

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER Julian J Levitt Family Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 770 Converse Street Longmeadow, MA 01106	

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 0656</p> <p>Level of Harm - 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>37086</p> <p>Based on records reviewed and interviews for one of three sampled residents (Resident #1), who's comprehensive care plan indicated he/she required assistance of two staff members for bed mobility, the Facility failed to ensure staff implemented and followed interventions in his/her care plan, when on 04/28/24 Certified Nurse Aide (CNA) #1 provided care to Resident #1, who was in bed, without another staff member present to assist her. CNA #1 rolled Resident #1 on his/her side, away from her, Resident #1 rolled off the bed, fell on to the floor, landing on his/her right side and immediately complained of pain. Resident #1 was transferred to the Hospital Emergency Department (ED) and diagnosed with acute non-displaced (stable) fractures of the right superior and inferior pubic rami (group of bones that make up the pelvis).</p> <p>Findings include:</p> <p>Review of the Facility's undated policy, titled Care Plans-Comprehensive, indicated residents will have a person-centered comprehensive care plan developed and implemented to meet preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs.</p> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 05/03/24, indicated that on 04/27/24 (per interview with the Director of Nurses the correct date of the incident was 04/28/24), Resident #1 slid out of bed during care. The Report indicated that he/she was transferred to the Hospital ED and was found to have pelvic fractures.</p> <p>Review of Resident #1's Hospital Discharge Summary, dated 04/28/24, indicated Resident #1 sustained acute non-displaced fractures of the right superior and inferior pubic rami, and the fractures did not require surgical intervention.</p> <p>Resident #1 was admitted to the Facility in May 2019, diagnoses included general Osteoarthritis and Rheumatoid Arthritis.</p> <p>Review of Resident #1's Fall Risk Assessment, dated 02/28/24, indicated he/she was at increased 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
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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 03/02/24, indicated he/she scored a 15 out of 15 on his/her Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). The MDS also indicated that he/she was totally dependent on staff for bathing, dressing, hygiene, transfers, incontinent care, and was non-ambulatory.</p> <p>During an interview on 05/21/23 at 8:18 A.M., Resident #1 said that about three weeks ago, he/she rolled out of bed onto the floor and broke his/her pelvis. Resident #1 said there were always supposed to be two staff members to provide his/her care but that day, there was only one CNA (identified as CNA #1), Resident #1 said CNA #1 washed him/her that morning and then rolled him/her onto his/her side. Resident #1 said that if they had used two CNAs like they were supposed to one of them would have been able to hold onto him/her so he/she would not have fallen out of bed.</p> <p>Review of Resident #1's Falls Care Plan, with a review date of 03/14/24, indicated he/she required assistance of two staff members for bed mobility and transfers.</p> <p>Review of Resident #1's Behavior Care Plan, with a review date of 03/14/24, indicated he/she required assistance of two staff members for care due to accusatory behaviors.</p> <p>Review of Resident #1's Activities of Daily Living (ADL) Care Plan, with a review date of 03/14/24, indicated he/she utilized bilateral 1/4 side rails in bed and required two staff members for turning and repositioning.</p> <p>Review of Resident #1's Care Kardex card (used by the CNAs to determine individual care needs) indicated he/she required assistance of two staff members for bed mobility and had padded side rails.</p> <p>During an interview on 05/21/24 at 1:22 P.M., (which included review of her 4/28/24, Nurse Progress Note) Nurse #1 said that on 04/28/24 at approximately 11:00 A.M., CNA #1 called for help and said that Resident #1 fell . Nurse #1 said it shocked her that Resident #1 had fallen because he/she was non ambulatory and had no previous falls.</p> <p>Nurse #1 said that she noticed immediately that Resident #1's side rails were down and that she asked CNA #1 (in the presence of Resident #1) why the side rails were down. Nurse #1 said Resident #1 answered her and said that he/she told CNA #1 to put the side rail down. Nurse #1 said that Resident #1 had always required assistance of two staff members for positioning and provision of care, but said CNA #1 did not have another staff member assist her that day.</p> <p>During a telephone interview on 05/22/24 at 2:01 P.M., (which included review of her 4/28/24, Nurse Progress Note) the Nursing Supervisor said that on 04/28/24 at approximately 11:00 A.M., CNA #1 called for help and said that Resident #1 fell . The Nursing Supervisor said she entered Resident #1's room with Nurse #1, and said she observed that both side rails were down and the bed was in a high position. The Nursing Supervisor said that immediately following the incident, she spoke with CNA #1 and reviewed Resident #1's care plan with her, which indicated he/she required assistance of two staff members for bed mobility and that he/she was also required that bilateral side rails were in use.