STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225523	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Glen Ridge	120 Murray Street Medford, MA 02155

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 37342 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was alert, oriented, and able to make his/her needs known, the Facility failed to ensure he/she was free from physical and emotional abuse from a staff member, when on 08/26/24, although Resident #1 was asleep, the Facility's contracted Podiatrist began to provide care to his/her feet, Resident #1 woke up abruptly, was startled by the Podiatrist touching his/her feet, told the Podiatrist to stop, they became engaged in a verbal and physical altercation, during which Resident #1 was struck on the left side of his/her face and left arm. Resident #1 was transferred and evaluated in the Hospital Emergency Department for an injury to his/her left cheek. Resident #1 said as a result of the altercation, he/she was fearful and anxious about the Podiatrist being in the building. Findings include: The Facility Policy, titled Abuse Prohibition, dated revised 03/2022, indicated: -Each resident had the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of their property. Every resident in the Facility would always be treated with respect and dignity, and residents would not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteer staff, family members, friends or other individuals. -Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical hurt or pain or mental anguish to a resident. -Physical abuse included, but was not limited to, hitting, slapping, pinching, kicking, and so on. -Staff would refrain from all actions that could be considered abuse, mistreatment, neglect, exploitation, and/or misappropriation. Resident #1 was admitted to the Facility in February 2023, diagnoses included dementia, insomnia, and anxiety. Review of Resident #1's Quarterly Minimum Data Set Assessment, dated 08/21/24, indicated he/she had a Brief Interview for Mental Status (BIMS, structured interview to assess attention, orientation and recall) score of 15/15, which indicated he/she was cognitively intact. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Nurse Progress Note, dated 08/26/24, indicated Nurse #1 was in the hallway on Resident #1's unit, and heard loud screaming come from Resident #1's room. The Note indicated Nurse #1 immediately went to Resident #1's room, discovered him/her sitting on his/her bed, he/she was bleeding from his/her left hand, the left side of his/her face and was anxious and scared. During a telephone interview on 10/30/24 at 01:08 P.M., Nurse #1 said that on 08/26/24 she was at the medication cart down the hall from Resident #1's room when she heard loud screaming come from Resident #1's room. Nurse #1 said she immediately went to Resident #1's room and saw him/her lying on his/her bed and the Podiatrist was standing at the foot of the bed. Nurse #1 said Resident #1 said he/she told the Podiatrist not to cut his/her toenails and said that the Podiatrist had hit him/her. Nurse #1 said Resident #1 was bleeding from a cut on the left side of his/her face and a cut on his/her left hand, and was transferred to the Hospital Emergency Department. Nurse #1 said she was familiar with Resident #1 and said he/she could be confused at times but was mostly alert and oriented. Nurse #1 said she had never heard Resident #1 make accusations against anyone before this incident. Nurse #1 said Resident #1 became anxious and fearful, would ask if the Podiatrist was coming back, would talk about the incident nonstop, and required reassurance from staff and family. During an interview on 10/30/24 at 02:06 P.M., Resident #1 said that about two months ago (exact date unknown), he/she was napping in bed in the middle of the morning, and he/she woke up because he/she felt someone pulling at his/her leg. Resident #1 said when he/she saw the Podiatrist at the foot of his/her bed, touching his/her feet, he/she told the Podiatrist not to clip his/her toenails. Resident #1 said the Podiatrist ignored him/her and continued to clip his/her toenails. so he/she then tried to get up from the bed. Resident #1 said the Podiatrist then hit him/her with a closed fist on the left side of his/her face, which resulted in a cut and bruising on the left side of his/her face and ear and a cut on his/her hand. Resident #1 said He hit me so hard. He just hauled off and whaled me! Who does he think he is hitting an old (person)? I was so afraid he would come back and hurt me again. Review of the Local Police Department Report, dated 08/26/24, indicated Resident #1 said he/she woke up and found the Podiatrist attempting to clip his/her toenails, and said he/she told the Podiatrist he/she did not want his/her toenails touched. The Police Report indicated Resident #1 said the Podiatrist then struck him/her on the left side of his/her face with a closed fist, and he/she had a visible laceration on his/her left cheek. The Police Report indicated the Podiatrist said that when he attempted to clip Resident #1's toenails, he/she lunged forward at him, that he put his hands out and had his clippers in his right hand. The Police Report indicated the Podiatrist said he was unsure if his hand made contact with Resident #1's face. Review of Resident #1's Interdisciplinary Team Discharge and Recapitulation Summary Note, dated 08/26/24, indicated Resident #1 stated that when the Podiatrist went to cut his/her toenails, he/she said no, and the Podiatrist punched him/her on the left side of his/her face and cut his/her left hand. The Summary indicated Resident #1 was transferred to the Hospital Emergency Department and was alert, oriented at the time of transfer. