

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/05/2024
NAME OF PROVIDER OR SUPPLIER  Quaboag Rehabilitation & Skilled Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 47 East Main Street West Brookfield, MA 01585	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>37227</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who could make his/her needs known, the Facility failed to ensure he/she was treated in a dignified and respectful manner, when on 09/30/24 at approximately 6:50 P.M., Certified Nurse Aide (CNA) #1 removed Resident #1's meal tray from his/her room, despite his/her protests that he/she had not finished eating, and spoke to him/her in a loud and inappropriate manner. Several residents who were in the unit's common areas were also subjected to having to listen to CNA #1's verbal outbursts of profanity.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Resident Rights, dated as revised 05/27/22, indicated that employees shall treat all residents with kindness, respect and dignity.</p> <p>Resident #1 was admitted to the Facility in September 2023, diagnoses included dementia with behavioral disturbances, anxiety disorder, and major depressive disorder.</p> <p>Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 09/19/24, indicated Resident #1 was cognitively intact with a score of 13 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact).</p> <p>Review of a Facility Investigation Report, undated, indicated that on 09/30/24 at approximately 6:50 P.M., Dietary Aide #1 witnessed CNA #1 take Resident #1's meal tray despite his/her objection. The Report indicated that when Resident #1 told CNA #1 that he/she had not finished eating, CNA #1 responded, you should have been eating instead of complaining about other residents.</p> <p>The Report indicated that a few minutes later, Resident #1 asked CNA #1 for food because he/she was hungry, and CNA #1 told him/her you should have eaten when it was available, you are not getting any food tonight.</p> <p>Further review of the Report indicated the Administrator called the unit and spoke with CNA #1 immediately after the incident and when she mentioned the need for an internal investigation, CNA #1 responded loudly, don't fucking bother, I quit.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/05/24 at 2:10 P.M., Resident #1 could not recall having any kind of altercations with staff.</p> <p>The Surveyor was unable to interview Certified Nurse Aide (CNA) #1 as she did not respond to the Department of Public Health's telephone or letter requests for an interview.</p> <p>During an interview on 11/05/24 at 4:10 P.M., Dietary Aide #1 (which also included a review of her Written Witness Statement dated 09/30/24) said she was in the hallway near Resident #1's room, at approximately 6:50 P.M., when she heard CNA #1 tell Resident #1, in a demeaning tone of voice, that he/she should have been eating instead of complaining about other residents. Dietary Aide #1 said that CNA #1 removed Resident #1's unfinished meal tray from his/her room despite his/her protest.</p> <p>Dietary Aide #1 said that Resident #1 followed CNA #1 into the hallway with his/her wheelchair, he/she asked CNA #1 for food and he/she told her that he/she had not eaten. Dietary Aide #1 said that CNA #1 told Resident #1 that he/she should have eaten earlier when the food was available to him/her. Dietary Aide #1 said that when CNA #1 spoke to Resident #1 she was demeaning and spoke very loudly, shouting at times.</p> <p>During an interview on 11/05/24 at 3:10 P.M., Certified Nurse Aide (CNA) #2 said that while he was providing care to another resident, a few doors away from Resident #1's room, during the evening shift on 09/30/24, he heard Resident #1 asking for food. CNA #2 said he heard CNA #1 shout at Resident #1 that he/she should have eaten his/her food earlier when he/she had the fucking chance. CNA #2 said that he heard Dietary Aide #1 ask CNA #1, Why are you talking to [Resident #1] that way?</p> <p>CNA #2 said he entered the hallway immediately after the altercation and observed CNA #1 yelling and swearing near the nurses' station in the presence of several residents.</p> <p>During a telephone interview on 11/06/24 at 7:19 A.M., Nurse #1 said that just before 7:00 P.M. on 09/30/24, she heard CNA #1 swearing in a loud angry voice at the end of the hall, near Resident #1's room. Nurse #1 said Dietary Aide #1 reported that she had witnessed an altercation involving Resident #1 and CNA #1.</p> <p>Nurse #1 said she immediately called the Administrator in Training (AIT) to report the altercation. Nurse #1 said that when CNA #1 spoke with the AIT on the phone, she swore and shouted in an angry tone, I fucking quit. Nurse #1 said she escorted CNA #1 out of the Facility. Nurse #1 said that CNA #1's use of profanity and her verbally inappropriate outburst had occurred in the presence of several residents in the adjacent common area.</p> <p>Nurse #1 said that after she escorted CNA #1 out of the Facility, she spoke with Resident #1 who was visibly upset, tearful, but that he/she couldn't verbalize what had happened during the altercation, due to his/her dementia. Nurse #1 said the only thing Resident #1 had clearly said was I have never seen anything as bad as that.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/05/24 at 4:28 P.M., the Administrator in Training (AIT) said she received a call on 09/30/24 at approximately 7:00 P.M., from Nurse #1 who reported an altercation involving CNA #1 and Resident #1. The AIT said that she told CNA #1, over the telephone, that she would be suspended pending an internal investigation. The AIT said CNA #1 got very upset, began swearing and told her, I fucking quit. The AIT said she waited on the telephone while Nurse #1 escorted CNA#1 out of the building.