

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER St Patrick's Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 863 Central Street Framingham, MA 01701	
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 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>37330</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), whose Comprehensive Plan of Care and Plan of Care Kardex, indicated he/she required extensive assistance from two staff members during transfers for safety, the Facility failed to ensure staff consistently implemented and followed interventions identified in his/her Plans of Care, when on 07/03/24, CNA #1 transferred Resident #1 using a Sit/Stand Lift device (lift device that helps individuals who have difficulty standing up, from a seated position), without having another staff member present to assist her with the transfer, Resident #1 became weak during the transfer, started to slide out of the lift seat, CNA #1 then tried to lower him/her to the floor, Resident #1 immediately complained of pain, was diagnosed with a right femur (thigh bone) fracture and required transfer, with admission to the Hospital for treatment.</p> <p>Findings include:</p> <p>Review of the Facility's Policy, Comprehensive Care Plans, dated 03/21/24, indicated it is policy of the Facility to develop and implement a Comprehensive Person-Centered Plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, qualified staff responsible for carrying out interventions specified in the residents care plan and notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.</p> <p>Review of the report submitted by the Facility via the Health Care Facility Reporting System, dated 07/03/24, indicated while being transferred and sitting in the Sit/Stand (mechanical transfer device), Resident #1 was lowered to the floor. The Report indicated Certified Nurse Aide (CNA) #1 used the Sit/Stand device incorrectly, and did not have another staff member assist her when transferring the resident back to bed to offer peri-care. The Report indicated Resident #1 complained of right hip pain, was assessed and an order was obtained to transfer him/her to the Hospital Emergency Department (ED) for evaluation.</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 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Facility's Internal Investigation's Final Report, dated 07/08/24, indicated that although Resident #1's ED Discharge Summary (from 07/03/24) indicated he/she did not have any fractures, he/she continued to experience pain to his/her right knee area, and an X-ray of his/her right knee was ordered. On 07/08/24, the facility was notified that Resident #1 had an acute distal right femur (thigh bone) supracondylar fracture (bone broken at the knee) with slight posterior displacement. The Report indicated Resident #1 was transferred and admitted to the Hospital.</p> <p>Resident #1 was admitted to the Facility in August 2023, diagnoses included Hemiplegia (paralysis on one side of the body) and Hemiparesis (muscle weakness or partial paralysis on one side of the body) following a Cerebral Infarction (stroke) affecting the left non-dominant side, difficulty walking, lack of coordination, unsteadiness on feet, and Anemia in the setting of Chronic Kidney Disease (Stage 4).</p> <p>Review of Resident #1's Fall Risk Assessment, dated 05/15/24, indicated he/she was assessed by Nursing as being at high risk for falls.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 05/16/24, indicated that Resident #1 had severe cognitive impairment and required maximum assistance from staff with transfers and mobility.</p> <p>Review of Resident #1's Activities of Daily Living (ADL) Care Plan, related to mobility status, reviewed and renewed in conjunction with completion of his/her May 2024 MDS, indicated that for transfers he/she required extensive assistance from two staff members.</p> <p>Review of Resident #1's Fall Care Plan, reviewed and renewed in conjunction with completion of his/her May 2024 MDS, indicated safety interventions included to ensure that Resident #1 wore appropriate footwear when ambulating or mobilizing while in wheelchair.</p> <p>Review of Resident #1's Certified Nurse Aide (CNA) Care Kardex (used as a reference guide by CNA's, provides direct care staff with a brief overview of each residents' care needs), dated 06/01/24, indicated that Resident #1 required extensive assistance from two staff members for all transfers.