STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 37227 Based on interviews and records reviewed, for one of three sampled residents (Resident #1) whose behaviors included disrobing and unsafe rising, the Facility failed to ensure Resident #1 was treated in a dignified respectful manner which included being free from the use of a physical restraint imposed for the purpose of staff, when on 07/04/24 during the overnight shift, Certified Nurse Aide #1 placed a sheet across Resident #1's waist and tied it in the back of his/her reclining chair, to prevent Resident #1 from disrobing, while she left to provide care to other residents. Findings include: Review of the Facility Policy titled Physical Restraint, dated as revised on 06/10/16, indicated the resident has a right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms/conditions. The Policy defined a restraint as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement that could ordinarily occur, or normal access to one's body. The Policy defined convenience as any action taken by the facility to control or manage a resident's behavior with lesser amount of effort by the facility and not in the resident's best interest. Resident #1 was admitted to the Facility in December 2023, diagnoses included neurocognitive disorder with Lewy body (a type of progressive dementia that leads to a decline in thinking, reasoning and independent function), dementia with behavioral disturbance, and delusional disorder. Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 05/08/24, indicated Resident #1 was severely cognitively impaired with a score of 6 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 Assessment indicated Resident #1 required substantial/maximum assistance from staff to transfer safely. Review of Resident #1's Behavior Care Plan, reviewed and renewed with his/her May 2024 Quarterly MDS, indicated his/her behaviors included impulsivity, disrobing, and resistance to care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's July 2024 Behavior Flowsheets indicated he/she frequently demonstrated episodes of unsafe rising from his/her chair and frequently disrobed during the evening and overnight shifts. During a telephone interview on 08/07/24 at 2:38 P.M., Certified Nurse Aide (CNA) #1 said that on 07/04/24 at 3:00 A.M., CNA #2 helped her transfer Resident #1 out of bed and into his/her reclining chair. CNA #1 said that around 3:30 A.M., while CNA #2 was on break, she supervised Resident #1 and two or more residents in the activity room. CNA #1 said that Resident #1 was restless and kept disrobing in his/her chair and a said another resident began yelling at him/her to put his/her clothes back on. CNA #1 said there were two residents that required immediate assistance with toileting, so she placed a sheet across Resident #1 waist area and tied it in the back of his/her chair to prevent him/her from disrobing, while she left to assist the other residents in the bathroom. CNA #1 said that at the time of the incident, CNA #2 was on break, and the nurse and a third CNA were on the other side of the locked doors. CNA #1 said she did not go to get help from the nurse or the CNA because she knew they were busy. CNA #1 said when she went back to check on Resident #1, she noticed he/she had fallen asleep in his/her chair. CNA #1 said that she was distracted while she was busy, and forgot to go back and untie the sheet from the back of Resident #1's chair before she left at the end of her shift. During an interview on 08/06/24 at 3:15 P.M., Certified Nurse Aide #2 said that on 07/04/24 at approximately 3:00 A.M., she helped CNA #1 transfer Resident #1 into his/her reclining chair, before she went on break. CNA #2 said that when she returned from break, Resident #1 was asleep in his/her chair, with a sheet placed over his/her lap. CNA #2 said that she did not notice anything out of the ordinary, because Resident #1 usually had a sheet or blanket on his/her lap, and said she had not noticed that the sheet was tied in the back. CNA #2 said that Resident #1 frequently disrobed during the overnight shift and that he/she was at risk for falling because he/she sometimes stood up from his/her chair without any assistance. Review of Certified Nurse Aide (CNA) #3's Written Witness Statement, dated 07/04/24, indicated that at 9:45 A.M. she attempted to transfer Resident #1 out of his/her chair, but he/she could not stand because he/she was restrained in the chair with a sheet. The Statement indicated that she (CNA #3) notified the nurse. During an interview on 08/06/24 at 1:40 P.M., Nurse #1 said that while he was working the day shift on 07/04/24, CNA #3 came to him at approximately 10:00 A.M., and reported that Resident #1 was tied in his/her chair. Nurse #1 said he observed that Resident #1 had a sheet across his/her waist that was tied behind the chair. Nurse #1 said the sheet become wedged in the side of the chair and he needed to cut the sheet to release it. Nurse #1 said that Resident #1's manner was calm at the time of the observation and said he/she was at his/her baseline for the remainder of the shift. During an interview on 08/06/24 at 12:58 P.M., Social Worker #1 said that she met with Resident #1 on 07/05/24, and said he/she had no recollection of the incident, and he/she did not appear to be in any distress. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/06/24 at 1:51 P.M., Unit Manager #1 said that on 07/04/24 when she and the Director of Nurses interviewed CNA #1 by telephone, CNA #1 admitted that she tied the sheet that was across Resident #1's waist, in the back of his/her chair, to keep him from disrobing and that CNA #1 had referred to the incident as a lapse in judgement. During an interview on 08/06/24 at 3:55 P.M., The Director of Nurses (DON) said that the Facility prides itself in being restraint free and said CNA #1 should not have tied the sheet, that was across Resident #1's waist, behind his/her chair as a way to prevent him/her from disrobing. The DON said that tying a sheet around a resident in his/her chair was not an appropriate behavioral intervention and said that it was considered a restraint. The DON said the Facility's investigation substantiated the improper use of a physical restraint and CNA #1 was terminated.