistance of one staff member with ambulation, transfers and toileting. Nurse #1 could not explain why she did not notify a staff member that Resident #1 was walking in his/her room without assistance and said she did not follow Resident #1's plan of care. During a telephone interview on 10/17/24 at 9:59 A.M., the Director of Nurses (DON) said that Resident #1 was at high risk for falls and had just sustained an unwitnessed fall when Nurse #1 saw Resident #1 walking in his/her room unassisted on her way home. The DON said that her expectation was that Nurse #1 should have assisted him/her to the bathroom and then notified a staff member that Resident #1 was walking in his/her room unassisted. The DON said that Nurse #1 did not follow Resident #1's plan of care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 37183 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was severely cognitively impaired, required supervision to substantial/maximal assistance from staff to meet his/her care needs, and was assessed by nursing as being at high risk for falls, the Facility failed to ensure he/she was provided nursing care and treatment in accordance with professional standards of practice, when on 09/20/24, after Resident #1 was found lying on the floor in his/her room by Certified Nurse Aide (CNA) #1 after an unwitnessed fall, CNA #1 proceeded get him/her up off the floor, walk him/her to the bathroom and then transfer him/her back to bed, before informing and having nursing assess him/her for any potential injury. After being made aware of Resident #1's unwitnessed fall, Nurse #1 did not assess Resident #1 for injuries, did not document the incident, did not complete an incident report, did not report the incident to his/her physician, or the oncoming shift nurse. Findings include: Standard Reference: Standard of Practice Reference: Pursuant to Massachusetts General Law (M.G.L), chapter 112, individuals are given the designation of registered nurse and practical nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a registered nurse and practical nurse respectively. The regulations stipulate that both the registered nurse and practical nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the registered and practical nurse incorporated into the plan of care and implement prescribed medical regimens. The rules and regulations 9.03 defined standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. Review of the Facility's Policies, titled Managing Falls and Fall Risk and Falls - Clinical Protocol, dated as revised March 2018, indicated the following: -the staff will evaluate, and document falls that occur while the resident is in the facility, when and where they happen and any observations of the events; -staff will identify interventions related to the resident's risks and causes to try to prevent the resident from falling and to try to minimize complications from falling; -when a resident if found on the floor, a fall is considered to have occurred; -falls should be identified as witnessed or unwitnessed; -staff will follow up on any fall with associated injury and delayed complications such as late fracture or subdural hematoma until the resident is stable; -delayed complications such as late fractures and major bruising may occur hours or days after a fall; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-staff will monitor and document resident's response to interventions. Review of the Facility Policy, titled Accidents and Incidents - Investigating and Reporting, dated as revised July 2017, indicated the following: -all accidents and incidents involving residents occurring on facility premises shall be investigated and reported to the Administrator; -the charge nurse shall promptly initiate and document investigation of the accident or incident; -the following data shall be included in the Accident/Incident form: - date and time the accident or incident took place, the nature of the injury, the circumstances surrounding the accident or incident, where the accident took place, the names of the witnesses and their accounts of the accident or incident, the time the resident's attending physician was notified, the date/time the resident's family was notified and by whom, the condition of the resident, including vital signs, the disposition of the resident, and other pertinent data as necessary or required. -the charge nurse shall complete an Incident/Accident Report form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident; -the Director of Nursing Services shall ensure that the administrator receives a copy of the Incident/Accident form. Review of the Facility Policy, titled Charting and Documentation, dated as revised July 2017, indicated that al services provided to the resident or any changes in the resident's medical, functional or psychosocial condition, shall be documented in the resident's medical record. The Policy further stated that incidents or accidents involving the resident shall be documented in the resident's medical record. Resident #1 was admitted to the Facility in March 2022, diagnoses included Alzheimer's disease, failure to thrive, type 2 diabetes mellitus, depression, hypertension, difficulty in walking and muscle weakness. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 08/27/24, indicated that Resident #1 was severely cognitively impaired, required supervision or touching assistance from a staff member with ambulation and substantial to maximal assistance from a staff member with transfers and sit to stand. Review of Resident #1's Fall Risk Assessment, dated 08/19/24, indicated that he/she was assessed by nursing as being at high risk for falls. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted on 09/22/24, indicated that on 09/21/24 at approximately 6:30 A.M., Resident #1 was found by a CNA with a closed and swollen right eye. The Report indicated that the CNA notified the nurse and Resident #1 was transferred to the ED for evaluation. The Report indicated that on 09/22/24, the facility received a telephone call from the hospital notifying the facility that Resident #1 had a right nasal bone fracture and a right lamina papyracea (paper like lacrimal bone which protects the optic nerve) and an investigation was initiated by the facility. The Report indicated that (on 9/20/24) nursing staff observed Resident #1 sitting on the floor at the end of the roommate's bed at approximately 11:00 P.M. The Report indicated that Resident #1 was without obvious signs of injury, was assisted off the floor, brought to the bathroom and then returned to bed. The Report further indicated that based on the information obtained, Resident #1 ambulated to the bathroom, lost his/her balance, fell , and accidentally struck his/her face on the end of the roommate's bed causing the injuries. During a telephone interview on 10/17/24 at 2:58 P.M., (which included review of her Witness Statement, dated 9/23/24), CNA #1 said that on 09/20/24 at approximately 11:00 P.M., she found Resident #1 sitting on the floor next to his/her roommate's bed. CNA #1 said she did not notify the nurse at that time. CNA #1 said that she stood Resident #1 up off the floor, walked him/her to the bathroom and then walked him/her back to bed. CNA #1 said after she assisted Resident #1 back to bed, that was when she told the 3:00 P.M. to 11:00 P.M. nurse (later identified as Nurse #1) that she found him/her on the floor. CNA #1 said that Resident #1 did not have any signs of injury, so she picked him/her off the floor and walked him/her to the bathroom and then back to bed. CNA #1 said that at approximately 6:00 A.M. the next morning (09/21/24) she checked on Resident #1 and observed that his/her right eye was shut and swollen and she notified the 11:00 P.M. to 7:00 A.M. nurse (later identified as Nurse #2). However, CNA #1 said that she did not inform Nurse #2 that she had found Resident #1 on the floor earlier in the shift. During an interview on 10/ 09/24 at 2:40 P.M., (which included review of her Witness Statement, undated), Nurse #1 said that she worked the 3:00 P.M. to 11:00 P.M. shift on 09/20/24 and was doing her last set of rounds at approximately 11:20 P.M. when CNA #1 reported to her that she found Resident #1 sitting on the floor in his/her room. Nurse #1 said that CNA #1 told her that she stood Resident #1 up, walked him/her to the bathroom and then walked him/her back to bed. Nurse #1 said that she observed Resident #1 quietly lying in bed and assumed that he/she was alright. Nurse #1 said that she did not assess Resident #1 for any injuries, did not notify the 11:00 P.M. to 7:00 A.M. nurse of the fall, did not document the incident in the medical record, did not complete an incident report, did not notify the physician or family of Resident #1's fall, but said she should have and could not explain why she did not follow the facility's policy. Nurse #1 said that the Director of Nurses asked her to complete an Incident Report on 09/23/24 regarding Resident #1's fall that occurred on 09/20/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 said (since it was the end of her shift) that she went to the nurse's station to get her personal belongings and when she went by Resident #1's room, on her way home, she saw Resident #1 walking to the bathroom. Nurse #1 said she did not notify any staff member that Resident #1 was walking in his/her room without assistance and said she went home. Nurse #1 said that Resident #1 is at high risk for falls and said Resident #1 requires supervision and assistance with ambulation. During an interview on 10/17/24 at 08:50 A.M., (which included a review of her Written Witness Statement, dated 09/23/24), Nurse #2 said that she worked the 11:00 P.M. to 7:00 A.M. shift on 09/20/24. Nurse #2 said that at approximately 6:00 A.M. on 09/21/24, CNA #1 reported to her that Resident #1's right eye was shut and swollen. Nurse #2 said that she went and assessed Resident #1 and observed that his/her right eye was swollen, puffy and closed shut. Nurse #2 