</p> <p>Review of a Nurse Progress Note, dated 07/03/24, (written by Nurse #1) indicated that approximately 4:00 P. M., CNA #1 came to the Nurses Station and said she had lowered Resident #1 to the floor. The Note indicated Resident #1 was found in his/her room, laying on the floor in front of the Sit/Stand Lift device, he/she had no socks or shoes on his/her feet and Resident #1's right hip was partially internally rotated (knee and foot twist toward the midline of the body). The Note indicated Resident #1 was unable to recall what happened, but said he/she had pain in his/her right hip and Resident #1 was transferred to the hospital.</p> <p>During an interview on 07/24/24 at 1:20 P.M., Nurse #1 said on 07/03/24, CNA #1 came to her and said Resident #1 was on the floor in his/her room. Nurse #1 said upon arrival to Resident #1's room, she observed him/her laying on his/her back on the floor in front of the Sit/Stand Lift device. Nurse #1 said CNA #1 told her that she had transferred Resident #1 by herself, (from the wheelchair to the bed to provide care) that Resident #1 lost his/her balance during the transfer, and that she lowered him/her onto the floor. Nurse #1 said she also noted that Resident #1 did not have socks or shoes on his/her feet at the time, and should have.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 08/07/24 at 2:59 P.M., CNA #1 said she was aware that each resident had a Care Kardex and that she knew how to access them. CNA #1 said that they (CNA's) needed to review the Care Kardex for each of their residents before providing care, but that she had not reviewed Resident #1's CNA Care Kardex on 07/03/24. CNA #1 said when she cared for Resident #1, she had always provided care to him/her by herself, and did not ask for help.</p> <p>CNA #1 said she knew how to work the Sit/Stand Lift and that she had transferred Resident #1 by herself without any assistance from another staff member before without an incident. CNA #1 said Resident #1 became weak during the transfer so she lowered him/her to the floor. CNA #1 said she thought Resident #1 was strong enough to participate, so she did the transfer without assistance from anyone else.</p> <p>Although CNA #1 said that Resident #1 had socks and shoes on his/her feet during the transfer, this conflicted with Nurse #1's interview in which she said when she went to Resident #1's room on 07/03/24 at CNA #1's request, she observed that he/she did not have socks or shoes on.</p> <p>Review of Resident #1's Facility's Radiology Report of his/her X-ray knee exam, dated 07/08/24, indicated he/she had an acute distal femur supracondylar fracture.</p> <p>Review of Resident #1's Medical Record indicated on 07/08/24, Resident #1 was sent to the Hospital for further evaluation, treatment and was admitted .</p> <p>During an interview on 07/24/24 at 4:08 P.M., the Director of Nursing (DON) said it was her expectations that nursing staff be knowledgeable about the residents' Plan of Care and to implement and follow interventions accordingly. The DON said, prior to providing care, including transfers, that the CNA's need to identify how a resident's transfers and how many staff are needed (using the CNA Care Kardex) and CNA's must also follow the Facility's Policies and Procedures.</p> <p>During an interview on 07/24/24 at 5:31 P.M. the Administrator said that on 07/03/24, CNA #1 told her, she was going to provide ADL care to Resident #1, that she used the Sit/Stand lift so she could transfer him/her back to bed for care, that while Resident #1 was standing on the Sit/Stand Lift, he/she started to fall and that she lowered Resident #1 to the floor. The Administrator said she had asked CNA #1 if she had reviewed Resident #1's CNA Care Kardex regarding how Resident #1 transferred, and that CNA #1 replied No.</p> <p>On 07/24/24, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction which addressed the area(s) of concern as evidence by:</p> <p>A. 07/03/24, Resident #1 fell , was immediately assessed by Nursing for any injuries, Resident #1 had reported he/she had pain to right hip, and was transferred to the Hospital Emergency Department (ED) for evaluation.</p> <p>B. 07/03/24, Resident #1's Care Plan was reviewed and updated to include the 07/03/24 fall, and to ensure transfer status indicated he/she required physical assistance of two staff for all transfers.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>C. 07/03/24, Resident #1 returned to the facility, nursing reviewed the Hospital ED Discharge Summary (Final Report) which indicated Resident #1 was assessed and treated at the ED with no fractures found. However the he/she continued to experience pain and an X-ray completed at the facility a few days later indicated he/she had a right femur fractures.</p> <p>D. 07/09/24, Resident #1's Care Plan was updated to include that on 07/08/24, Resident #1 was in pain, Facility X-ray, dated 07/8/24, indicated Resident #1's right femur was fracture status post fall on 07/03/24, which was not previously diagnosed , that he/she had been transferred back to the ED and was admitted to the Hospital.