STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225265	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Hampden LLC	34 Main Street Hampden, MA 01036

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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was a functional quadriplegic (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord), was essentially non-verbal, unable to participate in his/her care, and was totally dependent on staff to meet all of his/her care needs, the Facility failed to ensure he/she was provided with nursing care and treatment that met professional standards of quality, when on [DATE], after Nurse #1 was notified by Nurse Aide (NA #1) that during care Resident #1 began to slide out of bed and she (NA #1) lowered him/her to the floor, although Nurse #1 said she assessed Resident #1 for the potential for injury prior to moving him/her off the floor, Nurse #1 was unable to say what she did to assess him/her. There were no nursing assessments and no progress note to support Nurse #1 assessed Resident #1 at all. Nurse #1 also never reported the incident to anyone. Over the next several days Resident #1 was noted to have visual signs of discomfort, he/she verbalized being in pain and at one point when moved by staff, he/she yelled out my neck, was noted to have bruising, swelling to his/her neck and his/her head was tilted to one side. On [DATE], Resident #1 was transferred to the Hospital Emergency Department (ED) and was diagnosed with multiple cervical spine fractures, that typically occur as a result of an impact injury, he/she was placed in an Aspen (rigid neck brace, used to support neck by limiting movement) collar, was admitted to Hospice services in the Hospital, and on [DATE], he/she died . Findings include: Standard of Practice Reference: Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of Registered Nurse and Practical Nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulations (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and function of a Registered Nurse and Practical Nurse, respectively. The regulations stipulate that both the Registered Nurse and Practical Nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the Registered Nurse and Practical Nurse incorporate into the plan of care and implement prescribed medical regimens. The Rules and Regulations 9.03 define the Standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. Review of the Facility Policy, titled Falls- Clinical Protocol, dated 2017, indicated but was not limited to: (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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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The staff will evaluate, and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. - Falls should be identified as witnessed or unwitnessed events. - For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall. - Falls should be categorized as those that occur while trying to rise from sitting or lying to an upright position, those that occur while upright and attempting to ambulate, and other circumstances such as sliding out of a chair or rolling from a low bed to the floor. - Delayed complications such as late fractures and major bruising may occur hours or several days after a fall. Review of the Facility Policy, titled Accidents and Incidents - Investigating and Reporting, revised [DATE], indicated, but was not limited to: - All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. - The Nurse Supervisor/Charge Nurse and/or Department Director or Supervisor shall promptly initiate and document investigation of the accident or incident. - The following data, as applicable, shall be included in the Report of Incident/Accident Form: - The date and time accident took place - The nature of injury/illness (e.g., bruise, fall, nausea, etc.). - The circumstances surrounding the accident or incident. - Where the accident or incident took place. - The name(s) of witnesses and their accounts of the accident or incident. - The injured person's account of the accident or incident. - The time the injured person's attending Physician was notified as well as the time the Physician responded and his/her instructions. - The date/time the injured person's family was notified and by whom. - The condition of the injured person, including his/her vital signs. - The disposition of the injured (i.e., transferred to hospital, put to bed .). - Any corrective action taken. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Follow-up information. - Other pertinent data as necessary and required. - The signature of the person completing the report. Resident #1 was admitted to the facility in [DATE], diagnoses included Dementia and Functional Quadriplegia (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord). Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], indicated he/she was severely cognitively impaired, had unclear speech, was rarely/never understood and was totally dependent on staff for all Activities of Daily Living (ADLs). Review of Resident #1's ADL Care Plan, reviewed and renewed with his/her [DATE] MDS, indicated he/she was dependent on staff for care, that he/she required an assist of two for transfers and required one to two staff members to provide toileting/incontinence care needs. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted [DATE], indicated that Resident #1 began exhibiting non-verbal signs of pain on [DATE], the pain was thought to be muscular in nature and was treated with Ibuprofen. However, on [DATE], Resident #1 continued to express non-verbal signs of pain, the provider was notified, X-rays were ordered, bruising was noted on the right side of Resident #1's neck and an internal investigation was conducted. The Report indicated that on the evening of [DATE], NA #1 lowered Resident #1's siderail, rolled him/her over to remove the mechanical lift sling from underneath him/her and left his/her bedside to go into the bathroom to wet washcloths [to provide incontinence care]. Shortly thereafter, Nurse Aide (NA) #1 observed Resident #1's legs/lower torso sliding over the side of the bed, she went back to his/her bedside, lowered him/her to the floor and called out to Nurse #1 for help. The Report indicated Nurse #1 assessed Resident #1, determined there were no visible injuries, and assisted NA #1 with transferring Resident #1 back to bed. The Report further indicated that the facility concluded upon re-enactment of the incident, that NA #1 left Resident #1 unattended in his/her bed lying on his/her right side, on the right-hand side of the mattress with the right siderail down, with the bed in a high (raised) position while she went into the bathroom to wet washcloths with warm water. The Report also indicated that it was determined that the bruising [to Resident #1's neck] was likely a result of Resident #1's neck coming into contact with the bed's lowered siderail while he/she was being lowered to the floor. The Report indicated the hospital determined that Resident #1 had sustained neck fractures. Review of the Emergency Department Notes, dated [DATE], indicated the following: - Patient has pretty significant elevated blood pressure mildly elevated temperature and some tachycardia (heart rate higher than normal), not on antihypertensives (medication used to treat high blood pressure), or any other medications other than occasional Motrin for perceived discomfort. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Computerized Tomography (CT scan, a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) to be obtained of soft tissue of the neck and CT without contrast C-spine (cervical spine - area of the neck), to evaluate for fracture, abscess or hematoma. - Patient non-verbal, eyes open, bruise to right neck under right ear. Patient cries out in pain with palpation to swollen area and making noises like he/she wants to clear his/her throat. Facility staff reported this is his/her baseline to Emergency Medical Services, family states this is not his/her baseline. - Neurosurgery consulted, patient placed in cervical collar (device that supports the neck and limits its movement) for stability and pain control with Dilaudid (a potent opioid medication to control pain). Review of Resident #1's Hospital Admission History and Physical, dated [DATE], indicated the following: - CT of cervical spine with unstable fractures through T7 vertebral bodies (referring to part of the seventh thoracic vertebra found in the middle of the chest between the seventh and eighth pair of ribs) extending through the lamina, facets, and spinous process. The fracture extends through the lateral masses of the C5, fracture involves all three columns of the spine. -CT of the soft tissue of the neck with nondisplaced transverse fracture of the C5 vertebral body (fracture to part of the C5 vertebra where the broken bone pieces have not moved out of alignment) extending through the posterior elements (the back side of the vertebra which includes the spinous process and lamina which affect the supporting ligaments and bony structures at the back of the spine) with slight kyphosis (forward bend in the spine) at the fracture site but no fragment displacement. Mild paraspinal hemorrhage and edema, no associated mass effect. Review of a National Institutes of Health (NIH) .gov article titled Cervical Spine Fractures Overview, last updated [DATE], indicated fractures of the cervical spine result from abnormal movement or a combination of movements including hyperflexion, hyperextension (injuries that occur when a joint is moved beyond its normal range of motion), rotation (moving from side to side too far), axial loading (applying force directly along the axis of a structure), and lateral bending (caused by excessive sideways bending) of the spinal column, and sub-axial spine (C3-C7) fractures are commonly seen with high impact accidents such as motor vehicle accidents. Further review of the NIH.gov article indicated three-column fractures extending through the anterior vertebral body all the way through to the posterior ligaments are highly unstable, and cervical spine fractures are high-risk injuries with the potential for devastating neurological sequelae. Review of Resident #1's Hospital Hospice Consultation Notes, dated [DATE], indicated the following: - Patient lying in bed pale, resting with eyes closed, and unresponsive to verbal or physical stimulation. Bruising and swelling noted to right side of neck with Aspen collar in place. Respiratory rate 12 breaths per minute with shallow, irregular breathing noted. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Patient requiring the following medications for symptom management: Fentanyl (a potent pain medication) 12 micrograms (mcg) patch to right arm, change every 72 hours, Hydromorphone 0.5 milligrams (mg) intravenous (through the vein) administered seven times and Glycopyrrolate (a medication used to alleviate excess oral secretions in terminal patients) 0.2 mg intravenous administered one time, Lorazepam (a medication used to alleviate anxiety and/or restlessness) 0.5 mg administered five times. - Symptoms unable to be managed in alternative setting as patient continues to require frequent Registered Nurse (RN) assessment and IV medication titration (adjustments) that would not be possible outside of an acute care environment. Death appears imminent and moving patient out of this environment would be contraindicated. During a telephone interview on [DATE] at 1:30 P.M., Family Member #1 said when she went to visit Resident #1 on Thursday, [DATE] she noticed there were several people in his/her room, and she heard Resident #1 yelling out like he/she was in pain. Family Member #1 said she noticed that Resident #1's head was tilted sideways so far that his/her left ear was touching his/her left shoulder. Family Member #1 said she saw that Resident #1 had a red and purple lump behind his/her right ear. Family Member #1 said she was unaware of any recent falls or injuries Resident #1 may have sustained that would have explained the injury. Family Member #1 said she called Resident #1's Guardian to inform her of the situation and she said the Guardian requested Resident #1 be sent to the hospital immediately. Family Member #1 said Resident #1 was dependent on nursing staff for all his/her care needs. Family Member #1 said Resident #1 was unable to move on his/her own [he/she was dead weight], would generally just lay where he/she was placed and to her knowledge had never fallen out of bed. Family Member #1 said she went to the hospital after Resident #1 was transferred, and was informed that Resident #1 had several fractures in his/her neck that caused bleeding, and due to his/her age and condition, he/she was not a surgical candidate. Family Member #1 said Resident #1 was provided comfort measures at the Hospital and died on [DATE]. During a telephone interview on [DATE] at 2:28 P.M., (which included a review of her Written Witness Statement, dated [DATE]), Nurse Aide (NA) #1 said on the evening of [DATE], after she and another Certified Nurse Aide (CNA) transferred Resident #1 into bed utilizing a Hoyer lift, the other CNA left the room, and she removed the hoyer sling out from underneath him/her. NA #1 said she positioned Resident #1 on his/her right side, [on the right-hand side of the bed per facility re-enactment] with his/her left leg crossed over the top of his/her right leg, and left Resident #1 in that position because she needed to provide incontinent care. NA #1 said she left Resident #1 on his/her side and proceeded to go into the bathroom [which did not provide a direct view of Resident #1] and began to fill a wash basin and wet some washcloths. NA #1 said at one point, she looked out the bathroom door and noticed that Resident #1 had started to roll towards the edge of the bed with his/her legs extending over the side of the bed. NA #1 said she immediately returned to Resident #1's bedside, removed her gloves, lowered the bed closer to the floor [because she left Resident #1's bed in a higher position to provide care] grabbed a nearby cushioned fall mat, pulled it towards Resident #1's bedside, wrapped her arms around Resident #1's upper body, held his/her torso against her chest and lowered him/her to the floor. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NA #1 said after she lowered Resident #1 to the floor, she called out for help several times and when nobody came, she went to Resident #1's doorway, saw Nurse #1 at the medication cart and asked for assistance. NA #1 said Nurse #1 entered the room and asked her what happened. NA #1 said she heard Nurse #1 ask Resident #1, are you o.k.? NA #1 said Nurse #1 assisted her in using the Hoyer lift to transfer Resident #1 back to bed. During an interview on [DATE] at 2:58 P.M., (which included a review of her Written Witness Statement, dated [DATE]), Nurse #1 said on [DATE], while she was in the hallway at the medication cart, NA #1 came to Resident #1's doorway and asked for assistance. Nurse #1 said when she entered Resident #1's room, she saw Resident #1 lying face up on the floor next to his/her bed. Nurse #1 said she concluded he/she did not have any injuries, and she, along with NA #1, they transferred Resident #1 back to bed using a Hoyer lift. Nurse #1 said she asked NA #1 several times in several different ways what happened, and that NA #1 said Resident #1 was slipping off the bed, so she (NA #1) lowered Resident #1 to the floor, that Resident #1 did not fall, and he/she did not hit his/her head. Nurse #1 said this incident occurred around 8:00 P.M. on [DATE]. Nurse #1 said although she assessed Resident #1 prior to helping transfer him/her back to bed, she did not assess his/her vital signs, nor did she document anything or tell anybody about this incident. When the surveyor asked Nurse #1 to describe her assessment of Resident #1 prior to transferring him/her back to bed, Nurse #1 was unable to explain how she concluded that Resident #1 was not injured. Nurse #1 could not say what she conducted for assessments, including whether or not she checked for range of motion, or since Resident #1 was non-verbal, if she assessed him/her for visual signs of pain or discomfort and there was no documentation to support Nurse #1 even obtained a set of vital signs for Resident #1. During the interview, Nurse #1 never said she asked Resident #1 if he/she was o.k., or if she got a response at all from him/her. Nurse #1 said she was aware of the Facility's policies related to falls and reporting incidents, and said if NA #1 told her that Resident #1 fell , she would have completed the Fall Packet (documentation the facility requires nurses to complete after a resident falls), but said as far as she knew, Resident #1 had not fallen out of bed, but had been assisted to the floor with the help of NA #1. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:10 A.M., (which included a review of her Written Witness Statement, undated), Nurse #2 said on [DATE], she had just finished passing her morning medications, was seated at the nursing station, that Resident #1 was seated in the common area in his/her wheelchair directly across from the Nurse's Station and she heard Resident #1 screaming, which was unusual for him/her. Nurse #2 said she asked a CNA to assist her to transfer Resident #1 back to bed so she could assess him/her. Nurse #2 said she began her assessment of Resident #1 from the legs up and when she got to her upper extremities, Resident #1 yelled, my neck! Nurse #2 said she recognized that this was very unusual behavior for Resident #1 as he/she did not often form coherent words when talking. Nurse #2 said she immediately contacted Unit Manager #1 to update her on the situation and requested Unit Manager #1 contact the Nurse Practitioner (NP). Nurse #2 said given that she had no knowledge of, and there was no documentation of any accidents or trauma involving Resident #1, it was thought that his/her pain was muscular in nature and she administered pain medication to Resident #1 according to the NP's orders. When asked if an incident occurred in which a staff member had to lower a resident to the floor, would that be considered a fall? Nurse #2 said absolutely, it would be considered a fall. Nurse #2 also said for any incident deemed to be a fall, the Nurse is required to complete a Fall Packet which includes checklist to ensure a resident is thoroughly assessed for potential injury(s) and the incident itself, is documented and followed up on by nursing. Nurse #2 reviewed the Fall Packet with the surveyor. The Fall Packet checklist included the following: - Assess vital signs and initiate Neuros (Neurological Assessments - A neurological exam completed at fixed intervals that evaluates brain and nervous system functioning) if the fall was unwitnessed or the resident hit their head). - Witness statements obtained from everyone on the unit. - In the Electronic Health Record (EHR), document a Pain Assessment, Fall Assessment, and Skin Assessment. - Notify Physician and family, document person and time. - Initiate intervention specific to fall/injury and update Certified Nurse Aide (CNA) Care Card (instructions meant for the CNA relative to residents' individual care needs). - Document Nursing Note in EHR - Send screen request to rehab, and for evening and night shift, slide under therapy door. - Complete Risk Management Assessment in EHR - Return to Unit Manager/Supervisor when completed. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse #2 further said she had no knowledge Resident #1 had experienced a fall prior to his/her expression of severe pain on [DATE], and said had the Fall Packet been completed, subsequent shift nursing staff would have been aware he/she fell , that the reason for his/her pain would have been apparent and treatment interventions would likely have been different. During an interview on [DATE] at 11:40 A.M., Unit Manager #1 said looking back at things now, staff noticed a change in Resident #1 after [DATE] [the day of the unreported fall]. Unit Manager #1 said on [DATE], Resident #1 vomited and stayed in bed the whole day, [which was unusual for him/her] but he/she did not have any outward signs or complaints of pain. Unit Manager #1 said on [DATE], Nurse #2 alerted her that Resident #1 was yelling out in pain and complained of neck pain. Unit Manager #1 said that was unusual because Resident #1 did not often verbalize words that made sense. Unit Manager #1 said she notified the Nurse Practitioner (NP) who asked if Resident #1 had fallen or gotten hurt in any way. Unit Manager #1 said she told the NP Resident #1 had not had any falls, not that she was aware of, and the NP prescribed Motrin because he felt Resident #1's pain was likely muscular in nature. Unit Manager #1 said Resident #1 was administered pain medication, appeared comfortable, and upon assessment there did not appear to be any visible evidence of an injury. Unit Manager #1 said on [DATE], she observed a CNA feeding Resident #1 in bed and noticed his/her posture seemed off. Unit Manager #1 said Resident #1's bed was slightly reclined so she asked the CNA to sit Resident #1 up in a more upright position, but that the CNA then told her that Resident #1 exhibited signs of pain when the head of the bed was upright. Unit Manager #1 said she assessed Resident #1, noted he/she still had neck pain, so she contacted the NP again and requested an order for X-ray of his/her neck. Unit Manager #1 said during the X-ray, Resident #1 was observed to be in significant pain any time they tried to help position his/her head and neck for the X-ray. Unit Manager #1 said it was at that time, she noticed Resident #1 had bruising along the back right side of his/her neck that had not been observed previously and she knew Resident #1 needed to be sent to the Emergency Department (ED) for further evaluation. Unit Manger #1 said Resident #1's granddaughter was present