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 05/21/24 at 2:11 P.M., (which included review of her 4/28/24, Written Witness Statement) CNA #1 said that Resident #1 was on her assignment for the 7:00 A.M. to 3:00 P.M. shift on 04/28/24. CNA #1 said she was familiar with Resident #1 and had taken care of him/her before. CNA #1 said she was in the middle of washing Resident #1 in bed and once she was ready to roll Resident #1 onto his/her side to wash his/her back, Resident #1 told her to put the side rail down. CNA #1 said she told Resident #1 she could remove the padding to make it easier for Resident #1 to hold onto the side rail but that Resident #1 insisted she (CNA #1) put the side rail down, so she did. CNA #1 said once she began to roll Resident #1 (away from her) onto his/her side, he/she rolled off the bed and she could not catch him/her. CNA #1 said the bed was in the high position at the time of the fall.</p> <p>CNA #1 said she knew that Resident #1 required assistance of two staff members for mechanical lift transfers but until this incident happened, said no one had told her that Resident #1 also required assistance of two staff members for mobility and positioning. CNA #1 said she did not know Resident #1 also required assistance of two staff members due to accusatory behaviors. CNA #1 said she had recently completed her orientation and that no one showed her where the CNA Care Kardex cards was located.</p> <p>However, review of CNA #1's Education Acknowledgement Form, dated and signed by CNA #1 on 03/19/24, indicated CNA #1 acknowledged she was educated on the resident Care Kardex Cards and Care Plans. The Form indicated CNAs and nurses are required to check and be knowledgeable of resident's plan of care by checking the Care Kardex Cards or Care Plans before providing care.</p> <p>Review of CNA #1's Employee Conference Record, dated 04/29/24 and signed by the Director of Nurses (DON) and CNA #1, indicated CNA #1 failed to follow the plan of care when she provided care to Resident #1 without another staff member's assistance which was reflected as a requirement on his/her care plan. The Record indicated Resident #1 slid from the bed and sustained a fracture.</p> <p>During an interview on 05/21/24 at 3:45 P.M., the Director of Nurses (DON) said that her investigation indicated that CNA #1 had not gotten assistance from another staff member to help with Resident #1's bed mobility during care. The DON said CNA #1 should have followed Resident #1's care plan, that CNA #1 should have requested and obtained assistance from another staff member to help care for Resident #1 in bed.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>37086</p> <p>Based on records reviewed and interviews for one of three sampled residents (Resident #1), who required assistance of two staff members for bed mobility, the Facility failed to ensure he/she was provided with the necessary level of staff assistance and required assistive device (bilateral side rails) to maintain his/her safety and prevent an incident/accident resulting in an injury, when on 04/28/24 during the provision of care, Certified Nurse Aide (CNA) #1, who had not gotten another staff member to assist her, put the side rails down, rolled Resident #1 on to his/her side in bed, Resident #1 rolled off the bed onto the floor, landing on his/her right side and immediately complained of pain. Resident #1 was transferred to the Hospital Emergency Department (ED) and diagnosed with acute non-displaced (stable) fractures of the right superior and inferior pubic rami (group of bones that make up the pelvis).</p> <p>Findings include:</p> <p>Review of the Facility's undated policy for Activities of Daily Living (ADL), indicated in order to protect the safety and well-being of staff and residents, and to promote quality care, the facility provides assistance with activities of daily living as needed. The policy indicated ADL included (but was not limited to), positioning and transfers. The policy indicated ADL assistance will be provided according to the needs of the residents.</p> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 05/03/24, indicated that on 04/27/24 (per interview with the Director of Nurses the correct date of the incident was 04/28/24), Resident #1 slid out of bed during care. The Report indicated that he/she was transferred to the Hospital ED and was found to have pelvic fractures.</p> <p>Review of Resident #1's Hospital Discharge Summary, dated 04/28/24, indicated Resident #1 sustained acute non-displaced fractures of the right superior and inferior pubic rami, the fractures did not require surgical intervention.</p> <p>Resident #1 was admitted to the Facility in May 2019, diagnoses included general Osteoarthritis and Rheumatoid Arthritis.</p> <p>Review of Resident #1's Fall Risk Assessment, dated 02/28/24, indicated he/she was at increased risk for falls.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 03/02/24, indicated he/she scored a 15 out of 15 on his/her Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). The MDS also indicated that he/she was totally dependent on staff for bathing, dressing, hygiene, transfers, incontinent care, and was non-ambulatory.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/21/23 at 8:18 A.M., Resident #1 said that about three weeks ago, he/she rolled out of bed onto the floor and broke his/her pelvis. Resident #1 said there was always supposed to be two staff members to provide his/her care but that day, there was only one CNA (identified as CNA#1). Resident #1 said that CNA #1 washed him/her that morning and then rolled him/her onto his/her side. Resident #1 said that his/her right leg slid over his/her left leg and he/she rolled off the bed onto the floor. Resident #1 said that if they had used two CNAs like they were supposed to one of them would have been able to hold onto him/her so he/she would not have fallen out of bed.</p> <p>Resident #1 said he/she has not been out of bed since the fall because he/she would not be comfortable in his/her wheelchair. Resident #1 said that he/she continues to have right sided pain.</p> <p>Review of Resident #1's Falls Care Plan, with a review date of 03/14/24, indicated he/she required assistance of two staff members for bed mobility and transfers.