said there was no bruising and Resident #1 denied pain and denied falling. Nurse #2 said that she thought that maybe the swelling was related to an allergy or infection and notified the physician. Nurse #2 said that Resident #1 was transferred to the ED for evaluation. Nurse #2 said that neither CNA #1 or Nurse #1 reported to her that Resident #1 had been found sitting on the floor earlier during her shift and said she was unaware that Resident #1 had fallen earlier. During the facility's investigation, it was revealed that Resident indeed had fallen on 09/20/24 at approximately 11:00 P. M., but that no one had reported it. Nurse #2 said that Nurse #1 and CNA #1 should have reported to her that Resident #1 had fallen. Review of Resident #1's Medical Record indicated there was no documentation on 9/20/24, related to Resident #1's fall. There was no documentation to support Nurse #1 had assessed Resident #1 for potential injury or pain as a result of the fall. This was not consistent with the Facility's Managing Falls and Fall Risk, Falls - Clinical Protocol, Accidents and Incidents - Investigating and Reporting and Charting and Documentation Policies. Review of a Hospital Discharge Summary Report, dated 09/25/24, indicated that Resident #1 presented to the hospital from a nursing home with edema and erythema on the right side of his/her face around his/her eye and brow. The Summary indicated that a Head and Facial CT scan revealed a right frontal subgaleal hematoma (a collection of blood between the scalp and the skull) with right periorbital (swelling around the eye) soft tissue swelling, an age indeterminate fracture deformity of the right lamina papyracea (paper like lacrimal bone which protects the optic nerve) and age indeterminate right nasal bone fracture. The Summary further indicated that the Nursing Home reported that Resident #1 was found sitting on the floor near his/her bed at 11:20 P.M., that they did not realize he/she was hurt, and the next morning, he/she was noted with his/her right eye swollen and sent him/her to the hospital. During an interview on 10/09/24 at 3:45 P.M., the Director of Nurses (DON) said that Resident #1 was at high risk for falls. The DON said she could not find any documentation in Resident #1's Medical Record regarding his/her fall on 09/20/24. The DON said that she asked Nurse #1 to complete an Incident Report on 09/23/24 after she found out that Resident #1 had a fall on 09/20/24 The DON said it was her expectation that Nurse #1 should have assessed Resident #1 for injury, documented it in a Nurse's Note, completed an Incident Report, notified the physician, HCA and notified the oncoming nurse of Resident #1's fall, but she had not. The DON said that Nurse #1 did not follow the facility's policies. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/24, the Facility presented the Surveyor with a plan of correction that addressed the areas of concern identified in this survey, the Plan of Correction is as follows: A) 09/21/24, Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation and treatment of injuries as a result of an unwitnessed fall. B) 09/23/24, Nurse #1 and CNA #1 were immediately educated by the Director of Nurses (DON) to follow the Facility's Falls Clinical Protocol and Accident & Incidents - Investigating & Reporting Policies. C) 09/24/24, Unit Manager conducted a Unit wide skin assessments on the Unit CNA #1 worked for injuries of unknown origin. D) 09/27/24, Unit Managers interviewed staff regarding observing residents on the floor and compliance with notifications within past 14 days. E) 09/27/24, the Director of Nurses (DON) audited the past 14 days of incident reports for compliance with the requirement for nursing to complete an assessment prior to moving the resident F) 09/27/24, the DON reviewed all injuries of unknown origin for the past 14 days to ensure that the investigation and conclusion were consistent with unknown injury policy. G) 09/27/24, the Facility Educator inserviced all staff, nursing, therapy, activities, social services on the notification of assigned nursing staff of resident observed on the floor, accident and incidents, nursing assessment and moving of resident post fall, care and expectations for residents with suspected significant injury. H) 09/27/24 - 09/30/24, the Facility Educator administered CNA Fall Quiz, Abuse & Reporting Quiz, Nurse Responsibility Quiz to all Staff. I) 09/23/24, 09/24/24, 09/25/24 and 10/04/24, the DON randomly interviewed ten staff members regarding notification of resident on floor and reporting of falls. J) DON and/or Designee will randomly interview ten staff members regarding notification of resident on floor and reporting of falls weekly for three weeks then monthly for two months or until substantial compliance is met. K) Results of the Audits will be be presented to the Quality Assurance Performance Improvement (QAPI) committee monthly for three months for patterns, trends and continued recommendations for process monitoring and improvement. L) The DON and/or Designee are responsible for overall compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225356	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER Care One at Randolph		STREET ADDRESS, CITY, STATE, ZIP CODE 49 Thomas Patten Drive Randolph, MA 02368	

