STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225257	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Northampton	548 Elm Street Northampton, MA 01060

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37227 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who complained of pain that was new and for whom the Facility had initiated an investigation into an injury of unknown origin. the Facility failed to ensure that it was reported to the Department of Public Health (DPH) within two hours as required, and reported it to the DPH 48 hours later. Findings include: Review of the Facility Policy, titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated as revised September 2022, indicated the following: - All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. - If resident abuse, neglect, exploitation, misappropriation of resident property or an injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. - Immediately is defined as within two hours of an allegation involving abuse or resulting in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of the report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 01/16/25 at 11:44 A.M., indicated Resident #1's injury of an unknown source was reported to DPH. However, this was 48 hours after the facility administration had been made aware of the injury. Resident #1 was admitted to the Facility in December 2020, diagnoses included dementia, macular degeneration (eye disease that causes vision loss), osteopenia (a condition of diminished bone thickness) and iron deficiency anemia (low red blood cells). (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
	225257	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Northampton	548 Elm Street Northampton, MA 01060

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 12/19/24, indicated Resident #1 was severely cognitively impaired with a score of 3 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact). Further review of the MDS indicated Resident #1 was dependent on staff for Activities of Daily Living (ADLs) and transfers. Review of a Facility Incident Report, titled Injury of Unknown Source, dated 01/14/25, indicated Resident #1 had been complaining of left lower extremity pain, since 01/13/25. The Report indicated that an X-ray of Resident #1's left hip was performed on 01/13/25 and the results were negative for fracture. The Report indicated that Resident #1's pelvis and left knee were X-rayed on 01/14/25 and that the results, received at approximately 10:45 A.M., indicated an acute impacted distal femur supracondylar fracture. The Report further indicated that Resident #1 could not give a description of how the injury occurred, and there were no witnesses. During an interview on 02/04/25 at 5:00 P.M., the Director of Nurses (DON) said that on 01/14/25 at approximately 10:45 A.M., she was made aware that Resident #1's X-ray results indicated he/she had a fracture of the distal femur. The DON said that Resident #1 had no recent falls and no recent incidents, and that due to his/her impaired cognitive status he/she was unable to say how the injury may have occurred. The DON said that on 01/14/25 she determined the fracture to be an injury of an unknown source and initiated an investigation per the Facility Abuse Policy. The DON further said that she intended to report the injury to DPH immediately, but did not actually submit the report via HCFRS until 01/16/25. On 02/04/25, the Facility presented the Surveyor with a plan of correction that addressed the areas of concern identified in this survey, the Plan of Correction provided is as follows: A. On 01/16/25, the former Director of Nurses recognized that Resident # 1's injury of an unknown source had not been reported to DPH, and she alerted the DON, who then submitted the report in HCFRS. B. On 01/16/25, the Clinical Services Coordinator or designee educated the Facility Director of Nurses on ensuring allegations of abuse, neglect, mistreatment reports and injuries of an unknown source are correctly submitted through HCFRS within the two-hour reporting requirement. C. On 01/16/25, the DON audited the previous reportable incidents, to ensure they were submitted properly and timely to DPH through HCFRS. D. The Administrator or designee will audit abuse allegations for two-hour reporting and submission compliance, weekly for three weeks then monthly for two months. E. The Facility Plan of Correction, including audits, will be reviewed by the Quality Assurance Committee for three months for follow up and resolution. F. The Administrator and/or designee are responsible for overall compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225257	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Northampton	548 Elm Street Northampton, MA 01060

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. 45435 Based on records reviewed and interviews for one of three sampled residents (Resident #1) whose comprehensive care plan interventions included that he/she required assistance of two staff members and a mechanical lift for transfer due to non-weight bearing status, the Facility failed to ensure staff consistently implemented and followed interventions in his/her care plan, when on 01/12/25, during the evening shift, Certified Nurse Aide (CNA #1) without the assistance of another staff member and a mechanical lift, transferred Resident #1 using a stand/pivot transfer technique, Resident #1 screamed during the transfer and while care was being provided immediately after the transfer. Resident #1 was later diagnosed with a fracture involving the left distal femur (thigh bone) and was transferred to the Hospital Emergency Department (ED) for treatment. Findings include: Review of the Facility's policy, titled Care Plan, Comprehensive Person-Centered, dated as revised December 2016, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to receive the services and /or items included in the plan of care. Resident #1 was admitted to the Facility in December 2020, diagnoses included unspecified dementia, osteopenia (a condition of diminished bone thickness), anemia (low red blood cells), and Macular Degeneration (eye disease that causes vision loss). Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 12/19/24, indicated he/she was severely cognitively impaired with a score of 3 out 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 Resident #1 was dependent on staff for bathing, dressing, hygiene, transfers, incontinent care and was non-ambulatory. Review of Resident #1's Activities of Daily Living (ADL) Care Plan, reviewed and renewed with his/her 12/19/24 MDS, indicated he/she required assistance of two persons with a [mechanical lift] due to non-weight bearing status with ADL's. Review of Resident #1's Care Card (used by the CNAs to determine individual resident care needs) indicated he/she required assistance of two staff members with a [mechanical lift] for transfers due to non-weight bearing status with ADL's. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 01/16/25, indicated that Resident #1 sustained a fracture to his/her left distal femur. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225257	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Northampton	548 Elm Street Northampton, MA 01060