</p> <p>E. The Facility's Morning Meeting and the Weekly Risk Meeting Fall Review minutes indicated the Interdisciplinary Team (IDT) reviewed Resident #1's fall that occurred on 07/03/24, his/her X-ray results from 07/08/24, and need for him/her to be transferred back to the Hospital ED for evaluation. The minutes indicated the the IDT continues to discuss (and update as needed) Resident #1's Plan of Care including orthopedic appointments, weight bearing status, nutritional status, and overall health status.</p> <p>F. The Facility Nursing Staff completed an Audit to ensure all residents who used any type of mechanical device, that their individual Care Plan and the CNA Care Kardex indicated the appropriate type of device to be used and how many staff were needed for assistance with the transfer.</p> <p>G. 07/09/24, The Staff Development Coordinator (SDC) and the DON initiated mandatory education for all Licensed Nurses and CNA's, which included completion of competencies on Sit/Stand Lift device, and staff were required to complete return demonstration of appropriate use of the transfer device. Education also included nursing staff requirement to review and follow residents plan of care, knowledge of how to access and review the CNA Care Kardex, prior to providing care.</p> <p>H. 07/12/24, Resident #1's Care Plan was updated to include, right distal femur fracture related to a fall, and that he/she required extensive assistance from two staff members using a Hoyer Lift (mechanical lift used to safely transfer patients).</p> <p>I. 07/17/24, All Sit/Stand Lift devices were Inspected by the Maintenance Department, to ensure all parts were functioning properly and transfer device was safe to use.</p> <p>J. Physical Therapy Department Staff also initiated and completed Audits related the incident to ensure all residents including new admissions, that their transfer status degree and number of staff needed for assistance during the provision of all care need areas identified were up to date on residents Plan of Care and CNA Care Kardex.</p> <p>K. Random Audits were completed by administrative staff, on Resident transfers with the Sit/Stand Lift to ensure that transfer procedures from Sit/Stand Lift Competencies are being followed by staff. Random Audits will be completed by the DON three times weekly for 3 months.</p> <p>L. The DON presented the Audit results at monthly Quality Assurance Performance Improvement (QAPI) meeting, where the QAPI Committee discussed the results. The DON will present the Audit results for three months, then quarterly until the Committee determines 100 % staff compliance is met, and the concern area thereafter will be present for yearly review.</p> <p>(continued on next page)</p>		

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F 0656 Level of Harm - Actual harm Residents Affected - Few	M. Review of the facility's most recent QAPI meeting minutes indicated leaderships plan is to continue to review the concern areas for potential deficient practice, including falls, to ensure that residents were provided with appropriate level of assistance as determined by assessments and identified in the residents Plan of Care and CNA Care Kardex. N. The Director of Nurses (DON) and/or designee are responsible for overall compliance.		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37330</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was assessed by nursing as being at high risk of falls, was known to have poor safety awareness, weakness due to a stroke and required the assistance of two staff members for transfers, the Facility failed to ensure Resident #1 was provided with the necessary level of staff assistance during a transfer to prevent an incident/accident resulting in a serious injury. On 07/03/24, CNA #1 transferred Resident #1 with a Sit/Stand Lift device (device that helps individuals who have difficulty standing up, from a seated position) without having another staff member present to assist her, during the transfer Resident #1 started to slide out of the lift seat, CNA #1 then tried to lower him/her to the floor, Resident #1 immediately complained of pain to his/her right hip, was transferred to the Hospital Emergency Department (ED) and was diagnosed several days later with a right femur (thigh bone) fracture which required surgical intervention to repair.</p> <p>Findings include:</p> <p>Review of the Facility's Policy, Fall Prevention Program Policy and Procedure, dated reviewed 02/26/24, indicated it is policy of the Facility's Accidents/Supervision to ensure resident safety is a commitment to provide an environment that is free from Accident hazards over which the facility has control and provides supervision and assistance devices to each resident based on the identified hazards or risks to each resident to prevent accidents.