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 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. 37183 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was severely cognitively impaired and was assessed by nursing at high risk for falls, the Facility failed to ensure staff provided quality of care consistent with professional standards of practice, when on 09/20/24, after finding Resident #1 lying on the floor in his/her room after an unwitnessed fall, Certified Nurse Aide (CNA) #1 got him/her up off the floor, proceeded to walk with him/her to the bathroom and transfer him/her back to bed, before informing and having the nurse assess him/her for the potential for physical injury, and as a result, Resident #1 was found in bed the next morning with a swollen, puffy, closed right eye and was transferred to the Hospital Emergency Department (ED) for evaluation. Findings include: Review of a Certified Nurse Aide (CNA) Job Description, dated 2003, indicated the following: -the primary purpose of your job position is to provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan, an as may be directed by your supervisors; -report all changes in the resident's condition to the Nurse Supervisor/Charge Nurse as soon as practicable; -report all accidents and incidents you observe on the shift that they occur; -perform all assigned tasks in accordance with our established policies and procedures, and as instructed by your supervisors. Review of the Facility Policy, titled Accidents and Incidents - Investigating and Reporting, dated as revised July 2017, indicated the following: -all accidents and incidents involving residents occurring on facility premises shall be investigated and reported to the Administrator; -the charge nurse shall promptly initiate and document investigation of the accident or incident; -the following data shall be included in the Accident/Incident form: - date and time the accident or incident took place, the nature of the injury, the circumstances surrounding the accident or incident, where the accident took place, the names of the witnesses and their accounts of the accident or incident, the time the resident's attending physician was notified, the date/time the resident's family was notified and by whom, the condition of the resident, including vital signs, the disposition of the resident, and other pertinent data as necessary or required. -the charge nurse shall complete an Incident/Accident Report form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the Director of Nursing Services shall ensure that the administrator receives a copy of the Incident/Accident form. Resident #1 was admitted to the Facility in March 2022, diagnoses included Alzheimer's disease, failure to thrive, type 2 diabetes mellitus, depression, hypertension, difficulty in walking and muscle weakness. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 08/27/24, indicated that Resident #1 was severely cognitively impaired, required supervision or touching assistance from a staff member with ambulation and substantial to maximal assistance from a staff member with transfers and sit to stand. Review of Resident #1's Fall Risk Assessment, dated 08/19/24, indicated that he/she was assessed by nursing as being at high risk for falls. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted on 09/22/24, indicated that on 09/21/24 at approximately 6:30 A.M., Resident #1 was found by a CNA with a closed and swollen right eye. The Report indicated that the CNA notified the nurse and Resident #1 was transferred to the ED for evaluation. The Report indicated that on 09/20/24 nursing staff had observed Resident #1 sitting on the floor at the end of the roommate's bed at approximately 11:00 P.M. The Report indicated that Resident #1 was assisted off the floor, brought to the bathroom and then returned back to bed. The Report further indicated that based on the information obtained, Resident #1 ambulated to the bathroom, lost his/her balance, fell , and accidentally struck his/her face on the end of the roommate's bed causing the injuries. Review of CNA #1's Written Witness Statement, dated 09/23/24, indicated that on 09/20/24, upon arrival on the floor, while checking resident rooms, she noticed Resident #1 sitting (on the floor in his/her room) in an upright position on the floor facing the bathroom. The Statement indicated that she helped Resident #1 stand, walked him/her to the bathroom and walked him/her back to bed. The Statement indicated that she did not observe any signs of injury, and that Resident #1 did not complain of any pain. The Statement indicated that in the morning, she observed Resident #1 rubbing his/her eye and she noted that his/her