

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Quabbin Valley Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>37086</p> <p>Based on records reviewed, interviews, and observations, for one of three sampled residents (Resident #3), who resided on a secure unit, had a history of wandering on the evening shift, and staff said they needed to have their eyes on Resident #3 while he/she was ambulating on the unit, the Facility failed to ensure he/she was provided an adequate level of staff supervision in an effort to maintain his/her safety and prevent a fall resulting in an injury, when on 08/25/24, although Resident #3 was out of bed and ambulating in the hallway, he/she was not being supervised by unit staff, Resident #3 fell in the hallway, complained of pain, was transferred to the Hospital Emergency Department (ED) and diagnosed with intertrochanteric (hip) fracture of the left femur, which required surgical intervention to repair.</p> <p>Findings include:</p> <p>Review of the Facility's Policy titled Activities of Daily Living (ADL) Support, dated June 2022, indicated the following:</p> <ul style="list-style-type: none"> -Definition: Tasks related to personal care such as personal hygiene, toileting, feeding, ambulating, walking in the room and in the corridor. -Resident will perform self-care with ADLs at the level indicated on the Certified Nurse Aide (CNA) Care Plan or Care Card (used by CNAs to determine individual care needs). -Provide ambulation and transfer programs per the care plan. <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 08/29/24, indicated that on 08/25/24 at 8:50 P.M., Resident #3 was observed on the floor in the hallway with his/her walker next to him/her. The Report indicated that Resident #3 was transferred to the Hospital ED and was found to have a (left) hip fracture.</p> <p>Review of the Facility's Investigation, which included written statements from the staff, indicated that on 08/25/24 at 8:50 P.M., Resident #3 was observed on the floor in the hallway with his/her walker next to him/her. The Investigation indicated Resident #3 required staff supervision (staff to have eyes on him/her) for ambulation, that he/she had ambulated in the hallway independently and fell .</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #3's Fall Report, dated 08/25/24 and completed by Nurse #1, indicated the following items were identified as factors relative to Resident #3's fall:</p> <ul style="list-style-type: none"> -Predisposing Physiological Factors: confused, incontinent, gait imbalance, impaired memory, weakness. -Predisposing Situation Factors: ambulating without assistance, wanderer. <p>Review of Resident #3's Hospital Discharge Summary, dated 08/29/24, indicated Resident #3 sustained a left hip fracture and underwent surgical repair.</p> <p>Resident #3 was admitted to the Facility in September 2021, diagnoses included insomnia, anxiety disorder and vascular dementia.</p> <p>Review of Resident #3's Fall Risk Assessment, dated 07/10/24, indicated he/she was at risk for falls.</p> <p>Review of Resident #3's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 07/10/24, indicated he/she scored a 3 out of 15 on his/her Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). The MDS also indicated that he/she required staff supervision for ambulation (staff provides verbal cues or touching/steadying assistance as resident completes the activity) and had episodes of wandering.</p> <p>Review of Resident #3's Activities of Daily Living (ADL) Care Plan, reviewed and renewed with the most recent Quarterly MDS Assessment, indicated he/she required staff supervision for ambulation.</p> <p>Review of Resident #3's Elopement Risk Care Plan, reviewed with the most recent Quarterly MDS Assessment, indicated he/she was at risk for elopement and wandering due to impaired safety awareness.</p> <p>During an interview on 09/17/24 at 3:05 P.M., (which included review of her 08/25/24, Nurse Progress Note) Nurse #1 said on 08/25/24 at 8:50 P.M., she was in the Day Room reviewing Facility policies with a newly hired employee. Nurse #1 said it was her routine to spend most of the shift in the Unit Day Room.</p> <p>Nurse #1 said Resident #3 was well known to her and he/she often wandered the hallway of the unit. Nurse #1 said it was very common for Resident #3 to be up and about on the evening (3:00 P.M. to 11:00 P.M.) shift. Nurse #1 said Resident #3 had been in bed and had gotten up to use the bathroom in the hallway. Nurse #1 said that on 8/25/24, before Resident #3's fall, the two Certified Nurse Aides (CNAs) on duty for the evening on the shift had started their rounds, which they did together.</p> <p>Nurse #1 said because she was in the Day Room she could not see Resident #3 ambulating in the hallway. Nurse #1 said she heard a terrible crash in the hallway and ran out from the Day Room to see what happened. Nurse #1 said she observed Resident #3 on the floor in the hallway with his/her walker nearby. Nurse #1 said Resident #3 complained of significant left hip pain and was transferred to the Hospital ED for evaluation.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/17/24 at 9:38 A.M., the Surveyor made the following observation on the unit where Resident #3 resided.</p> <ul style="list-style-type: none"> - The Day Room (where Nurse #1 was while Resident #3 was ambulating in the hallway) was located at the near end of the unit hallway. - The Unit hallway, or residents ambulating in the hallway, could not be seen (monitored) by staff from inside the Day Room. <p>During a telephone interview on 09/17/24 at 2:07 P.M., (which included review of her 08/25/24, Post Fall CNA Report), Certified Nurse Aide (CNA) #1 said she was familiar with Resident #3 and it was normal for him/her to be up at that time of night on the evening shift. CNA #1 said on 8/25/24, she and one other CNA (CNA #2) were on duty for the evening shift and were in a resident's room at the time of Resident #3's fall. CNA #1 said she heard Resident #3 yell and when she came out of the room, she saw Resident #3 on the floor in the hallway. CNA #1 said Resident #3 immediately complained of hip pain.</p> <p>During a telephone interview on 09/17/24 at 1:37 P.M., (which included review of her 08/25/24, Post Fall CNA Report), Certified Nurse Aide (CNA) #2 said Resident #3 was well known to her. CNA #2 said Resident #3 had also sustained a fall in July 2024 and since that fall, Resident #3 had been increasingly confused and had a shuffled gait, which was new for him/her. CNA #2 said not only did Resident #3 shuffle when he/she walked, but he/she also did so very quickly. CNA #2 said Resident #3 never stayed in bed, was up every 15 minutes, and was always looking to get up and go.</p> <p>CNA #2 said Resident #3 and all of the residents on the secured unit required supervision (having a resident within staff members line of vision), but said it was not always possible because some residents required assistance of two staff members during care, which often left common areas (such as the hallway) unsupervised.</p> <p>During an interview on 09/17/24 at 1:20 P.M., (which included review of her 8/26/24, Falls Assessment Tool), Unit Manager #1 said she reviewed Resident #3's fall which occurred on 08/25/24 and she, along with other members of the Facility's clinical team, determined Resident #3 ambulated independently and did not have staff supervision at the time of his/her fall. Unit Manager #1 said Resident #3 should have been supervised by staff for ambulation.</p> <p>Unit Manager #1 said it was difficult with Resident #3 because he/she often spent time in the unit's Day Room where staff were able to adequately supervise him/her, but when Resident #3 was not in the Day Room staff may not have realized they needed to provide him/her with supervision during ambulation in the hallway. Unit Manager #1 said after Resident #3's fall on 8/25/24, his/her plan of care and care kardex's were updated and interventions included he/her requires assistance of one staff member with ambulation.</p> <p>During an interview on 09/17/24 at 4:02 P.M., the Director of Nurses (DON) said if a resident required supervision for ambulation, she expected staff to watch the resident from a safe distance during ambulation. The DON said in the case of Resident #3's fall on 08/25/24, the staff did not provide the required level of supervision during ambulation.</p>		