STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225253	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam West Rehab and Nursing	61 Cooper Street Agawam, MA 01001

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 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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:	(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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Based on records reviewed, interviews, and observations for one of three sampled residents (Resident #1), who was dependent on staff members for bathing, dressing, incontinence care, bed mobility, and positioning, the Facility failed to ensure his/her safety was maintained during care, when during the provision of care, Certified Nurse Aide (CNA) #1 positioned Resident #1 on his/her side in bed then turned away from him/her to obtain a wet cloth, and Resident #1 rolled off the bed and onto the floor. Resident #1 sustained a laceration to the back of his/her head, was transferred to the Hospital Emergency Department (ED) for evaluation, where he/she required staples to close the wound and was diagnosed with an epidural hematoma (a collection of blood between the skull and outermost protective membrane of the brain).Findings include:Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 09/30/25, indicated that on 09/23/25, around 6:30 P.M., CNA #1 was providing care to Resident #1 while standing at the bedside when Resident #1 unexpectedly rolled off the bed and onto the floor, was assessed to have a cut to the back of his/her head, and he/she was sent to the ED for further evaluation.Review of the Hospital Discharge/Transfer Note, dated 09/26/25, indicated the Facility sent Resident #1 to the Hospital ED after staff was attempting to change him/her and he/she accidentally rolled off of the bed and hit his/her head, his/her CT scan (a medical imaging procedure that uses x-rays to create detailed, cross-sectional images of the body's internal structure) indicated he/she sustained a left lateral epidural hematoma. Resident #1 was admitted to the Facility in December 2024, diagnoses included Dementia, Dysphagia (difficulty swallowing) and Glaucoma (a condition of increased pressure within the eyeball causing gradual loss of sight).Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 06/24/25, indicated he/she was severely cognitively impaired and dependent on staff for hygiene, dressing, bed mobility, and transfers in and out of bed.Review of Resident #1's Activities of Daily Living (ADL) Care Plan, reviewed and renewed with his/her Quarterly MDS Assessment, dated 06/24/25, indicated he/she was dependent on staff for hygiene, dressing, bed mobility, and transfers in and out of bed. Review of a Nursing Progress Note, dated 09/23/25, which included an SBAR (a communication tool that stands for Situation, Background, Assessment, and Recommendation) that indicated Resident #1 experienced a fall from bed while a CNA was performing care, and that he/she sustained a visible injury to his/her head with active bleeding noted, and that he/she was sent to the Hospital ED for further evaluation and treatment.During a telephone interview on 10/14/25 at 3:50 P.M., Family Member #1 said a nurse from the Facility called him on 09/23/25 to notify him that Resident #1 had fallen, and that he was surprised the fall happened because Resident #1 was unable to turn or move him/herself on his/her own. Family Member #1 said Facility staff told him that while a CNA was in the process of bathing Resident #1, the CNA had rolled him/her onto his/her side in bed, and that Resident #1 subsequently fell out of the bed and onto the floor. During an interview on 10/15/25 at 9:00 A.M., CNA #1 said she was familiar with Resident #1's care needs because he/she was on her assignment and that Resident #1 was totally dependent on staff for everything, including bed mobility, bathing, and incontinent care.CNA #1 said during the evening shift on 09/23/25, she was preparing to provide incontinent care to Resident #1 while he/she was lying in his/her bed. CNA #1 said Resident #1's bed was in the highest position, said she rolled Resident #1 away from her, so he/she was positioned on his/her left side, and that she was standing behind him/her. CNA #1 said she had Resident #1's bathing supplies placed on a table diagonally behind her and off to the side. CNA #1 said she needed a wet cloth that was on the table, that Resident #1 was out of her reach when she turned to grab the cloth, and said when she turned back towards Resident #1, he/she had rolled from the bed and onto the floor.CNA #1 said Resident #1 landed on his/her back, he/she was bleeding from a cut on the back of his/her head, and that she yelled for help while she applied a cloth to the back of Resident #1's head. During an interview on 10/15/25 at 12:30 P.M., (which included a review of his written witness statement, dated 09/13/25), Nurse #1 said Resident #1 required extensive assistance and was dependent on staff for all his/her ADLs, including dressing, bathing, incontinent care, and bed mobility, and if he/she was placed in a particular position while in bed, he/she generally remained in that position.Nurse #1 said he was working on 09/23/25 and at approximately 6:45 P.M., CNA #1 told him his assistance was needed in Resident #1's room because Resident #1 fell out of bed and his/her head was bleeding. Nurse #1 said he responded to Resident #1's room, where he observed him/her to be lying on the floor positioned on his/her back and noticed that he/she was bleeding from a wound on the back of his/her head.Nurse #1 said CNA #1 told him that she was about