eye was swollen, and she notified the nurse. Further review of CNA #1's Written Witness Statement indicated there was no documentation to support that after finding Resident #1 on the floor, that she reported it to the nurse so he/she could be assessed for injury, prior to moving him/her. During a telephone interview on 10/17/24 at 2:58 P.M., CNA #1 said that on 09/20/24 at approximately 11:00 P.M., she found Resident #1 sitting on the floor next to his/her roommate's bed. CNA #1 said that she stood Resident #1 up off the floor, walked him/her to the bathroom and then walked him/her to bed. CNA #1 said (after she assisted Resident #1 with care) that she notified the 3:00 P.M. to 11:00 P.M. nurse (later identified as Nurse #1) that she had found Resident #1 on the floor, and she picked him/her up off the floor, walked him/her to the bathroom and then to bed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Care One at Randolph		STREET ADDRESS, CITY, STATE, ZIP CODE 49 Thomas Patten Drive Randolph, MA 02368	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 said that at approximately 6:00 A.M. the next morning (09/21/24) she checked on Resident #1 and observed that his/her right eye was shut and swollen and that she notified the 11:00 P.M. to 7:00 A.M. nurse (later identified as Nurse #2). However, CNA #1 said that she did not inform Nurse #2 that she had found Resident #1 on the floor earlier in the shift. Review of Nurse #1's Written Witness Statement, undated, indicated that at approximately 11:30 P.M., a CNA (later identified as CNA #1) told her that she helped Resident #1 get up off the floor and transferred him/her to his/her bed. The Statement indicated that Nurse #1 saw Resident #1 lying down comfortably in bed since it was the end of her shift, she went to the nursing station to get his/her belongings and left the facility. During an interview on 10/ 09/24 at 2:40 P.M., Nurse #1 said that she worked the 3:00 P.M. to 11:00 P.M. shift on 09/20/24 and was doing her last set of rounds at approximately 11:20 P.M. when CNA #1 reported to her that she found Resident #1 sitting on the floor in his/her room. Nurse #1 said that CNA #1 said that she stood Resident #1 up, walked him/her to the bathroom and then walked him/her back to bed. Nurse #1 said that CNA #1 should not have picked Resident #1 up off the floor after an unwitnessed fall, and said she should have immediately notified her of the fall she could assess the resident for any injuries. Review of Nurse #2's Written Witness Statement, dated 09/23/24, indicated that on 09/21/24 at 6:30 A.M., a CNA (later identified as CNA #1) called her into Resident #1's room. The Statement indicated that she was surprised to see Resident #1's right eye puffy, swollen and closed. The Statement indicated that although Resident #1 kept saying he/she did not fall and had no pain and no bruising was noted to his/her face. The Statement indicated that Resident #1 was transferred to the ED. During an interview on 10/17/24 at 08:50 A.M., Nurse #2 said that she worked the 11:00 P.M. to 7:00 A.M. shift on 09/20/24. Nurse #2 said that at approximately 6:00 A.M. on 09/21/24, CNA #1 reported to her that Resident #1's right eye was shut and swollen. Nurse #2 said that she went and assessed Resident #1 and observed that his/her right eye was swollen, puffy and closed shut. Nurse #2 said there was no bruising and Resident #1 denied pain and denied falling. Nurse #2 said that she thought that maybe the swelling was related to an allergy or infection and notified the physician. Nurse #2 said that Resident #1 was transferred to the ED for evaluation. Review of a Hospital Discharge Summary Report, dated 09/25/24, indicated that Resident #1 presented to the hospital from a nursing home with edema and erythema on the right side of his/her face around his/her eye and brow. The Summary indicated that a Head and Facial CT scan revealed a right frontal subgaleal hematoma (a collection of blood between the scalp and the skull) with right periorbital (swelling around the eye) soft tissue swelling, an age indeterminate fracture deformity of the right lamina papyracea (paper like lacrimal bone which protects the optic nerve) and age indeterminate right nasal bone fracture. The Summary further indicated that the Nursing Home reported that Resident #1 was found sitting on the floor near his/her bed at 11:20 P.M., that they did not realize he/she was hurt, and the next morning, he/she was noted with his/her right eye swollen and sent him/her to the hospital. During an interview on 10/09/24 at 3:45 P.M., the Director of Nurses (DON) said that Resident #1 was at high risk for falls. The DON said the Facility's policy is that with any unwitnessed fall, that a licensed nurse assesses the resident before he/she is moved. The DON said that Resident #1 should have been assessed for any injuries by the nurse before being moved following a fall, but was not. (continued on next page)

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