STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225749	A. BUILDING _____ B. WING _____	03/15/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED NURSING & REHABILITATION-LAUREL LAKE	**620 LAUREL STREET LEE, MA 01238**

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 0282 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for 1 of 3 sampled residents (Resident #1), the facility failed to follow Resident #1's plan of care for a one assist with ambulation when on 2/15/17, CNA #1 left Resident #1 was left alone in the bathroom, without supervision, and Resident #1 fell and sustained fractures to the 3rd and 4th metatarsals (foot bones). Findings include: Resident #1's [DIAGNOSES REDACTED]. The Nursing Care Plan for Falls, dated 6/7/16 indicated Resident #1 is at risk for falls, was a one assist for transfers with the use of a gait belt, and had alarms in bed and in the chair. An Investigation Report, dated 2/15/17, indicated at 9:40 P.M. Resident #1 was found on the tiled floor in the bathroom, and he/she had removed the alarm. The Report indicated Resident #1 had toileted self and was trying to get a pajamas off the door hook. The attached Radiology Report, dated 2/18/17 indicated Resident #1 had an unwitnessed fall and sustained an acute left foot fracture (the 3rd and 4th metatarsal neck). The Certified Nursing Assistant (CNA) #1's Witness Statement, dated 2/15/17, indicated she observed Resident #1 brushing his/her teeth in the bathroom and told Resident #1 to ring the call bell if he/she needed help. CNA #1 heard saw the call bell was ringing and found Resident #1 laying on the bathroom floor. A Nurses Note, dated 2/15/17 and timed at 10:45 P.M., indicated on 2/15/17 Resident #1 was found on the bathroom floor, and prior to the fall, Resident #1 was sitting in the recliner chair and had turned off the alarm. The alarm was found on chair. The Surveyor interviewed CNA #1 at 10:10 A.M. on 3/15/17. CNA #1 said she was assigned to Resident #1 after 9:00 P.M. on 2/15/17. CNA #1 said she checked on Resident #1 at approximately 9:20 P.M. on 2/15/17. Resident #1 was standing up in the bathroom brushing his/her teeth. CNA #1 said Resident #1 did not need any assistance, so she left the Resident alone in the bathroom and went back to the Nurse's station to do her charting. CNA #1 said she heard the call bell ringing from Resident #1's room about 5 minutes later, and found Resident #1 lying on the floor. CNA #1 said she was not aware that Resident #1 was a one assist for ambulation, and required an alarm and needed supervision in the bathroom. CNA #1 said she did not review Resident #1's plan of care prior to providing care. The Surveyor interviewed the Director of Nursing Services (DNS) at 7:50 A.M. on 3/15/17. The DNS said CNA #1 did not follow Resident #1's plan for supervision in the bathroom Past Noncompliance: CNA #1 received safety responsibility education on 1/16/17. Staff education for supervising residents during their care needs when using the bathroom was completed on 2/22/17. CNA monitoring for following the plan of care was started on 2/21/17 and is on going 3 times a week. The Director of Nurses said she was responsible for ensuring compliance with following the Residents plans of care. The Director of Nurses will incorporate her audits into the Quality Assurance Process at the Facility.
F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for 1 of 3 sampled residents (Resident #1), the Facility failed to ensure Resident #1's plan of care for a one assist with ambulation was followed. CNA #1 left Resident #1 in the bathroom without supervision, Resident #1 fell and sustained fractures to the 3rd and 4th metatarsals (foot bones). Findings include: The Facility's Policy, titled Managing Fall Risk, dated 2/14/16, indicated that each resident is evaluated for fall risk upon admission, at designated intervals. Predisposing risk factors for falls are identified to determine why a patient is a risk for falls, and interventions are developed based on predisposing risk factors to reduce the risk of falls and/or prevent falls from occurring. Resident #1's [DIAGNOSES REDACTED]. The Fall Risk Assessment Tool, dated 1/28/17 indicated Resident #1 had prior falls in the past 3 months, had impaired functional mobility and was at risk for falls. The Quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident #1 was cognitively intact and dependence with a 1 person physical assist for ambulation and transfers. The Nursing Care Plan for Falls, dated 6/7/16 indicated Resident #1 was at risk for falls, Resident #1 was a one assist for transfers with the use of a gait belt, and had alarms in bed and in the chair. An Investigation Report, dated 1/15/17, indicated at 9:40 P.M. Resident #1 was found on the tiled floor in the bathroom, and had removed the alarm. The Report indicated Resident #1 had toileted him/her self and was trying to get a pajamas off the door hook. The attached Radiology Report, dated 2/18/17 indicated Resident #1 had an unwitnessed fall and sustained an acute left foot fracture (the 3rd and 4th metatarsal neck). The Certified Nursing Assistant #1's Witness Statement, dated 2/15/17 indicated she observed Resident #1 brushing his/her teeth in the bathroom and told this Resident to ring the call bell if the Resident needed help to ring the bell. CNA #1 saw that the call bell was ringing and found Resident #1 laying on the bathroom floor. A Nurses Note, dated 2/15/17 and timed at 10:45 P.M., indicated on 2/15/17 Resident #1 was found on the bathroom floor and prior the the fall Resident #1 was sitting in the recliner chair and turned off the alarm. The alarm was found in the chair. The Surveyor interviewed CNA #1 at 10:10 A.M. on 3/15/17. CNA #1 said she was assigned to Resident #1 after 9:00 P.M. on 2/15/17. CNA #1 said she checked on Resident #1 at approximately 9:20 P.M. on 2/15/17. Resident #1 was standing up in the bathroom brushing his/her teeth. CNA #1 said Resident #1 did not need any assistance, so she left the Resident alone in the bathroom and went back to the Nurse's station to do her charting. CNA #1 heard a call bell ringing from Resident #1's room about 5 minutes later and found Resident #1 lying on the floor. CNA #1 said she was not aware that Resident #1 was a one assist for ambulation, required an alarm and needed supervision in the bathroom. CNA #1 said she did not review Resident #1's plan of care prior to providing care. The Surveyor interviewed the Director of Nursing Services (DNS) at 7:50 A.M. on 3/15/17. The DNS said CNA #1 did not follow Resident #1's plan for supervision in the bathroom Past Noncompliance: CNA #1 received safety responsibility education on 1/16/17. Staff education occurred for supervising residents during their care needs when using the bathroom. This staff education was

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

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.

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) completed on 2/22/17 by the Staff Developer. CNA monitoring for following the plan of care was started on 2/21/17 and is on going 3 times a week. The Director of Nursing audits the CNAs three times a week to ensure they are knowledgeable of the Resident's care plans and are implementing the interventions. The Director of Nurses said she was responsible for ensuring compliance with following the Residents plans of care. The Director of Nurses will incorporate her audits into the Quality Assurance Process at the Facility.