</p> <p>Review of the Facility's (Sit/Stand Lift) Stand Aid Lift Competency Checklist, dated January 2023, indicated staff to check the residents' Plan (CNA) Care Kardex for the correct number of assistants necessary to transfer the resident and use a gait belt if the resident requires help pulling themselves up.</p> <p>Review of the report submitted by the Facility via the Health Care Facility Reporting System, dated 07/03/24, indicated while being transferred and sitting in the Sit/Stand (mechanical transfer device), Resident #1 was lowered to the floor. The Report indicated Certified Nurse Aide (CNA) #1 used the Sit/Stand device incorrectly, and did not have another staff member assist her when transferring the resident back to bed to offer peri-care. The Report indicated Resident #1 complained of right hip pain, was assessed and an order was obtained to transfer him/her to the Hospital Emergency Department (ED) for evaluation. The Report indicated Resident #1 returned to the facility the same day, and that the ED Discharge Summary indicated there were no fractures.</p> <p>However, review of the Facility's Internal Investigation's Final Report, dated 07/08/24, indicated that Resident #1 continued to experience pain to his/her right knee area, and an X-ray of his/her right knee was ordered. On 07/08/24, the facility was notified that Resident #1 had an acute distal right femur (thigh bone) supracondylar fracture (bone broken at the knee) with slight posterior displacement. The Report indicated that when the facility's Physician Assistant reviewed Resident #1's Hospital Discharge Summary from 07/03/24, it was determined that although the Hospital ED Physician had ordered an X-ray of his/her right femur, that it had not been completed. Therefore, Resident #1 was not diagnosed with a right femur fracture until 07/08/24, at which point he/she was transferred back and admitted to the Hospital, for further treatment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1 was admitted to the Facility in August 2023, diagnoses included Hemiplegia (paralysis on one side of the body) and Hemiparesis (muscle weakness or partial paralysis on one side of the body) following Cerebral Infarction (stroke) affecting the left non-dominant side, difficulty walking, lack of coordination, unsteadiness on feet, and Anemia in the setting of Chronic Kidney Disease (Stage 4).</p> <p>Review of Resident #1's Fall Risk Assessment, dated 05/15/24, indicated he/she was assessed by Nursing as being at high risk for falls.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 05/16/24, indicated that Resident #1 had severe cognitive impairment and required substantial, maximum assistance (more than half the effort) from staff with transfers and mobility.</p> <p>Review of Resident #1's Fall Care Plan, reviewed and renewed in conjunction with completion of his/her May 2024 MDS, indicated safety interventions included the following; ensure Resident #1 wore appropriate footwear when ambulating and mobilizing (when in wheelchair).</p> <p>Review of Resident #1's Activities of Daily Living (ADL) Care Plan related to mobility and transfers, reviewed and renewed in conjunction with completion of his/her May 2024 MDS, indicated interventions included that for all transfers he/she required extensive assistance of two staff members.</p> <p>Review of Resident #1's Certified Nurse Aide (CNA) Care Kardex (used as a reference guide by CNA's and provides direct care staff with an overview of each residents' needs), dated 06/01/24, indicated interventions included that he/she required extensive assistance from two staff members with all transfers.</p> <p>During a telephone interview on 08/07/24 at 2:59 P.M., CNA #1 said she was assisting Resident #1 in his/her room with a transfer from his/her wheelchair to his/her bed using a Sit/Stand Lift. CNA #1 said Resident #1 was unable to pull him/herself up from the wheelchair to the Sit/Stand Lift because he/she was too weak. CNA #1 said she had to pull Resident #1 up to standing position very hard, using her hand and then assisted Resident #1 onto the seat of the Sit/Stand Lift. CNA #1 said when she was moving the Sit/Stand Lift closer to Resident #1's bed, she observed that Resident #1 was sliding out of the lift seat, so she had held onto Resident #1 with one hand and used her other hand to push the lift away, while using her own body to lower Resident #1 to the floor.