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	Review of the Facility's Investigation Summary, dated 01/20/25, indicated that on 01/12/25 during the evening shift Resident #1 was transferred from wheelchair to bed [by CNA #1] as an assist of one, via stand/pivot, and not according to his/her care plan status which indicated he/she required an assist of two staff members utilizing a mechanical lift. The Investigation Summary indicated that the Facility's conclusion was that it was more likely than not the fracture occurred during the transfer on 01/12/25 at 4:00 P.M. Review of the Mobile X-ray Report, dated 01/14/25 at 10:07 A.M., indicated Resident #1 had a fracture involving the left distal femur supracondylar region (complex lesions that are usually difficult to treat) with impaction. Review of Resident #1's Hospital Discharge Summary, dated 01/14/25, indicated Resident #1 sustained a distal left femur fracture, was placed in a knee immobilizer for comfort and to help facilitate healing. Review of the Director of Nurses (DON) Written Summary of her interview with CNA #1, undated, indicated CNA #1 told her that on 01/12/25 at 4:00 P.M, she stood Resident #1 up and pivot transferred him/her into bed without assistance from a second staff member, and without a mechanical lift. The Summary indicated CNA #1 told the DON that once she began to roll Resident #1 over in bed to perform care, he/she started yelling out. During an interview on 02/4/25 at 2:12 P.M., Certified Nurse Aide (CNA) #1 said that she had worked at the Facility since April of 2024 and had been assigned to care for Resident #1 on 01/12/25, during the 3:00 P.M. through 11:00 P.M. shift. CNA #1 said that she had not provided care for Resident #1 in the past. CNA #1 said that despite never having care for or having transferred Resident #1 before, said she did not check Resident #1's Care Card or Care Plan prior to transferring him/her. CNA #1 said that on 01/12/25 at about 4:00 P.M., she transferred Resident #1 from his/her wheelchair to his/her bed by herself using a stand/pivot transfer instead of a mechanical lift. CNA #1 said she performed the transfer by placing Resident #1's arms on her shoulders, reaching her arms around Resident #1's body, like she was hugging him/her, stood Resident #1 up, and pivoted him/her to a sitting position on the bed. CNA #1 said that Resident #1 was screaming during the entire transfer. CNA #1 further said that once Resident #1 was lying in bed, she rolled him/her back and forth to provide incontinent care and that Resident #1 was screaming when he/she was moved. During an interview on 02/4/25 at 4:10 P.M., the Director of Nurses (DON) said the Facility began an investigation after Resident #1's knee X-ray report on 01/14/25 indicated he/she had a fracture. The DON said that during her investigation she became aware that CNA #1, CNA #2 and CNA #3, during different times of the day, had transferred Resident #1 on 01/12/25 without using a mechanical lift as indicated in his/her care plan. The DON said during the investigation she discovered that CNA #1 had transferred Resident #1 by herself using a stand/pivot transfer, and that CNA #2 and CNA #3 had transferred Resident #1 together by manually lifting him/her up to transfer him/her, and that none of them had used a mechanical lift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225257	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Northampton	548 Elm Street Northampton, MA 01060

