STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225435	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colony Center for Health and Rehabilitation	277 Washington Street Abington, MA 02351

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 0658 Level of Harm - 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 cognitively intact, and on 6/23/24 during the overnight shift had been heard calling out for help and was found on the floor by two Certified Nurse Aides (CNAs) after an unwitnessed fall, the Facility failed to ensure he/she was provided with nursing care and treatment that met professional standards of practice, when although Nurse #1 went to Resident #1's room with the two CNA's to check him/her, after a brief assessment Nurse #1 assisted the CNA's with lifting him/her off the floor and putting him/her back in to bed. However, Nurse #1 did not document the incident, did not complete an incident report, did not report the incident to the oncoming nurse during shift change report and there was no documentation in Resident #1's medical record to support she had adequately assessed him/her after the fall. Resident #1 verbalized complaints of pain in his/her left upper leg/thigh area for the next two shifts after the incident, and approximately 24 hours after the incident, Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation, where he/she was diagnosed with acute fractures of the pelvis. 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 Policy titled, Falls - Clinical Protocol, undated, indicated the following: -the staff will evaluate, and document falls both witnessed and unwitnessed that occur while the resident is in the facility, when and where they happen and any observations of the events; -the staff will follow up on any fall with associated injury until the resident is stable. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	Review of the Facility Policy, titled, Accidents and Incidents - Investigating and Reporting, undated, indicated the following: -all accidents or 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 date shall be included on the Report of Incident/Accident: date and time of accident or incident took place; nature of the injury, circumstances surrounding the accident or incident; where the accident or incident took place; name of witnesses and their accounts of the accident or incident; the time the physician was notified and his/her instructions; the condition of the resident, including vital signs, the signature and title of the person completing the report; -charge nurse shall complete a Report of Incident/Accident form and submit the original to the Director of Nurses (DON) within 24 hours of the incident or accident; -the DON shall ensure that the administrator receives a copy of the Report of Incident/Accident form for each occurrence. Resident #1 was admitted to the Facility in May 2024, diagnoses included osteoarthritis of the knee, chronic kidney disease, repeated falls, hypertension, depression, disorientation and atherosclerotic heart disease Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted on 07/01/24, indicated that on 06/23/24 at approximately 3:00 A.M., Resident #1 was found by Certified Nurse Aide (CNA) #1 and CNA #2 lying flat on his/her back on the floor with his/her feet towards the side of the bed and his/her head towards the door of his/her room. The Report indicated Nurse #1 assessed Resident #1 and he/she complained of back pain. The Report indicated that CNA #1, CNA #2 and Nurse #1 assisted Resident #1 back into bed and Resident #1 began complaining of leg pain. The Report indicated Nurse #1 administered pain medication with moderate effect. The Report indicated that Nurse #2 assumed care of Resident #1 from 7:00 A.M. through 11:00 P.M. on 6/23/24. The Report indicated throughout the day, Resident #1 complained several times of 10/10 pain in his/her groin and leg and pain worsened with movement. The Report indicated Nurse #2 notified the physician and orders were obtained for pain management. The Report indicated that at the end of Nurse #2's shift, Resident #1 as observed lying in bed and had no complaints of pain. The Report further indicated that Nurse #3 assumed care of Resident #1 at 11:00 P.M. and assessed Resident #1 shortly after the start of the shift. The Report indicated that Nurse #3 assessed Resident #1 hips by applying light pressure, he/she screamed out in pain, and stated his/her pain was 10/10 when his/her left lower extremity was moved, and he/she could not move his/her left lower extremity. The Report indicated that Nurse #3 notified the physician and Resident #1 was transferred to the Hospital ED at 2:30 A.M. on 6/24/24. The Report indicated Resident #1 was diagnosed with acute fractures of the left anterior acetabulum and left inferior pubic ramus (pelvic fractures). (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 0658 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 07/16/24 at 08:00 A.M., (which included a review of her Written Witness Statement, dated 06/24/24), CNA #1 said on 06/23/24, somewhere around 2:30 A.M.