

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/15/2024
NAME OF PROVIDER OR SUPPLIER  Meadow Green Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  45 Woburn Street Waltham, MA 02453	

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 - Minimal harm or potential for 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>37342</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required assistance from two staff members for transfers, the Facility failed to ensure they developed and implemented a comprehensive care plan that included interventions, goals, and outcomes related to his/her transfer status.</p> <p>Findings include:</p> <p>The Facility's Policy, titled Comprehensive, Person-Centered Care Plans, dated 08/01/23, indicated the interdisciplinary team, in conjunction with the resident and his/her family or legal representative, would develop and implement a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs for each resident.</p> <p>The Facility's Policy, titled Safe Lifting and Movement of Residents, dated 08/01/23, indicated resident safety, dignity, comfort, and medical conditions would be incorporated into goals and decisions regarding safe lifting and moving of residents, and nursing staff, in conjunction with rehabilitation staff, would assess the resident's needs for transfer assistance on an ongoing basis and document resident transfer needs in the care plan.</p> <p>Resident #1 was admitted to the Facility in September 2023, diagnoses included history of falls, dementia, rheumatoid arthritis and osteoarthritis.</p> <p>Review of Resident #1's Hospital Physical Therapy Discharge Assessment Note, dated 09/11/23, indicated Resident #1 required two staff members to assist with transfers.</p> <p>Review of Resident #1's Post Admission Care Plan Meeting Note, dated 09/26/23, indicated he/she required max assist of two staff for transfers.</p> <p>Review of Resident #1's Certified Nurse Aide Activities of Daily Living Flowsheet for September 2024 indicated he/she was dependent on staff for all transfers.</p> <p>Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 09/07/24, indicated he/she was dependent for transfers.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/15/2024
NAME OF PROVIDER OR SUPPLIER  Meadow Green Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  45 Woburn Street Waltham, MA 02453	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Physical Therapy Evaluation and Plan of Treatment, dated 10/08/24, indicated he/she was assessed as being at his/her baseline for transfers, and required maximum assist of two staff members for transfers.</p> <p>Review of Resident #1's Activities of Living (ADL) Care Plan, dated as initiated 02/07/24 and revised 08/23/24, indicated staff were to assist resident with transfers.</p> <p>However, further review of Resident #1's Care Plan indicated there was no documentation to support he/she had interventions related to his/her need for two staff member assistance with transfers, or goals or outcomes related to his/her transfer status.</p> <p>During an interview on 10/15/24 at 02:02 P.M., the Director of Nurses (DON) said Resident #1's ADL Care Plan intervention for transfers was vague and said she would expect that the Care Plan would reflect the care specific to what the resident was receiving and required, but did not.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/15/2024
NAME OF PROVIDER OR SUPPLIER  Meadow Green Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 45 Woburn Street Waltham, MA 02453	
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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>37342</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required assistance of two staff members for all transfers, the Facility failed to ensure he/she was provided with the necessary level of staff assistance, when on 09/28/24 Certified Nurse Aide #1 transferred him/her without assistance from another staff member, and as a result Resident #1 sustained a fractured right ankle, which required surgical intervention to repair.</p> <p>Findings include:</p> <p>The Facility's Policy, titled Safe Lifting and Movement of Residents, dated 08/01/23, indicated resident safety, dignity, comfort, and medical condition would be incorporated into goals and decisions regarding the safe lifting and movement of residents.</p> <p>Review of the Report submitted by the Facility via the Health Care Facilities Reporting System (HCFRS), dated 10/03/24, indicated that on 09/29/24, Resident #1's right ankle was assessed to be swollen and bruised, X-Ray results indicated his/her right ankle was fractured, and through the Facility's internal investigation, it was determined that on 9/28/24, Certified Nurse Aide #1 transferred Resident #1 without assistance from another staff member, which was identified as the source of his/her injury.</p> <p>Resident #1 was admitted to the Facility in September 2023, diagnoses included history of falls, dementia, rheumatoid arthritis, and osteoarthritis.</p> <p>Review of Resident #1's Hospital Physical Therapy Discharge Assessment Note, dated 09/11/23, indicated Resident #1 required two staff members to assist with transfers.</p> <p>Review of Resident #1's Post Admission Care Plan Meeting Note, dated 09/26/23, indicated he/she required maximum assistance of two staff for transfers.</p> <p>Review of Resident #1's Certified Nurse Aide Activities of Daily Living Flowsheet for September 2024 indicated he/she was dependent on staff for all transfers (that resident does none of the effort to complete the task, and/or requires the assistance of two or more staff to complete the activity).</p> <p>Review of Resident #1's Annual Minimum Data Set (MDS) assessment (a comprehensive assessment of each resident's functional capabilities), dated 09/07/24, indicated he/she was dependent for transfers.</p> <p>Review of Resident #1's Nurse Progress Note, dated 09/29/24, indicated Resident #1's right foot was bruised and swollen, and a physician's order for an x-ray was obtained.</p> <p>Review of Resident #1's Radiology Report, dated 09/29/24, indicated he/she had an acute fracture of the right distal fibular shaft (long bone on the outside of the lower leg).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/15/2024
NAME OF PROVIDER OR SUPPLIER  Meadow Green Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 45 Woburn Street Waltham, MA 02453	
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 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Review of Resident #1's Hospital Admission History and Physical, dated 10/02/24, indicated he/she was diagnosed with a displaced fracture of the right distal fibular shaft with valgus angulation (type of fracture where the distal part (part furthest away from the center of the body) of the bone points away from the body's midline), and required surgical intervention of a closed reduction percutaneous pinning.</p> <p>During a telephone interview on 10/16/24 at 01:10 P.M., Nurse #2 said she was Resident #1's nurse on 09/28/24 and 09/29/24. Nurse #2 said CNA #1, who was familiar with Resident #1 and had provided care for him/her many times, was assigned to Resident #1 during the 07:00 A.M., to 03:00 P.M., shift on 09/28/24. Nurse #2 said that on the morning on 09/29/24 Resident #1's right ankle was observed to be bruised and swollen.</p> <p>During a telephone interview on 10/16/24 at 01:59 P.M., Nurse Supervisor #1 said that on 09/29/24 she was called to Resident #1's room by Nurse #2 because his/her foot was bruised and swollen. Nurse Supervisor #1 said she interviewed Certified Nurse Aide (CNA) #1, who had provided care for Resident #1 on 09/28/24, and said CNA #1 told her that she had transferred Resident #1 from his/her bed to his/her chair without any help from another staff member.</p> <p>Nurse Supervisor #1 said CNA #1 should have gotten and had assistance from another staff member to transfer Resident #1, but did not.</p> <p>Review of Certified Nurse Aide (CNA) #1's signed written statement, dated 09/29/24, indicated that on 09/28/24 at 10:30 A.M., she provided ADL care to Resident #1, and that she transferred him/her from his/her bed to his/her wheelchair without assistance from another staff member.</p> <p>CNA #1 did not respond to the Department of Public Health telephone or letter request for an interview.</p> <p>During an interview on 10/15/24 at 12:25 P.M., the Director of Nurses (DON) said CNA #1 should have had another staff member present to assist her with transferring Resident #1 on 09/28/24, but did not, and as a result Resident #1 sustained a right ankle fracture.</p>		