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	During an interview on 02/4/25 at 10:55 A.M., Certified Nurse Aide (CNA) #2 said she worked at the facility for two years, was familiar with Resident #1's care and had him/her on her assignment on 01/12/25 on the day shift. CNA #2 said that she and CNA #3 had transferred Resident #1 from his/her bed to his/her wheelchair on 01/12/25 around 11:00 A.M. without using the mechanical lift. CNA #2 said that the Care Card and the Therapy Binder are supposed to be used by the CNA's to learn how to provide resident care which included how they transferred, but said that she only checks them hit or miss. CNA #2 said she did not check Resident #1's Care Card prior to transferring him/her on 01/12/25. During an interview on 02/4/25 at 9:20 A.M., Certified Nurse Aide (CNA) #3 said that she had worked at the Facility for three years, mostly on the night shift but was now working the day shift. CNA #3 said that on 01/12/25 she assisted CNA #2 with transferring Resident #1 without using a mechanical lift. CNA #3 said that she had never transferred Resident #1 before, and said she did not check his/her Care Card to determine his/her transfer status prior to the transfer. The DON said that at the conclusion of the Facility's Internal Investigation, they determined it was more likely than not that Resident #1's fracture occurred during the transfer on 01/12/25 at 4:00 P.M., when CNA #1 said she transferred Resident #1 [who was non-weight bearing] unassisted using a stand/pivot transfer and that Resident #1 had yelled out during the transfer. On 02/4/25, the Facility presented the Surveyor with a plan of correction that addressed the areas of concern identified in this survey, the Plan of Correction is as follows: A . Resident #1 was transferred to the Hospital Emergency Department for evaluation and treatment on 01/14/25 and returned to the facility later the same day with a knee immobilizer. A pain management plan was put in place. B . CNA #1, CNA #2, and CNA #3 received disciplinary actions specifically for not following Resident #1 plan of care. C. On 01/16/25 Unit Managers and/or designee completed audits of current residents requiring assistance from two staff members with a mechanical lift, for compliance with care plans, CNA Care Card, and observation that transfers were conducted per the plan of care. D. On 1/22/25 Unit Managers conducted staff interviews with questionnaires completed by CNAs to ensure knowledge and competence of requirement to review Care Cards and appropriate transfer of residents. E. On 01/14/25 the Facility Staff Educator initiated re-education for Nurses and CNAs on following Resident Care Plans and safe lifting and movement of residents. The education was completed 01/22/25. F. On 1/16/25 the DON and/or designee initiated random weekly observations of staff to ensure compliance with Resident transfers according to Care Plan. Audits will continue weekly for three weeks and monthly for two months. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225257	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Northampton	548 Elm Street Northampton, MA 01060

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	G. The care area concern was discussed by the Quality Assurance Performance Improvement (QAPI) Committee on 01/15/25 and on-going audit results will continue to be reviewed at the QAPI Committee meetings monthly for three months. H. The DON and/or designee is responsible for compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225257	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Northampton	548 Elm Street Northampton, MA 01060

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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45435 Based on records reviewed and interviews for one of three sampled residents (Resident #1),who was non-weight bearing, required the assistance of two staff members and a mechanical lift for all transfers, the Facility failed to ensure he/she was provided with the necessary level of staff assistance and assistive device (mechanical lift) in a effort to maintain Resident #'1's safety during transfers to prevent incident/accidents resulting in an injury. On 01/12/25, Certified Nurse Aide (CNA) #1, without another staff member or use of the mechanical lift, transferred Resident #1 by herself from his/her wheelchair to bed using stand/pivot transfer, Resident #1 screamed out during the transfer and during care provided by CNA #1 immediately after the transfer, and was later diagnosed with a fracture to his/he left distal femur (thigh bone). Findings include: Review of the Facility's policy, titled Safe Lifting and Movement of Residents, dated as revised July 2017, indicated that in order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Manual lifting of residents shall be eliminated when feasible. Staff will document resident transferring and lifting needs in the care plan. Review of the Facility's policy, titled Activities of Daily Living (ADL) Supporting, dated as revised March 2018, indicated Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: mobility (transfer and ambulation). Resident #1 was admitted to the Facility in December 2020, diagnoses included unspecified dementia, osteopenia (a condition of diminished bone thickness), anemia (low red blood cells), and macular degeneration (eye disease that causes vision loss.) Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 12/19/24, indicated he/she was severely cognitively impaired with a score of 3 out 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 dependent on staff for bathing, dressing, hygiene, transfer, incontinent care and was non-ambulatory. Review of Resident #1's Activities of Daily Living (ADL) Care Plan reviewed and renewed with his/her 12/19/24 MDS, indicated he/she required assistance of two persons with a [mechanical lift] due to non-weight bearing status with ADL's. Review of Resident #1's Care Card (used by the CNA's to determine individual care needs) indicated he/she required assistance of two staff members with a [mechanical lift] for transfer due to non-weight bearing status with ADL's. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225257	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Northampton	548 Elm Street Northampton, MA 01060