- 3:00 A.M. (exact time unknown) she heard someone calling out help, she walked down the hall, went into Resident #1's room and found him/her lying on his/her back on the floor in his/her room. CNA #1 said she went to get help and CNA #2 and then Nurse #1 came into Resident #1's room. CNA #1 said that Resident #1 was complaining that his/her back hurt, that Nurse #1 checked his/her back and all three of them transferred Resident #1 into bed by lifting his/her body and putting him/her back into bed. During an interview on 07/15/24 at 03:20 P.M., (which included a review of her Written Witness Statement, dated 06/24/24), CNA #2 said on 06/23/24, sometime around 2:30 A.M. (exact time unknown) she was in the dining room when CNA #1 entered and informed her that a resident was on the floor. CNA #2 said that she and CNA #1 went into Resident #1's room and found him/her lying on his/her back on the floor in front of the bathroom door of his/her room. CNA #2 said that they called out for the Nurse (later identified as Nurse #1), Nurse #1 entered the room with a blood pressure cuff, obtained Resident #1's blood pressure and then all three of them transferred Resident #1 back into bed by lifting his/her body and putting him/her into bed. CNA #2 said that Resident #1 kept yelling out my head, my leg, hurts during the transfer and after he/she was lying in bed. CNA #2 said that Nurse #1 gave Resident #1 pain medication and told her (CNA #2) that Resident #1 was okay. CNA #2 said that Nurse #1 did not ask her for a statement about the incident. CNA #2 said later that same day (6/23/24) she returned to work on the same unit for the 3:00 P.M. to 11:00 P.M. shift. CNA #2 said that Resident #1 was yelling out in pain during the shift. CNA #2 said that she believed that the nurses on that shift were aware that Resident #1 had fallen during the overnight shift because the nurses give each other report, so she assumed that the nurses were aware. During an interview on 7/15/24 at 04:15 P.M., (which included a review of her Written Witness Statement, dated 06/23/24), Nurse #2 said that during change of shift report on 6/23/24, from the 11:00 P.M. to 07:00 A.M. nurse (later identified as Nurse #1), Nurse #1 shared that Resident #1 had almost fallen, but had not and that he/she was fine. Nurse #2 said that after report, she went in to assess Resident #1, said Resident #1 was in bed and when asked if he/she had pain, he/she pointed to his/her left upper leg/thigh area and began to yell out in pain. Nurse #2 said she administered Tylenol to Resident #1, checked on him/her later and Resident #1 said he/she did not have any effect from the Tylenol. Nurse #2 said she administered Tramadol (pain reliever for moderate to severe pain) and Resident #1 did not have any effect from the Tramadol. Nurse #2 said that when she moved Resident #1's left leg, he/she cried out in pain. Nurse #2 said she notified the physician of Resident #1's pain, of her interventions and said the physician ordered Ibuprofen 800 milligrams (mg) one time dose and to not move Resident #1's left leg, that the MD said he believed he/she had a stiff leg which would self-resolve. Nurse #2 said that she followed the physician's orders and later on the 03:00 P.M. to 11:00 P.M. shift, Resident #1 continued to complain of pain, that she notified the physician several times on 06/23/24 of Resident #1's unresolved pain and he ordered another dose of Tramadol and scheduled his/her Tylenol to three times a day. Nurse #2 said that Resident #1's pain medication was effective if she did not move his/her left lower extremity. Nurse #2 said she was not aware that Resident #1 had fallen on 6/23/24, during the overnight shift. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	CNA #1 said that she worked the 11:00 P.M. to 07:00 A.M. shift (from 6/23/24 into 6/24/24) and when she came on duty, she told the Nurse (later identified as Nurse #3) that she did not write a statement about Resident #1's fall last night. CNA #1 said that Nurse #3 said he was unaware of Resident #1's fall, said Nurse #3 then called the Director of Nurses (DON) and Resident #1 was transferred to the hospital. During an interview on 7/15/24 at 04:45 P.M., (which included a review of his Written Witness Statement, undated,) Nurse #3 said that during change of shift report from the 3:00 P.M. to 11:00 P.M. nurse (later identified as Nurse #2) that Nurse #2 had said that Resident #1 was in excruciating pain the whole day. Nurse #3 said that Nurse #2 said that she notified the physician and received multiple orders for pain management. Nurse #3 said that he asked Nurse #2 if Resident #1 had fallen and said Nurse #2 said she had not received any reports that Resident #1 had sustained a fall. Nurse #3 said that the CNA (later identified as CNA #1) who had worked that overnight shift (06/24/24) was the one that told him that Resident #1 had fallen the previous night. Nurse #3 said he then completed a head-to-toe assessment on Resident #1 who stated he/she was experiencing a 10/10 pain in his/her left lower extremity and screamed out in pain when he lightly pressed on Resident #1's left hip area and said Resident #1 was unable to move his/her left lower extremity. Nurse #3 said he notified the DON, notified the physician and Resident #1 was transferred to the Hospital ED for evaluation. During a telephone interview on 7/16/24 at 1:33 P.M., (which included a review of her Written Witness Statement, dated 6/25/24), Nurse #1 said that on 6/23/24, sometime around 03:30 A.M. (exact time unknown), one of the CNA's notified her and the other CNA that she heard help help and thought that a resident had fallen. Nurse #1 said that the two CNA's (later identified as CNA #1 and CNA #2) went into Resident #1's room and she followed them. Nurse #1 said that when she entered Resident #1's room, he/she was in a near falling position, with his/her legs and feet dangling on the floor sliding off the bed and his/her upper body was sliding off the bed, and it looked like he/she was trying to reach the bedside commode. Nurse #1 said that she asked Resident #1 if he/she was okay and said that Resident #1 said he/she was okay and just needed to go to the bathroom. Nurse #1 said that the CNA's transferred Resident #1 onto the commode and then transferred him/her back into bed. Nurse #1 said that she obtained Resident #1's vital signs and assessed him/her for injury and that no injuries were noted. Nurse #1 said that a few minutes later, Resident #1 complained of back pain and she administered Tylenol to him/her. Nurse #1 said that for the remainder of the shift, Resident #1 did not complain to her of any pain. Nurse #1 said that she reported to the next shift nurse that Resident #1 almost fell and that she gave him/her Tylenol for back pain. Nurse #1 said that she thought she wrote a nurse progress note about the incident and said she thought she documented that she administered Tylenol to Resident #1 for back pain. Nurse #1 said she should have written a nurse progress note about the incident and should have documented that she administered Tylenol to Resident #1. Nurse #1 said that she did not complete an incident report, did not notify the DON, and did not notify the physician because Resident #1 did not fall. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Although Nurse #1's Written Witness Statement and Telephone Interview indicated she found Resident #1 in a near falling position on 06/23/24 at approximately 3:30 A.M., review of Resident #1's Medical Record indicated there was no documentation to support this, and no documentation to support that Nurse #1 had assessed Resident #1 after the incident, documented the incident in a nurses note, completed an Incident Report, notified the Director of Nurses or notified Resident #1's physician, per Facility Policy. The Facility was unable to provide any documentation related to Resident #1's incident on 06/23/24. The was no documentation to support Nurse #1 had assessed Resident #1 for potential injury or pain as a result of the fall. Review of a Hospital Discharge Summary Report, dated 06/24/24, indicated that Resident #1 presented after a fall with left knee, hip, groin and leg pain. The Report indicated that a Pelvic CT scan revealed acute fractures of left anterior acetabulum and left inferior pubic ramus (fractured pelvis). During an interview on 07/15/24 at 3:41 P.M., the Director of Nurses (DON) said that Resident #1 was at high risk for falls and had a history of multiple falls at home. The DON said that Resident #1's injuries were consistent with injuries sustained after a fall and said that near fall incidents are still considered a fall. The DON said she could not find any documentation in Resident #1's Medical Record regarding his/her fall on 06/23/24. 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 and notified her (DON), but she had not.