

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER Walpole Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 160 Main Street Walpole, MA 02081	

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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>41601</p> <p>Based on interviews and records reviewed, for one of three sampled residents (Resident #1), who was severely cognitively impaired, unable to make his/her needs known to staff and was dependent on staff for all care, the Facility failed to ensure Resident #1 was free from restraints, when on 09/16/24, he/she was found in the day room by the Unit Manager in his/her Broda chair which was fully reclined, with a couch up against the left side of the Broda chair, and the right side was positioned against the wall, which restricted his/her movements on either side.</p> <p>Findings include:</p> <p>Review of the Facility's Policy, titled Use of Restraints, dated as revised January 2017, indicated the following:</p> <p>-physical restraints are defined as any manual method, or physical, or mechanical device, material or equipment attached to adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts access to one's body.</p> <p>-the definition of a restraint if based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition, and this restricts his/her typical ability change position or place, that device is considered a restraint.</p> <p>Resident #1 was admitted to the Facility in May 2024, diagnoses included dementia, left femur fracture, coronary artery disease, and dysphagia.</p> <p>Review of Resident #1's medical record indicated his/her Health Care Proxy was activated on 05/10/24, due to cognitive impairment related to Dementia.</p> <p>Review of Resident #1's Medical Record indicated he/she had a Physician's order, dated 07/31/24, for Hospice Care and an order for the Broda chair.</p> <p>Review of Resident #1's most recent Minimum Data Set (MDS) Assessment, dated 08/05/24, indicated Resident #1 was severely cognitively impaired, was dependent on staff for completion of Activities of Daily Living (ADLs) and required two staff members to assist with mobility, with handheld assistance.</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/16/24 at 1:35 P.M., the Unit Manager said that on 09/16/24 at 7:20 A.M., when she went to the nurse's station [on Resident #1's unit] to check the schedule for the day, she noticed that Resident #1 was in the dayroom, in his/her Broda chair, that the chair was fully reclined back, the right side of the chair was against the wall and a couch was placed up against the left side of the Broda chair. The Unit Manager said she asked Nurse #1 why Resident #1 was placed in this position, because it would restrict Resident #1 movement. The Unit Manager said Nurse #1 reported that she had moved the couch away from Resident #1 chair earlier that night, and had questioned the overnight staff (later identified as CNA #1 and CNA #2) about it. The Unit Manager said both overnight CNAs had left at their shift's end and where not on the unit to question.</p> <p>The Unit Manager said that Resident #1 was at risk of falling due to weakness, unsteady gait and had a history of falls with injuries. The Unit Manager said Resident #1's intervention for safety included the use of the Broda chair and placing Resident #1 at the nursing station or in the day room, where he/she was visible to staff. The Unit Manager said Resident #1 sometimes would get up from the chair, that staff members would walk him/her around the unit, and that he/she required two staff member for assistance with mobility.</p> <p>During a telephone interview on 10/22/24 at 10:00 A.M., Nurse #1 said that at approximately 7:20 A.M. on 09/16/24, while conducting her last set of safety checks, she was approached by the Unit Manager who told her she found Resident #1 in the day room in his/her Broda chair, with the right side against the wall and a couch up against the left side of the Broda chair. Nurse #1 said she did not put the couch up against Resident #1's chair.</p> <p>Nurse #1 said that at approximately 1:00 A.M., she had found Resident #1 in the day room, in his/her Broda chair, and that Certified Nurse Aide (CNA) #1 reported that Resident #1 was restless. Nurse #1 said she noticed a couch was placed up against the left side of Resident #1's Broda chair and immediately moved it. Nurse #1 said that she educated both CNA #1 and CNA #2 that placing the couch beside Resident #1's chair was not an appropriate intervention, that they should report Resident #1's restlessness to her, and that they should not implement any intervention that could be considered a restraint. Nurse #1 said that both CNA #1 and CNA #2 denied placing the couch up against Resident #1's chair.</p> <p>During a telephone interview on 10/21/24 at 11:00 A.M., Certified Nurse Aide (CNA) #1 said before her shift ended at 6:30 A.M., with the assistance of CNA #2, they provided personal care for Resident #1 and placed him/her (in his/her Broda chair) in the day room where morning shift staff could keep their eyes on him/her. CNA #1 said Resident #1 was comfortable and sleeping when she left. CNA #1 denied moving the couch and placing it up against the left side of Resident #1's Broda chair.</p> <p>During a telephone interview on 10/21/24 at 1:18 P.M., Certified Nurse Aide (CNA) #2 said that approximately at 6:00 A.M., he assisted CNA #1 with completing personal care for Resident #1. CNA #2 said Resident #1 was placed his/her Broda chair in the day room. CNA #2 said after helping CNA #1, he left to provide care for other residents. CNA #2 denied the moving the couch and placing it against the left side of Resident #1's Broda chair.</p> <p>Although CNA #1 and CNA #2 denied placing the couch up against the left side of Resident #1's Broda chair, while it was also positioned up against the wall on the right side, (and Nurse #1 said she had not seen either of them actually put the couch there) they were the only other staff members working on the unit that night and Resident #1 was not physically capable of doing it him/herself.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/16/24 at 2:05 P.M., the Director of Nurses (DON) said that the Facility prides itself on being restraint-free, that the facility policy is designed to ensure the safety and well-being of their residents. The DON said placing the couch on the side of Resident #1's Broda chair (with the other side up against the wall) was inappropriate and considered a restraint. The DON said CNA #1 resigned and no longer works at the facility and CNA #2 was re-educated about restraints.</p>		