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	Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 01/16/25, indicated that Resident #1 sustained a fracture to his/her left distal femur. Review of the Facility's Investigation Summary, dated 01/20/25, indicated that [on 01/12/25 during the evening shift]Resident #1 was transferred from wheelchair to bed as an assist of one via stand/pivot, and not according to his/her care plan status which indicated he/she required an assist of two utilizing a mechanical lift. The Report indicated that the Facility's Investigation conclusion was that it was more likely than not the fracture occurred during the transfer on 01/12/25 at 4:00 P.M. [completed by CNA #1]. Review of the mobile X-ray report, dated 01/14/25 at 10:07 A.M., indicated Resident #1 sustained a fracture involving the left distal femur supracondylar region (complex lesions that are usually difficult to treat) with impaction. Review of Resident #1's Hospital Discharge Summary, dated 01/14/25, indicated Resident #1 sustained a distal left femur fracture and was placed in a knee immobilizer for comfort and to help facilitate healing. Review of the Director of Nurses' (DON) written summary of her interview with CNA #1, undated, indicated that CNA #1 transferred Resident #1 into bed on 01/12/25 at 4:00 P.M utilizing a one person assist stand/pivot transfer and without a mechanical lift. The Interview Summary indicated CNA #1 said that once Resident #1 was in bed and she (CNA #1) began to roll him/her to perform care, Resident #1 started yelling out. During an interview on 02/4/25 at 2:12 P.M., Certified Nurse Aide (CNA) #1 said that she had worked at the Facility since April of 2024 and had been assigned to care for Resident #1 on 01/12/25 during the 3:00 P.M. through 11:00 P.M. shift. CNA #1 said that she had not provided care for Resident #1 in the past. CNA #1 said that despite never having cared for or having transferred Resident #1 before, said she did not check his/her Care Card or Care Plan prior to transferring him/her. CNA #1 said that on 01/12/25 at about 4:00 P.M., she transferred Resident #1 from his/her wheelchair to his/her bed alone, using a stand/pivot transfer instead of the mechanical lift. CNA #1 said she performed the transfer by placing Resident #1's arms on her shoulders, reaching her arms around Resident #1's body, like she was hugging him/her, stood him/her up and pivoted Resident #1 to a sitting position on the bed. CNA #1 said that Resident #1 was screaming during the entire transfer. CNA #1 further said that once Resident #1 was sitting on the edge of the bed, she wrapped one of her arms around his/her shoulders and put her other arm under his/her legs to position him/her from sitting to lying in the bed. CNA #1 said that once Resident#1 was lying in bed, she rolled him/her back and forth to provide incontinent care and that Resident #1 was screaming whenever he/she was moved. CNA #1 said that she did not report Resident #1's screaming during the transfer and/or during care to the nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225257	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Northampton	548 Elm Street Northampton, MA 01060

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	During an interview on 02/4/25 at 4:10 P.M., the Director of Nurses (DON) said that the facility began an investigation after Resident's #1's knee X-ray report on 01/14/25 indicated he/she had a fracture. The DON said that during her investigation into the injury she became aware that CNA #1 had transferred Resident #1 by herself on 01/12/25, without getting another staff person or using a mechanical lift, as indicated in his/her care plan. The DON said they determined that Resident #1's [who was non-weight bearing] fracture more likely than not, occurred during the stand/pivot transfer by CNA #1 on 01/12/25. On 02/4/25, the Facility presented the Surveyor with a plan of correction that addressed the areas of concern identified in this survey, the Plan of Correction is as follows: A . Resident #1 was transferred to the Hospital Emergency Department for evaluation and treatment on 01/14/25 and returned to the facility later the same day with a knee immobilizer. A pain management plan was put in place. B . CNA #1 received disciplinary actions specifically for not following Resident #1 plan of care. C. On 01/16/25 Unit Managers and/or designee completed audits of current residents requiring assistance from two staff members with a mechanical lift, for compliance with care plans, CNA Care Card, and observation that transfers were conducted per the plan of care. D. On 1/22/25 Unit Managers conducted staff interviews with questionnaires completed by CNAs to ensure knowledge and competence of requirement to review Care Cards and appropriate transfer of residents. E. On 01/14/25 the Facility Staff Educator initiated re-education for Nurses and CNAs on following Resident Care Plan and safe lifting and movement of residents. The education was completed 01/22/25. F. On 1/16/25 the DON and/or designee initiated random weekly observations of staff to ensure compliance with Resident transfers according to Care Plan. Audits will continue weekly for three weeks and monthly for two months. G. The care area concern was discussed by the Quality Assurance Performance Improvement (QAPI) Committee on 01/15/25 and on-going audit results will continue to be reviewed at the QAPI Committee meetings monthly for three months. H. The DON and/or designee is responsible for compliance.