and on the telephone with Resident #1's Guardian who consented for him/her to be transferred to the Hospital. Unit Manager #1 said she notified the Director of Nurses who began an investigation, and that it was during that investigation that they learned NA #1 had lowered Resident #1 to the floor on [DATE], because he/she was falling out of bed. Unit Manager #1 said Nurse #1 did not follow facility protocol relative to falls. Unit Manager #1 said that Nurse #1 should have completed the Fall Packet as well as the Risk Management Assessment in the Electronic Health Record (EHR) which includes Fall Risk, Pain, and Skin Assessments as well as a Neurological Assessment if the resident hit their head or if the fall was unwitnessed. Unit Manager #1 said the Nurse is required to fully assess the resident at the time of the fall [which includes when a resident is lowered to the floor] and only if the resident was assessed as being stable, then the resident could be moved and transferred back to a chair or bed. Unit Manager #1 said for Resident #1, none of this documentation was completed for the incident on [DATE], and had this been done, they would have known that his/her pain was likely related to the fall and would have been treated as such. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:30 P.M., the Director of Nurses (DON) said she was sitting in the Nursing office located near Resident #1's room on [DATE] and overheard Resident #1 yelling out in pain. The DON said she went to see what was happening and observed Resident #1 cry out in pain every time the X-ray Technician and nursing staff attempted to adjust his/her position. The DON said they immediately stopped the process, determined that Resident #1 needed to be transported to the Hospital ED and called 911. The DON said Nursing staff observed bruising to Resident #1's neck during the X-ray process, and she began an internal investigation. The DON said that during her interviews with staff, Nurse #1 said during the evening shift on [DATE], NA #1 had reported to her that she lowered Resident #1 to the floor to prevent him/her from falling out of bed, and that Nurse #1 said she never reported, documented or told anybody about the incident. The DON said she was made aware of Resident #1's increasing pain, as well as the interventions put in place to alleviate it, but if it had been known that Resident #1 had been lowered to the floor, different interventions would likely have been implemented when he/she began to exhibit pain. The DON said Nurse #1 should have completed an A&I (Accident/Incident) Report, completed the Risk Management documentation in the Electronic Health Record (EHR) which included Pain, Fall and Skin Assessments, should have written a Progress Note, and obtained witness statements on the spot, however Nurse #1 did none of this. On [DATE], the Facility was found to be in Past Non-Compliance and 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) [DATE], Resident #1 was transferred to the Hospital for further assessment and treatment, and did not return to the facility. B) [DATE] through [DATE], Administrative staff reviewed previous incident reports for the potential for residents with suspected injury of unknown origin, with review of individual residents nursing Plans of Care and CNA Care Kardex, no concerns for failure to report where identified, reviews will continue as needed. C) [DATE], Facility Administration conducted an ad hoc Quality Assessment and Performance Improvement (QAPI) meeting, with review of current facility policies, and development of an Action Plan, review of the meeting minutes indicated the Facility Leadership team met and developed a plan of correction related to the deficient practices. D) [DATE], Facility Administration suspended Certified Nurse Aide (CNA) #1 and Nurse #1, and as as a result of the facility's internal investigation, they were both terminated. E) [DATE] through [DATE], the Staff Development Coordinator and Director of Nursing educated all clinical staff regarding the following: -Facility policy's related to Falls and Clinical Protocols which included nursing assessments and nursing documentation and the Facility Policy related to Accidents/Incidents, Investigating and Reporting, - Incident reports and staff statements must be completed at the time of the incident. (continued on next page)

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	225265	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Hampden LLC	34 Main Street Hampden, MA 01036

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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Events that required reporting to the nurses, Nursing Supervisor(s), the on-call Nurse, or the Director of Nursing - Falls: witnessed, unwitnessed, which included if a resident is lowered to the floor, - Abuse: verbal, physical, neglect, and reporting requirements, - Skin issues: skin tears, bruises, documentation and reporting, - Plans of Care/ CNA Care Kardex review of interventions for appropriateness and current based on care needs. F) [DATE] through [DATE], The Director of Nursing initiated and conducted facility-wide audits to ensure all incidents that have occurred had appropriate and complete incident and accident reports and reviewed that any new onset of pain, skin changes and changes in condition to determine if they should be further investigated. Audits to be continued as needed. G) The Director of Nursing or designee will conduct daily audits of incidents and condition changes, and findings will be reviewed at the Quarterly QAPI meetings, ongoing. H) The DON and/or designee are responsible for overall compliance.