</p> <p>CNA #1 said after Resident #1 was on the floor, she called out for help, but no one came. CNA #1 said Resident #1 was in pain when he/she was on the floor, he/she was making groaning sounds, so she left Resident #1 alone on the floor and went to the Nurse's station to get help. CNA #1 said she had worked with Resident #1 in the past and had always provided care to him/her by herself. CNA #1 said she usually does her job by herself, and does not ask for help.</p> <p>During an telephone interview on 07/25/24 at 10:10 A.M., the Nursing Supervisor said on 07/03/24, CNA #1 reported that Resident #1 fell in his/her room and that she lowered Resident #1 to the floor. The Nursing Supervisor said upon entering Resident #1's room, Resident #1 was on the floor, moaning, making sounds, and leaning slightly on his/her left side holding his/her right hip. The Nursing Supervisor said she was concerned about Resident #1's fall, his/her complaints of pain, and because Resident #1 was prescribed an anticoagulant medication which put him/her at risk for bleeding, that Resident #1 was transferred to the Hospital ED for evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/24/24 at 12:18 P.M., the facility's Physician Assistant (PA) said on 07/03/24, CNA #1 reported that Resident #1 fell . The PA said she had asked CNA #1 what happened, and that CNA #1 said Resident #1 let go of the handlebars of the Sit/Stand Lift and that she lowered him/her to the floor.</p> <p>The PA said upon arrival to Resident #1's room, he/she was found laying on his/her back on the floor in front of the Sit/Stand Lift device. The PA said Resident #1 said he/she had pain in his/her legs, and she observed that Resident #1's right leg was internally rotated (knee and foot twist toward the midline of the body). The PA said she assessed Resident #1 and ordered that he/she be transferred to the Hospital ED for further evaluation.</p> <p>The PA said Resident #1 returned to the facility on [DATE], and that the Hospital ED Report indicated that Resident #1 did not have any fractures. The PA said Resident #1 continued to have pain including to his/her right knee, and that nursing had observed and reported his/her right knee had become swollen. The PA said she re-assessed Resident #1 who was still complaining that he/she was in a lot of pain. The PA said on 07/08/24, the Facility obtained an X-ray of Resident #1's right femur (thigh bone) which indicated Resident #1 had a distal right femur fracture and Resident #1 was transferred back and admitted to the Hospital that same day.</p> <p>The PA said she reviewed Resident #1's Hospital ED Records from 07/03/24 and said the Hospital did not obtain an X-ray of Resident #1's right femur per Hospital ED Physician Orders. The PA said the type of fracture Resident #1 sustained would be the result of movement with force, and that Resident #1's fall on 07/03/24 would have been a contributing factor. The PA said when Resident #1 returned from the Hospital ED on 07/03/24, he/she had remained bed ridden, that he/she had not gotten out of bed at all, until 07/08/24, when he/she was transferred back to the Hospital.</p> <p>During an interview on 07/24/24 at 4:08 P.M., the Director of Nursing (DON) said on 07/03/24, upon entering Resident #1's room, Resident #1 had been laying on the floor, moaning and he/she seemed to be in a lot of pain. The DON said CNA #1 said she was using the Sit/Stand Lift to provide Activities of Daily Living (ADL) care (personal care) to Resident #1 which included the need to transfer him/her from the wheelchair back into bed. The DON said CNA #1 said Resident #1 was standing up on the Sit/Stand Lift device holding onto the handlebars, before she (CNA #1) lowered him/her to the floor. The DON said the Sit/Stand Lift was not to be utilized by staff during ADL care and was only to be used for short distances transfers.</p> <p>During an interview on 07/24/24 at 5:31 P.M. the Administrator said on 07/03/24, upon entering Resident #1's room, Resident #1 was laying on the floor, moaning, crying and was in pain. The Administrator said CNA #1 said she was providing ADL care to Resident #1, that he/she was standing on the Sit/Stand Lift, started to fall and that she lowered Resident #1 to the floor.</p> <p>However, during a telephone follow-up interview on 08/08/24 at 2:39 P.M., CNA #1 said that on 07/03/24, she had not put a gait belt or had a another staff member help her during Resident #1's transfer. CNA #1 confirmed that Resident #1 was sitting on the seat of the Sit/Stand Lift device, not standing, when he/she became weak, and started sliding out of the chair, before she lowered him/her to the floor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>This contradicted what CNA #1 reported to the PA, DON and Administrator, when she told them that Resident #1 was standing up in the Sit/Stand Lift device, holding onto the handle bars, before she had lowered him/her down to the floor.