

|  |  |   |  |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>225544 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY COMPLETED<br><br>11/19/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Wingate at Silver Lake |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>17 Chipman Way<br>Kingston, MA 02364 |  |

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<br>(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41107</b></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 for falls, and whose comprehensive plan of care indicated that non-slip strips were to be adhered to the floor next to his/her bed, the Facility failed to ensure staff consistently implemented and followed interventions identified in his/her plan of care, when on 11/06/24, after moving Resident #1 to a different room, the non-slip strips required to help maintain his/her safety, were not immediately put in place in his/her new room next to the bed, and were not put in place until he/she experienced a fall.</p> <p>Findings include:</p> <p>Review of the Facility's policy, titled Comprehensive Care Plan Policy, dated as revised March 2024, indicated that a comprehensive person-centered care plan that includes measurable objectives and timelines to meet the resident's physical, psychological and functional needs, is developed and implemented for each resident.</p> <p>Review of the Facility's policy, titled Fall Management Guidelines, dated as revised July 2015, indicated that residents who are at risk for falls will be identified. Interventions will be implemented and the resident's environment will be adapted in an effort to reduce falls and reduce injury.</p> <p>Resident #1 was admitted to the Facility in April 2024, diagnoses included stroke and vascular dementia.</p> <p>Review of Resident #1's Minimum Data Set (MDS) assessment, dated 08/01/24, indicated he/she had moderate cognitive impairment.</p> <p>Review of Resident #1's Care Plan titled Falls, reviewed and renewed with his/her August 2024 MDS, indicated he/she required non-slip strips to be adhered to the floor in his/her room as an fall prevention intervention. The Care Plan also indicated he/she required the assist of one staff member for transfers.</p> <p>Review of Resident #1's Fall Risk Assessment, dated 10/01/24 indicated he/she was at high risk for falls.</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:<br><br>225544   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY COMPLETED<br><br>11/19/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Wingate at Silver Lake   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>17 Chipman Way<br>Kingston, MA 02364 |  |
| 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<br>(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 Fall Incident Report, dated 11/06/24, indicated he/she had an unwitnessed fall in his/her room while attempting to transfer from his/her wheelchair to his/her bed. The Report indicated that non-slip strips were immediately added to Resident #1's floor.</p> <p>Further review of the Falls Care Plan, indicated that on 11/06/24 non-slip strips were added to Resident #1's bedside in his/her current room because he/she had recently switched rooms, and that the non-slip strips had not been applied to the floor in his/her new room before he/she fell on [DATE].</p> <p>During an interview on 11/19/24 at 11:52 A.M. which included review of her Written Witness Statement, Nurse #1 said that on 11/06/24, she heard Resident #1 yell from his/her room and then found him/her on the floor between his/her bed and wheelchair.</p> <p>During an interview on 11/19/24 at 12:24 P.M. the Unit Manager said that immediately after Resident #1 fell on [DATE], she added the non-slip strips to the floor in his/her room since they had not been added to the floor when he/she changed rooms. The Unit Manager said that non-slip strips should have been in place, but were not.</p> <p>During an interview on 11/19/24 at 11:52 A.M., the Director of Nurses (DON) said Resident #1 had an unwitnessed fall on 11/06/24. The DON said that when staff moved Resident #1 to a different room closer to the nurse's station, they did not make sure the non-slip strips were applied to the floor in his/her new room next to his/her bed. The DON said the non-slip strips should have been adhered to the floor next to Resident #1's bed as a fall prevention intervention, but were not in place at the time of his/her fall on 11/06/24.</p> |   |  |