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was a functional quadriplegic (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord), who was totally dependent on staff to meet all of his/her needs, the facility failed ensure he/she was provided with an adequate level of staff supervision during the provision of care to maintain his/safety to prevent an incident/accident resulting in serious injury. On [DATE], Nurse Aide (NA) #1, prepared Resident #1, who was in bed, for incontinent care. NA #1 raised the bed from the low position, repositioned Resident #1 on his/her right side, and left Resident #1 unattended while she went into the bathroom to fill the wash basin with water. Although Nurse Aide #1 said she was able to monitor Resident #1 while she was in the bathroom, while standing at the sink, the facility determined during their investigation that NA #1 could not visualize him/her. NA #1 said she saw Resident #1 start to slide out of bed, and after Resident #1 was on the floor, NA #1 reported to nursing that she had lowered him/her to the floor. Over the next several days Resident #1 was noted to have visual signs discomfort, he/she verbalized being in pain and at one point when moved by staff, he/she yelled out my neck and was noted to have bruising, swelling to his/her neck and it was tilted off to one side. On [DATE], Resident #1 was transferred to the Hospital Emergency Department (ED) and was diagnosed with multiple cervical spine fractures, that typically occur as a result of an impact injury, like a fall, he/she was placed in an Aspen (rigid neck brace used to support neck by limiting movement) collar, was admitted to Hospice Services at the Hospital, and on [DATE] he/she died . Findings include: The Facility's Policy, titled Falls-Clinical Protocol, dated 2017 indicated but was not limited to: - As part of the initial assessment the physician will help identify individuals with a history of falls and risk factors of subsequent falling - The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. - Falls should be categorized as those that occur while trying to rise from sitting or lying to an upright position, those that occur while upright and attempting to ambulate, and other circumstances such as sliding out of a chair or rolling from a low bed to the floor. The Facility's Policy, titled Accidents and Incidents - Investigating and Reporting, revised [DATE] indicated but was not limited to: - All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Emergency Department Notes, dated [DATE], indicated the following: - Patient has pretty significant elevated blood pressure mildly elevated temperature and some tachycardia (heart rate higher than normal), not on antihypertensives (medication used to treat high blood pressure), or any other medications other than occasional Motrin for perceived discomfort. - Computerized Tomography (CT scan, a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) to be obtained of soft tissue of the neck and CT without contrast C-spine (cervical spine - area of the neck), to evaluate for fracture, abscess or hematoma. - Patient non-verbal, eyes open, bruise to right neck under right ear. Patient cries out in pain with palpation to swollen area and making noises like he/she wants to clear his/her throat. Facility staff report this is baseline to Emergency Medical Services, family states this is not baseline. - Neurosurgery consulted, patient placed in cervical collar (device that supports the neck and limits its movement) for stability and pain control with Dilaudid (a potent opioid medication to control pain). Review of Resident #1's Hospital Admission History and Physical, dated [DATE], indicated the following: - CT of cervical spine with unstable fractures through T7 vertebral bodies (referring to part of the seventh thoracic vertebra found in the middle of the chest between the seventh and eighth pair of ribs) extending through the lamina, facets, and spinous process. The fracture extends through the lateral masses of the C5, fracture involves all three columns of the spine. -CT of the soft tissue of the neck with nondisplaced transverse fracture of the C5 vertebral body (fracture to part of the C5 vertebra where the broken bone pieces have not moved out of alignment) extending through the posterior elements (the back side of the vertebra which includes the spinous process and lamina which affect the supporting ligaments and bony structures at the back of the spine) with slight kyphosis (forward bend in the spine) at the fracture site but no fragment displacement. Mild paraspinal hemorrhage and edema, no associated mass effect. Resident #1 was admitted to the facility in [DATE], diagnoses included Dementia and Functional Quadriplegia (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord). Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], indicated he/she was severely cognitively impaired, had unclear speech, was rarely/never understood, and was totally dependent on staff for all levels of care. Review of Resident #1's ADL Care Plan, reviewed and renewed with his/her [DATE] MDS, indicated he/she was dependent for care and required one to two staff members for toileting/incontinence care needs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Care Kardex (utilized by Certified Nurse Aides, provides direct care staff with a brief overview of each resident's needs) indicated that he/she was dependent with personal hygiene, and required one to two staff members for toileting/incontinence care. During a telephone interview on [DATE] at 1:30 P.M., Family Member #1 said when she went to visit Resident #1 on Thursday, [DATE] she noticed there were several people in his/her room, and she heard Resident #1 yelling out like he/she was in pain. Family Member #1 said she noticed that Resident #1's head was tilted sideways so far that his/her left ear was touching his/her left shoulder and saw that Resident #1 had a red and purple lump behind his/her right ear. Family Member #1 said she was unaware of any recent falls or injuries Resident #1 may have sustained that would have explained his/her condition. Family Member #1 said she call Resident #1's Guardian to inform her of the situation and that the Guardian requested Resident #1 be sent to the hospital immediately. Family Member #1 said Resident #1 was dependent on nursing staff for all his/her care needs. Family Member #1 said Resident #1 was unable to move on his/her own [he/she was dead weight], would generally just lay where he/she was placed and to her knowledge had never fallen out of bed. Family Member #1 said she went to the hospital after Resident #1 was transferred, and was informed that Resident #1 had several fractures in his/her neck that caused bleeding, and due to his/her age and condition, he/she was not a surgical candidate. Family Member #1 said Resident #1 was provided comfort measures at the Hospital and died on [DATE]. During a telephone interview on [DATE] at 2:28 P.M., (which included a review of her Written Witness Statement, dated [DATE]) NA #1 said on the evening of [DATE], she and another Certified Nurse Aide (CNA) utilized a Hoyer lift (a mechanical device that helps move people with limited mobility from one place to another) to transfer Resident #1 into bed. NA #1 said the other CNA left the room, she removed the Hoyer sling that was underneath Resident #1 and then positioned Resident #1 on his/her right side with his/her left leg crossed over the top of his/her right leg. NA #1 said she left Resident #1 in this position because she needed to provide incontinent care. NA #1 said left Resident #1 on his/her side, unattended, and went into the bathroom to began to fill a wash basin and wet some washcloths. NA #1 said she monitored Resident #1 by looking out the bathroom door, because she knew Resident #1's bed was raised in a higher position. However, based on staff interviews and the facility's investigation into the incident, it was determined that while NA #1 was filling the basin with water at the sink, NA #1 did not have a direct view of and could not visualize Resident #1, to ensure his/her safety. NA #1 said at one point she saw that Resident #1 had started to roll towards the edge of the bed with his/her legs extending over the side of the bed, so she immediately returned to Resident #1's bedside. NA #1 said she removed her gloves, lowered the position of the bed so it was closer to the floor, grabbed a nearby cushioned fall mat, pulled it towards Resident #1's bedside, wrapped her arms around Resident #1's upper body, held his/her torso against her chest and lowered him/her to the floor. NA #1 said she called out for help several times and when nobody came, she went to Resident #1's doorway, saw Nurse #1 at the medication cart and asked for assistance. NA #1 said Nurse #1 entered the room and asked her what happened and then asked Resident #1 if he/she was ok. NA #1 said she and Nurse #1 transferred Resident #1 back to bed using the Hoyer lift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:58 P.M., (which included a review of her Written Witness Statement, dated [DATE]), Nurse #1 said while she was in the hallway at the medication cart, NA #1 came to Resident #1's doorway and asked her for assistance. Nurse #1 said when she entered Resident #1's room, she saw Resident #1 lying face up on the floor next to his/her bed. Nurse #1 said she concluded he/she did not have any injuries, and she, along with NA #1 transferred Resident #1 back to bed using a Hoyer lift. Nurse #1 said she asked NA #1 several times in several different ways what happened, and that NA #1 said Resident #1 was slipping off his/her bed, so she lowered Resident #1 to the floor. Nurse #1 said NA #1 told her that Resident #1 did not fall, and he/she did not hit his/her head. Nurse #1 said this incident occurred around 8:00 P.M. on [DATE]. Nurse #1 said although she assessed Resident #1 prior to returning him/her back to bed, she did not assess his/her vital signs, nor did she document anything in his/her medical record or write a report related to this incident, and said she did not report the incident to anybody. During an interview on [DATE] at 11:10 A.M., (which included a review of her Written Witness Statement, undated), Nurse #2 said on [DATE], she had just finished passing her morning medications, was seated at the nursing station and Resident #1 was seated in the common area in his/her wheelchair directly across from the Nurse's Station. Nurse #2 said she heard Resident #1 screaming which was unusual for him/her. Nurse #2 said she asked a CNA to assist her to transfer Resident #1 back to bed so she could assess him/her. Nurse #2 said when she assessed Resident #1's upper extremities, Resident #1 yelled, my neck! Nurse #2 said this was very unusual behavior for Resident #1 as he/she does not often form words when talking. Nurse #2 said she immediately contacted Unit Manager #1 to update her on the situation. Nurse #2 said given they had no knowledge of, and there was no documentation of any accidents or trauma involving Resident #1, after speaking with the Nurse Practitioner (NP), it was thought the pain was muscular in nature and she administered pain medication to Resident #1, according to the NP's order. During an interview on [DATE] at 11:40 A.M., Unit Manager #1 said, looking back on things, staff noticed a change in Resident #1 after [DATE], when he/she had an [unreported] fall. Unit Manager #1 said on [DATE], Resident #1 vomited and stayed in bed the whole day, which was unusual for him/her. Unit Manager #1 said on [DATE], Nurse #2 alerted her that Resident #1 was yelling out in pain and complained of neck pain. Unit Manager #1 said that was odd because Resident #1 did not often verbalize words that made sense. Unit Manager #1 said on [DATE], she observed a CNA feeding Resident #1 in bed and noticed his/her posture seemed off. Unit Manager #1 said Resident #1's bed was slightly reclined and that she asked the CNA to sit Resident #1 in a more upright position, but the CNA told her that Resident #1 exhibited signs of pain when the head of the bed was too upright. Unit Manager #1 said she assessed Resident #1, noted he/she still had neck pain, so she contacted the NP again and requested an order for a neck X-ray. Unit Manager #1 said during the neck X-ray, Resident #1 was in significant pain any time they tried to position his/her head and neck for the X-ray. Unit Manager #1 said she noticed that Resident #1 had bruising along the back right side of his/her neck that had not been observed previously. Unit Manager #1 said Resident #1's granddaughter was present and on the telephone with Resident #1's Guardian who consented to him/her being transferred to the Hospital ED for evaluation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Unit Manager #1 said she notified the Director of Nurses who began an investigation, and that it was during that investigation that they learned that on [DATE], that NA #1 said she lowered Resident #1 to the floor because he/she was falling out of bed. Unit Manager #1 said Resident #1 was unable to roll him/herself if placed on his/her back, but he/she could have possibly rolled over by him/herself if he/she were left on his/her side. Unit Manager #1 said Resident 1's bed was not visible to staff who were at the bathroom sink, and he/she should not have been left unattended in the position NA #1 described because it was unsafe. During an interview on [DATE] at 3:30 P.M., the Director of Nurses (DON) said she was sitting in the Nursing office located near Resident #1's room on [DATE] and overheard Resident #1 yelling in pain. The DON said she went to see what was happening and observed Resident #1 cry out in pain every time the X-ray Technician and nursing staff attempted to adjust his/her position. The DON said nursing staff also observed bruising to Resident #1's neck during the X-ray process. The DON said they immediately stopped the process, determined that Resident #1 needed to be transported to the Emergency Department and called 911. The DON said she immediately began an internal investigation. The DON said that during her interviews with staff, Nurse #1 reported that on [DATE], Resident #1 was lowered to the floor by NA #1 during the evening shift. The DON said after she learned that NA #1 had reportedly lowered Resident #1 to the floor on [DATE], she had NA #1 show her exactly what had happened by having NA #1 do a re-enactment demonstration in Resident #1's room. The DON said they recreated the incident with herself (DON) assuming the role of Resident #1. The DON said she positioned herself by lying in the bed on her right side, left leg crossed over her right leg, with the side rail down, and the bed not in the lowest position. The DON said NA #1 then re-enacted the incident by trying to lower her (DON) to the floor just as she said she lowered Resident #1 to the floor. The DON said there was no way Resident #1's head or neck did not encounter the side rail, despite the side rail being lowered, because the top edge of the side rail extended above the mattress. The DON also said Resident #1 was not visible to NA #1 from the bathroom, that his/her bed should have been in the lowest position and was not, and he/she should not have been left unattended and out of direct view of NA #1. On [DATE], the Facility was found to be in Past Non-Compliance and 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) [DATE], Resident #1 was transferred to the Hospital for further assessment and treatment, and did not return to the facility. B) [DATE] through [DATE], Administrative staff reviewed previous incident reports for the potential for residents with suspected injury of unknown origin, with review of individual residents nursing Plans of Care and CNA Care Kardex, no concerns for failure to report where identified, reviews will continue as needed. C) [DATE], Facility Administration conducted an ad hoc Quality Assessment and Performance Improvement (QAPI) meeting, with review of current facility policies, and development of an Action Plan, review of the meeting minutes indicated the Facility Leadership team met and developed a plan of correction related to the deficient practices. (continued on next page)

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