</p> <p>On 07/24/24, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction which addressed the area(s) of concern as evidence by:</p> <p>A. 07/03/24, Resident #1 fell , was immediately assessed by Nursing for any injuries, Resident #1 had reported he/she had pain to right hip, and was transferred to the Hospital Emergency Department (ED) for evaluation.</p> <p>B. 07/03/24, Resident #1's Care Plan was reviewed and updated to include the 07/03/24 fall, and to ensure transfer status indicated he/she required physical assistance of two staff for all transfers.</p> <p>C. 07/03/24, Resident #1 returned to the facility, nursing reviewed the Hospital ED Discharge Summary (Final Report) which indicated Resident #1 was assessed and treated at the ED with no fractures found. However the he/she continued to experience pain and an X-ray completed at the facility a few days later indicated he/she had a right femur fractures.</p> <p>D. 07/09/24, Resident #1's Care Plan was updated to include that on 07/08/24, Resident #1 was in pain, Facility X-ray, dated 07/8/24, indicated Resident #1's right femur was fracture status post fall on 07/03/24, which was not previously diagnosed , that he/she had been transferred back to the ED and was admitted to the Hospital.</p> <p>E. The Facility's Morning Meeting and the Weekly Risk Meeting Fall Review minutes indicated the Interdisciplinary Team (IDT) reviewed Resident #1's fall that occurred on 07/03/24, his/her X-ray results from 07/08/24, and need for him/her to be transferred back to the Hospital ED for evaluation. The minutes indicated the the IDT continues to discuss (and update as needed) Resident #1's Plan of Care including orthopedic appointments, weight bearing status, nutritional status, and overall health status.</p> <p>F. The Facility Nursing Staff completed an Audit to ensure all residents who used any type of mechanical device, that their individual Care Plan and the CNA Care Kardex indicated the appropriate type of device to be used and how many staff were needed for assistance with the transfer.</p> <p>G. 07/09/24, The Staff Development Coordinator (SDC) and the DON initiated mandatory education for all Licensed Nurses and CNA's, which included completion of competencies on Sit/Stand Lift device, and staff were required to complete return demonstration of appropriate use of the transfer device. Education also included nursing staff requirement to review and follow residents plan of care, knowledge of how to access and review the CNA Care Kardex, prior to providing care.</p> <p>H. 07/12/24, Resident #1's Care Plan was updated to include, right distal femur fracture related to a fall, and that he/she required extensive assistance from two staff members using a Hoyer Lift (mechanical lift used to safely transfer patients).</p> <p>I. 07/17/24, All Sit/Stand Lift devices were Inspected by the Maintenance Department, to ensure all parts were functioning properly and transfer device was safe to use.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER St Patrick's Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 863 Central Street Framingham, MA 01701	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>J. Physical Therapy Department Staff also initiated and completed Audits related the incident to ensure all residents including new admissions, that their transfer status degree and number of staff needed for assistance during the provision of all care need areas identified were up to date on residents Plan of Care and CNA Care Kardex.</p> <p>K. Random Audits were completed by administrative staff, on Resident transfers with the Sit/Stand Lift to ensure that transfer procedures from Sit/Stand Lift Competencies are being followed by staff. Random Audits will be completed by the DON three times weekly for 3 months.</p> <p>L. The DON presented the Audit results at monthly Quality Assurance Performance Improvement (QAPI) meeting, where the QAPI Committee discussed the results. The DON will present the Audit results for three months, then quarterly until the Committee determines 100 % staff compliance is met, and the concern area thereafter will be present for yearly review.</p> <p>M. Review of the facility's most recent QAPI meeting minutes indicated leaderships plan is to continue to review the concern areas for potential deficient practice, including falls, to ensure that residents were provided with appropriate level of assistance as determined by assessments and identified in the residents Plan of Care and CNA Care Kardex.</p> <p>N. The Director of Nurses (DON) and/or designee are responsible for overall compliance.</p>		