| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225573 | A. Building<br>B. Wing | 05/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sancta Maria Nursing Facility | 799 Concord Avenue<br>Cambridge, MA 02138 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on records reviewed, interviews and observations, for one of three sampled residents (Resident #1) who was assessed as being at high risk for falls and required staff assistance for bed mobility, the Facility failed to ensure his/her safety was adequately maintained during the provision of care to prevent an incident resulting in serious injury, when on 04/22/26, Certified Nurse Aide (CNA) #1 assisted and rolled Resident #1 onto his/her side, turned away to get a towel and Resident #1 rolled off the bed and fell to the floor. Resident #1 was transferred to the Hospital's Emergency Department (ED) for evaluation and was diagnosed with a left knee laceration measuring seven centimeters (cm) long which required a running lock suture (a continuous suturing technique) to close the wound.Findings include: Review of the Facility's policy, titled Falls Management, dated as revised, October 2023, indicated that a fall is defined as any incident in which a resident unintentionally has a change in elevation/plane, an occasion where the resident would have lost their balance without staff intervention, or an incidence where a resident rolls off a bed or mattress close to the floor.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 04/22/26, indicated that while providing care to Resident #1 on 04/22/27 around 6:20 A.M., Certified Nurse Aide (CNA) #1 raised Resident #1's bed up to provide care, then from Resident #1's left side, assisted and rolled Resident #1 onto his/her right side (rolling Resident #1 away from herself). The Report indicated that CNA #1 turned away from Resident #1 to get a towel, and Resident #1's leg shifted and caused him/him to roll out of the bed onto the floor, which caused a left knee laceration and head strike.Review of the Facility's Post Fall Investigation Report, dated 04/22/26, indicated that according to CNA #1 and Resident #1, on 04/22/26 at about 6:20 A.M., CNA #1 had raised Resident #1's bed up to provide care, and while she provided assistance from Resident #1's left side, CNA #1 assisted and rolled Resident #1 onto his/her right side. The Report indicated that CNA #1 said that when she turned around to get a towel, Resident #1's left leg shifted off the side of the bed, which caused him/her (Resident #1) to roll out of bed onto the floor. The Report indicated that Resident #1 was sent to the Hospital's ED for a left knee laceration and returned with a running lock suture measuring seven cm in length, to close the laceration. Resident #1 was admitted to the Facility in April 2026, diagnoses included nontraumatic intracranial hemorrhage (stroke) and heart failure.Review of Resident #1's admission Fall Risk Assessment, dated 04/17/26, indicated he/she was at high risk for falls.Review of Resident #1's admission Brief Interview for Mental Status (BIMS) evaluation, dated 04/17/26, indicated he/she had moderate cognitive impairment.Review of Resident #1's Activities of Daily Living (ADL) Care Plan, dated 04/17/26, indicated that Resident #1 required assistance from one to two staff members to turn and reposition in bed.Review of a Nurse's Note, dated 04/22/26, indicated Resident #1 had a witnessed fall with a head strike during care, sustained a left knee laceration and required transfer to the Hospital's Emergency Department (ED).Review of the Hospital ED Discharge Report, dated 04/22/26, indicated Resident #1's left knee laceration measured seven centimeters (cm) long, two cm deep, and required a running lock suture, (measuring seven cm in length), to close the wound. Review of an Interview documented by the Director of Nurses (DON), dated 04/24/26, indicated that Resident #1 said CNA #1 was providing<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | morning care when he/she (Resident #1) rolled out of bed. The Interview indicated that Resident #1 said CNA #1 was on his/her left side when CNA #1 helped him/her (Resident #1) roll over to his/her right side (rolling him/her away from herself). The Interview indicated that Resident #1 said his/her leg went over the side of the bed, and he/she rolled out onto the floor and hit his/her head.During an interview on 05/07/26 at 12:36 P.M., Resident #1 said that after CNA #1 raised his/her bed up, CNA #1 stood on his/her left side and told him/her (Resident #1) to roll onto his/her right side (away from CNA #1). Resident #1 said she told CNA #1 he/she was too close to the edge of the bed to roll over, but CNA #1 told him/her he /she was fine, and that CNA #1 then helped him/her roll onto his/her right side (away from CNA #1, and not towards her). Resident #1 said once he/she was on his/her right side, his/her left leg somehow moved off the bed, which caused him/her to roll off the bed onto the floor.During a telephone interview on 05/19/26 at 4:02 P.M., (which included a review of her written witness statement, dated 04/22/26,) CNA #1 said that before she provided morning care to Resident #1, she raised the height of his/her bed, and while she stood on Resident #1's left side, she assisted him/her to roll onto his/her right side, which was away from her. CNA #1 said that once Resident #1 was on his/her right side, she turned away to get a towel and when she did, Resident #1 pulled on the small bed rail by his/her head, quickly shifted his/her body in the bed, and rolled off his/her bed onto the floor. CNA #1 said she was unable to prevent Resident #1 from falling out of bed because she was on the opposite side of the bed and could not reach him/her. CNA #1 said she should have assisted and rolled Resident #1 toward her, not away from herself.During a telephone interview on 05/19/26 at 4:19 P.M., Nurse #1 said that CNA #1 told her that Resident #1 fell out of bed. Nurse #1 said that when she walked into Resident #1's room, she saw him/her (Resident #1) on the floor between his/her bed and the window, lying on his/her left side. Nurse #1 said she assessed Resident #1, and due to a left knee laceration, he/she (Resident #1) was transferred to the Hospital's ED.During an interview 05/07/26 at 2:13 P.M., the Unit Manager said Resident #1 could roll in bed with assistance of one staff person. The Unit Manager said that Resident #1 told her that CNA #1 had him/her (Resident #1) roll onto his/her right side (away from CNA #1). The Unit Manager said Resident #1 struck his/her head during the fall and suffered a left knee laceration, which required sutures. The Unit Manager said that for safety reasons, CNAs were always expected to roll a resident toward themselves, never away. The Unit Manager said this is part of CNA basic training for their certificate and is considered basic knowledge.During an interview on 05/07/26 at 2:33 P.M., the Director of Nurses (DON) said that based on his investigation, while providing morning care on 04/22/26, CNA #1 assisted and had Resident #1 roll away from herself (CNA #1) instead of toward herself (CNA #1), and when CNA #1 turned to get a towel, Resident #1 rolled off of the opposite side of the bed from where CNA #1 was standing. The DON said that as a result of the fall from his/her bed, Resident #1 suffered a head strike (no injury) and a left knee laceration and was sent to the ED for evaluation. The DON said Resident #1 returned to the Facility the same day with sutures in place to repair his/her left knee laceration. The DON said that CNA #1 should not have rolled Resident #1 away from herself, but she had and was therefore not able to prevent Resident #1 from rolling off his/her bed onto the floor. |