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Hospital Emergency Department Encounter Note, dated 08/26/24, indicated he/she was evaluated and treated for a dime sized abrasion to the left side of his/her face, left ear redness and reported an altercation with the Facility's Podiatrist. The Encounter Note indicated Resident #1 reported that the Podiatrist struck him/her on the left side of his/her face, and that he/she had full recall of the event. Review of Resident #1's Skin Observation Tool, dated 08/26/24, indicated he/she had an abrasion on the left side of his/her face and a laceration on his/her left lower arm, which were new. Review of Resident #1's Nurse Progress Note, dated 08/27/24, indicated Resident #1, who was normally social, was withdrawn, isolating in his/her room, expressing concerns about his/her safety, and refused to take a shower which he/she was usually very eager for. Review of Resident #1's Nurse Progress Note, dated 08/28/24, timed 06:57 A.M., indicated he/she expressed fear over the incident with the Podiatrist from two days prior. Review of Resident #1's Nurse Progress Note, dated 08/28/24, timed 10:26 A.M., indicated he/she was anxious regarding the incident and required reassurance from staff. Review Resident #1's Psychological Progress Note, dated 08/28/24, indicated he/she was generally oriented to self, time, place and situation. The Note indicated Resident #1 discussed the recent incident where the Podiatrist had reportedly hit him/her in the face. The Report indicated Resident #1 said I am so scared of him. I am fearful he will come back and hurt me again. Review of Resident #1's Nurse Progress Note, dated 08/31/24, indicated Resident #1 called the Local Police Department because he/she was in fear that the Podiatrist would be coming in that day. Review of Resident #1's Nurse Progress Note, dated 09/04/24, indicated he/she was very anxious to know when the Podiatrist was coming back to the Facility. Review of the Podiatrist's written statement, that he provided to the facility but was unsigned, indicated that on 08/26/24, he went to see Resident #1 in his/her room, introduced himself, pulled back his/her open toe stockings, and Resident #1 lunged at him, yelled stop stop stop, and grabbed his clippers. During a telephone interview on 10/30/24 at 10:50 A.M., The Podiatrist said that on 08/26/24 at 10:00 A.M., he entered Resident #1's room and found him/her sleeping. The Podiatrist said he made two or three attempts to wake Resident #1, however he/she did not wake up, and said he did not ask a staff member to come to help wake Resident #1 up. The Podiatrist said he then proceeded to pull back Resident #1's open toe stockings and started clipping his/her toenails, without ensuring Resident #1 knew he was there, who he was, or what he was doing. The Podiatrist said as he was clipping his/her toenails, Resident #1 suddenly woke up and lunged at him. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Podiatrist said he never left the foot of Resident #1's bed, and could not recall if he moved his right hand (which was holding the toenail clippers) to the left, right, forward, or backward. The Podiatrist said it was possible, but he could not recall if Resident #1's face or arm came in contact with his clippers, and said they are very sharp and could easily cause a cut. Although the Podiatrist denied hitting/punching Resident #1 in the face, the Podiatrist's written statement conflicted with the statement he made to the Police on 08/26/24 and conflicted with his account of the incident on 10/30/24 during his telephone interview with the surveyor. During an interview on 10/29/24 at 01:18 P.M., the Director of Nurses (DON) said that on 08/26/24, some time in the morning, she was called to Resident #1's unit by Nurse #1 who reported that Resident #1 said the Podiatrist had punched him/her. The DON said Resident #1 had fresh blood on his/her left cheek and left lower arm near his/her hand that were from new injuries, and that he/she said the Podiatrist had hit him/her with a closed fist. The DON said Resident #1 was consistent with his/her story, and said she believed that something did happen, but she was not there to witness the incident. The DON said that during an interview with the Podiatrist, he said he had begun clipping Resident #1's toenails while he/she was sleeping and that's when Resident #1 was startled awake and lunged forward, causing his/her injuries. The DON said she was unsure how Resident #1's face could have come in contact with the Podiatrist's clippers if he was at the foot of the bed.