</p> <p>The AIT said Resident #1 was given a replacement meal immediately after the incident. The AIT further said that based on the results of the Facility's investigation, CNA #1's employment was terminated for her unprofessional manner.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>44129</p> <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on records reviewed and interviews for one of three sampled residents (Resident #2), who required a Foley catheter (a flexible tube that drains urine from the bladder into a collection bag outside the body), the facility failed to ensure Resident #2 was provided with nursing care and treatment that met professional standards for quality, when Nursing staff did not follow up with his/her Urologist (a medical doctor who specializes in the diagnosis and treatment of diseases and conditions of the urinary tract) after he/she missed a scheduled appointment to have his/her catheter changed, to obtain a new appointment or new orders for when it needed to be changed.</p> <p>Findings include:</p> <p>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 Regulations (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and function 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 Nurse and Practical Nurse incorporate into the plan of care and implement prescribed medical regimens. The Rules and Regulations 9.03 define the 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.</p> <p>Resident #2 was admitted to the Facility in February 2024, diagnoses included Urinary Retention, chronic Foley catheter (a flexible tube that drains urine from the bladder into a collection bag outside the body), and recurrent urinary tract infections.</p> <p>During a telephone interview on 11/1/24 at 10:22 A.M., Family Member #1 said she brought Resident #2 to his/her Urologist in May 2024, and during that visit, the Urologist inserted a Coude catheter (a type of catheter with a slightly curved tip which allows the catheter to bypass obstructions and navigate spaces). Family Member #1 said the Urologist told her that the catheter should be changed monthly. Family Member #1 said the Facility Nurses did not follow through with this recommendation.</p> <p>Review of Resident #2's Medical Record which included a Urology Office Visit note, dated 05/21/24, indicated the following:</p> <ul style="list-style-type: none"> <li>- Resident #2 recently had urinary retention after a hip fracture three months ago, is immobile, cannot get up to go to the bathroom and has a Foley catheter in place.</li> <li>- Urinary retention likely due to deconditioning and immobility. Per family wishes, Foley catheter reinserted today as they believe going to the toilet poses a fall risk for Resident #2.</li> <li>- Plan: Return in one month for Foley catheter change with the Nurses.</li> </ul> <p>Further review of Resident #2's Medical Record indicated there was no documentation to support that the Resident visited the Urologist in June 2024.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/05/24 at 2:00 P.M., the Regional Nurse said he located a Nursing Progress Note dated 06/21/24 authored by a Unit Manager no longer employed at the facility.</p> <p>The Progress Note indicated the following:</p> <p>This writer received an email from Resident #2's daughter regarding a cancellation she had to make for the Urologist and asked if we could call regarding a catheter change. Family has concerns as it is an uncomfortable procedure for Resident #2, and he/she often gets combative during the change. This writer called and spoke to a staff member at the Urology office who said he would message the Urologist and ask. The Urology staff member was advised that we [facility staff] are capable of changing the catheter here if it is the recommendation.</p> <p>However, further review of Resident #2's medical record indicated there was no documentation to support the previous Unit Manager or one of the unit nurse's received or made a follow-up call to Resident #2's Urologist.</p> <p>During an interview on 11/05/24 at 3:30 P.M., Unit Manager #1 said if a Nurse was awaiting a call back from the Urology office and did not receive a response, the Nurse should have called the Urology office back again for further direction, given that Resident #2 was supposed to have had the catheter changed at the Urology office.</p> <p>During an interview on 11/05/24 at 3:54 P.M., Unit Manager #2 said it was Facility policy not to do monthly catheter changes unless Urology requested or recommended to do so. Unit Manager #2 looked in the appointment book and saw that Resident #2 was scheduled to visit the Urologist on 06/17/24. Upon reviewing the Nursing Progress Note, dated 06/21/24, Unit Manager #2 said Nursing staff should have attempted to call Urology again to ensure Resident #2 had a solid plan in place for his/her catheter maintenance, if he/she was unable to go to the office.</p> <p>During a telephone interview on 11/06/24 at 11:25 A.M., the Nurse Practitioner (NP) said she was unaware Resident #2's Urologist recommended changing the catheter monthly, but had she known, she would have ensured an order was in place to do so.</p> <p>The Regional Nurse said he was unable to find evidence of any further communication between the Facility Nurses and the Urologist, and no evidence that Resident #2's catheter was ever changed at the Facility after his/her Urology appointment on 05/21/24.</p>		