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	08/16/2021

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37342 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required an assist of two staff persons for bed mobility and repositioning, the Facility failed to ensure staff implemented interventions from his/her comprehensive plan of care for bed mobility, when Certified Nurse Aide (CNA) #1 rolled Resident #1 over in bed, without another staff member's assistance, Resident #1 fell off the side of his/her bed, sustained a right knee fracture, and was admitted to the Hospital. Findings include: Review of the Facility's Policy, titled, Person Centered Care Plan, dated 7/01/19, indicated the purpose of the care plan was to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being, and eliminate or mitigate triggers that may cause re-traumatization of the resident. Review of Resident #1's Medical Record indicated he/she was admitted to the Facility in December 2016, diagnoses included history of stroke with hemiplegia (paralysis of half of the body) of the left side, and dementia. Review of Resident #1's Quarterly Minimum Data Set assessment, dated 4/23/21, indicated Resident #1 required extensive assistance of two or more staff for bed mobility. Review of Resident #1's Activities of Daily Living Care Plan, dated 12/09/16 and revised on 7/07/21, indicated he/she required extensive assistance of two staff for bed mobility. Review of Resident #1's Change in Condition Note, dated 7/15/21, indicated Resident #1 had fallen out of bed during care, complained of right knee pain, the Nurse Practitioner was notified, and an X-ray of his/her right knee was ordered. Review of Resident #1's Radiology Report, dated 7/15/21, indicated there was an acute fracture of his/her right distal femur (bone at the top of the knee joint). (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	The Facility's Internal Investigation Summary, dated 7/15/21, indicated that at 8:30 P.M., on 7/15/21, CNA #1 was providing care to Resident #1 in bed, and when she rolled Resident #1 towards his/her left side, Resident #1 slid off the mattress onto the floor, sustained a right knee fracture, and required admission to the Hospital. Review of CNA #1's written statement, dated 7/15/21, indicated that while she was providing care for Resident #1 in his/her bed, Resident #1 was laughing and jovial, and was moving around in the bed, and when she rolled Resident #1 in the bed, he/she fell off the side of the bed and onto the floor. CNA #1 was not available to be interviewed at the time of this survey. Review of Resident #1's Hospital History and Physical, dated 7/16/21, indicated Resident #1 was admitted to the Hospital on 7/16/21 with diagnosis of right distal femur (knee) fracture as the result of a fall. During interview on 8/16/21 at 3:40 P.M., Nurse #1 said that on 7/15/21, CNA #1 told him that Resident #1 was on the floor. Nurse #1 said he went to Resident #1's room and saw him/her lying on his/her back on the floor, and he/she was complaining of right knee pain. Nurse #1 said CNA #1 told him that while she provided care for Resident #1, she had rolled him/her onto his/her side facing away from her, and Resident #1 fell off the opposite side of the bed. During interview on 8/16/21 at 9:46 A.M., the Director of Nurses said CNA #1 should have had a second staff member with her to provide care to Resident #1.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37342 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required an assist of two staff members with bed mobility, the Facility failed to ensure his/her safety was maintained to prevent incidents or accidents resulting in an injury, when on 7/15/21, Certified Nurse Aide (CNA) #1 rolled Resident #1 over in his/her bed without assistance from another staff member, resulting in him/her falling off the bed, sustaining a right knee fracture, was transferred and admitted to the Hospital. Findings include: Review of the Facility's Policy, titled, Accidents and Incidents, dated 5/02/18, indicated an incident was defined as any occurrence not consistent with the routine operation of the center or normal care of the resident. Review of Resident #1's Medical Record indicated he/she was admitted to the Facility in December 2016, diagnoses included history of stroke with hemiplegia (paralysis of half of the body) of the left side, and dementia. Review of Resident #1's Quarterly Minimum Data Set assessment, dated 4/23/21, indicated Resident #1 required extensive assistance of two or more staff for bed mobility. Review of Resident #1's Licensed Nursing Summaries, dated 5/26/21 and 6/27/21, indicated Resident #1 was essentially helpless, had decreased strength and endurance, contractures, and required assist of two staff members for repositioning in bed. Review of Resident #1's Lift Transfer Reposition assessment, dated 6/01/21, indicated Resident #1 required extensive assistance of two staff members for bed mobility. Review of Resident #1's Activities of Daily Living Care Plan, dated as revised on 7/07/21, indicated he/she required extensive assistance of two staff members for bed mobility. Review of Resident #1's Change in Condition Note, dated 7/15/21, indicated Resident #1 had fallen out of bed during care, complained of right knee pain, the Nurse Practitioner was notified, and an X-ray of his/her knee was ordered. Review of Resident #1's Radiology Report, dated 7/15/21, indicated there was an acute fracture of his/her right distal femur (bone at the top of the knee joint). The Facility's Internal Investigation Summary, dated 7/15/21, indicated that at 8:30 P.M., on 7/15/21, CNA #1 was providing care to Resident #1 in bed, and when she rolled Resident #1 towards his/her left side, Resident #1 slid off the mattress onto the floor, sustained a right knee fracture, and required admission to the Hospital. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of CNA #1's written statement, dated 7/15/21, indicated that while she was providing care for Resident #1 in his/her bed, Resident #1 was laughing and jovial, and was moving around in the bed, and when she rolled Resident #1 over in the bed, he/she fell off the side of the bed and onto the floor. CNA #1 was not available to be interviewed at the time of this survey. Review of Resident #1's Hospital History and Physical, dated 7/16/21, indicated Resident #1 was admitted to the Hospital with diagnosis of right distal femur (knee) fracture as the result of a fall. During interview on 8/16/21 at 3:40 P.M., Nurse #1 said that on 7/15/21, CNA #1 told him that Resident #1 was on the floor. Nurse #1 said he went to Resident #1's room and saw him/her lying on his/her back on the floor, and was complaining of right knee pain. Nurse #1 said CNA #1 told him that while she provided care for Resident #1, she had rolled him/her onto his/her side facing away from her, and Resident #1 fell off the opposite side of the bed. During interview on 8/16/21, at 9:46 A.M., the Director of Nurses said CNA #1 should have had a second staff member with her to provide care to Resident #1.