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F 0691 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 37342 Based on records reviewed and interviews, for one of three sampled residents (Resident #2), who had an ileostomy (surgical procedure that creates an opening in the abdominal wall to direct the small intestine and allow waste to exit the body), the Facility failed to ensure they provided care consistent with professional standards of practice, when on 09/23/24, although nursing was aware Resident #2 did not have ostomy appliances in place over his/her stoma, which was actively secreting stool, no additional nursing interventions were implemented to protect his/her abdominal wound, resulting in fecal matter contamination of his/her abdominal incision, excoriation of surrounding skin, and he/she required transfer and re-admission to the Hospital for treatment. Findings include: The Facility's Policy, titled, Ostomy Care, dated 04/2022, indicated an ileostomy was a surgically created opening from the small bowel which was brought through the abdominal wall and used to create a stoma. The Ostomy Care Policy did not indicate any professional procedure for the appliance or maintenance of placement of an ostomy device. The Facility's Policy, titled Dry/Clean Dressings, dated 03/2022, indicated wound care and dressings would be applied as ordered by the physician. Resident #2 was admitted to the Facility in September 2024, diagnoses included intestinal obstruction and ileostomy. Review of Resident #1's Treatment Administration Record (TAR) for September 2024 indicated he/she had physician's orders for the following: -9/20/24, Ileostomy Care every shift, -Change Abdominal Incision dressing every shift, cleanse with wound spray, pack middle of incision with sterile gauze, and cover with abdominal pad (large absorbent pad) or telfa (nonstick gauze) and secure with paper tape. Review of Resident #2's Physician's Note, dated 09/23/24, indicated that at 11:00 A.M., Physician #1 assessed Resident #2, in person. The Physician's Note indicated Physician #1 removed a dressing from Resident #2's abdomen and found that he/she did not have an ostomy appliance in place at all, and that his/her abdomen, dressing, and abdominal incision were covered in fecal matter, the gauze that was within the abdominal incision was soaked in fecal matter, and the wound edges and peristomal skin (area of skin around the stoma) were red and inflamed. The Physician's Note indicated that Nurse #2 said she had been aware that Resident #2 did not have an ostomy appliance on, that his/her supplies were ordered and would be arriving later that day. (continued on next page)

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F 0691 Level of Harm - Actual harm Residents Affected - Few	Resident #2's Physician's Note indicated he/she was transferred to the Hospital Emergency Department for further care of his/her abdominal wound and high risk of infection due to the presence of fecal matter in his/her open wound. Review of Resident #2's Hospital Emergency Department Admission Note, dated 09/23/24, indicated he/she was diagnosed with abdominal wound dehiscence (opening) and was admitted to the Hospital. During a telephone interview on 10/30/24 at 01:23 P.M., Physician #1 said that on 09/23/24 at 11:00 A.M., she assessed Resident #2, who was in his/her bed at the Facility, and when she removed the dressing that was in place on Resident #2's abdomen, she discovered that he/she did not have an appliance on his/her ostomy stoma. Physician #1 said there was one large dressing taped down covering Resident #2's entire abdominal incision and the ileostomy stoma, that there was fecal material covering his/her entire abdomen, the dressing, and soaked into the gauze that was in his/her abdominal incision. Physician #1 said she asked Nurse #2 to look at Resident #2's abdomen as well, and that Nurse #2 said she knew Resident #2 did not have an ostomy appliance in place when she took over that morning at 07:00 A.M., as Resident #2's nurse. During an interview on 10/29/24 at 02:16 P.M., Nurse #2 said that on 09/23/24 she was the nurse assigned to Resident #2, and said she was told at 07:00 A.M., during change of shift report that Resident #2 did not have an ostomy appliance in place, and that supplies had been ordered. Nurse #2 said she did not assess Resident #2's abdomen or stoma until Physician #1 called her in to Resident #2's room. Nurse #2 said the skin surrounding Resident #2's abdominal incision and stoma was red, excoriated, and the incision had dehisced (opened). Nurse #2 said although Resident #1's specific ostomy supplies had not been delivered, there were ostomy supplies that could be used temporarily in the Facility at the time, and that she applied the ostomy appliance after Physician #1 assessed Resident #2. During an interview on 10/29/24 at 01:18 P.M., the Director of Nurses (DON) said she received a call from the Director of Care at Physician #1's practice and was told that Physician #1 had found Resident #2 without an ostomy appliance with fecal material in his/her wound. The DON said Resident #2 should have had an ostomy appliance in place and his/her abdominal incision should have been protected from fecal contamination.