</p> <p>Review of Resident #1's Behavior Care Plan, with a review date of 03/14/24, indicated he/she required assistance of two staff members for care due to accusatory behaviors.</p> <p>Review of Resident #1's ADL Care Plan, with a review date of 03/14/24, indicated he/she utilized bilateral 1/4 side rails in bed and required two staff members for turning and repositioning.</p> <p>Review of Resident #1's Care Kardex Card (used by the CNAs to determine individual care needs) indicated he/she required assistance of two staff members for bed mobility and had padded side rails.</p> <p>During an interview on 05/21/24 at 1:22 P.M., (which included review of her 4/28/24, Nurse Progress Note) Nurse #1 said that on 04/28/24 at approximately 11:00 A.M., CNA #1 called for help and said that Resident #1 fell . Nurse #1 said that she went to Resident #1's room and observed him/her lying on the floor on his/her right side. Nurse #1 said Resident #1 was alert and complained of right sided pain but there was no visible injury. Nurse #1 said it shocked her that Resident #1 had fallen because he/she was non ambulatory and had no previous falls.</p> <p>Nurse #1 said that she noticed immediately that Resident #1's side rails were down and asked CNA #1 (in the presence of Resident #1) why the side rails were down. Nurse #1 said Resident #1 answered her and said that he/she told CNA #1 to put the side rail down. Nurse #1 said that Resident #1 had always required assistance of two staff members for positioning and when providing care, but that CNA #1 did not have another staff member assist her that day.</p> <p>Nurse #1 said Resident #1 has not been out of bed since his/her fall because Resident #1 does not feel like he/she could tolerate sitting in his/her wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 05/22/24 at 2:01 P.M., (which included review of her 4/28/24, Nurse Progress Note) the Nursing Supervisor said that on 04/28/24 at approximately 11:00 A.M., CNA #1 called for help and said that Resident #1 fell . The Nursing Supervisor said she entered Resident #1's room with Nurse #1 and Resident #1 was on the floor, lying on his/her right side, and said he/she had right sided pain. The Nursing Supervisor said Resident #1 was transferred to the Hospital ED. The Nursing Supervisor said she observed that both side rails were down and the bed was in a high position. The Nursing Supervisor said that immediately following the incident, she spoke with CNA #1 and reviewed Resident #1's care plan with her, which indicated he/she required assistance of two staff members for bed mobility and when providing care, as well as also requiring bilateral side rails in use.</p> <p>The Nursing Supervisor said Resident #1 now has more pain than he/she did prior to the fall on 04/28/24.</p> <p>During a telephone interview on 05/21/24 at 2:11 P.M., (which included review of her 4/28/24, Written Witness Statement) CNA #1 said that Resident #1 was on her assignment for the 7:00 A.M. to 3:00 P.M. shift on 04/28/24. CNA #1 said she was familiar with Resident #1 and had taken care of him/her before. CNA #1 said she was in the middle of washing Resident #1 in bed and once she was ready to roll Resident #1 onto his/her side to wash his/her back, Resident #1 told her to put the side rail down. CNA #1 said she told Resident #1 she could remove the padding on the side rail so Resident #1 could hold onto the rail but that Resident #1 insisted she (CNA #1) put the side rail down, so she did.</p> <p>CNA #1 said once she began to roll Resident #1, onto his/her side away from her, he/she rolled off the bed and she could not catch him/her. CNA #1 said she knew that Resident #1 required assistance of two staff members for mechanical lift transfers but until this incident happened, but no one told her that Resident #1 required assistance of two staff members for mobility and positioning. CNA #1 and she did not know Resident #1 required assistance of two staff members during care due to accusatory behavior. CNA #1 said she had recently completed her orientation and that no one showed her where the CNA Care Kardex was located.</p> <p>However, review of CNA #1's Education Acknowledgement Form, dated and signed on 03/19/24 by CNA #1, indicated CNA #1 acknowledged she was educated on the residents' Care Kardex Cards and Care Plans. The Form indicated CNAs and nurses are required to check and be knowledgeable of resident's plan of care by checking the (Kardex) Care Cards or Care Plans before providing care.</p> <p>Review of CNA #1's Employee Conference Record, dated 04/29/24 and signed by the Director of Nurses (DON) and CNA #1, indicated CNA #1 failed to follow the plan of care when she provided care to Resident #1 without another staff member's assistance which was reflected as a requirement on his/her care plan. The Record indicated Resident #1 slid from the bed and sustained a fracture.</p> <p>During an interview on 05/21/24 at 3:45 P.M., the Director of Nurses (DON) said that Resident #1 required assistance of two staff members for repositioning, bed mobility, and due to accusatory behaviors, as indicated on his/her resident Kardex Care Card. The DON said that on 04/28/24 at approximately 11:00 A.M. , CNA #1 lowered Resident #1's side rail, rolled him/her onto his/she side [away from her] without the assistance of another staff member for assistance, Resident #1 rolled off the bed, onto the floor, and sustained pelvic fractures.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON said she was unaware that Resident #1 had not been out of bed since the fall on 04/28/24. The DON said CNA #1 should have followed Resident #1's care plan and Kardex, that CNA #1 and should have requested and obtained assistance from another staff member to help provide care for Resident #1, who was in bed