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	12/23/2025

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 0656 Level of Harm - Minimal harm or potential for 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. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose comprehensive care plan indicated he/she required assistance of two staff members for bed mobility/positioning, the Facility failed to ensure staff consistently implemented and followed interventions in his/her care plan, when on 12/05/25, CNA #1 repositioned Resident #1 in bed without another staff member present to assist her, and he/she fell out of bed. Findings include: Review of the Facility's policy titled, Plans of Care, dated as revised on 04/04/25, indicated all staff involved in the resident's care must be familiar with and follow the care plan. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 12/08/25, indicated that during morning care on 12/05/25, Resident #1 was sliding off an air mattress and could not be retrieved to midline of the bed, was lowered to the floor, and did not have any injuries.Review of the Facility's Internal Investigation Narrative indicated the following:-Resident #1 sustained a witnessed fall on 12/05/25.-Certified Nurse Aide (CNA) #1 was providing care to Resident #1 (who was on an air mattress), his/her legs slid towards the edge of the bed, CNA #1 repositioned him/her back to the center of the bed, turned to obtain linens and when she turned her head back to Resident #1, he/she was sliding off the bed.-CNA #1 grabbed Resident #1's midsection to reposition him/her, but he/she continued to slide with his/her weight being more than CNA #1 could manage, and he/she subsequently fell to the floor.Review of the Administrator's interview with CNA #1, dated 12/08/25, indicated CNA #1 said she had cared for Resident #1 in the past (on a different unit), that she did not know that Resident #1 required two persons to assist with his/her care, and while there was another CNA (CNA #2) present in the room, that CNA was caring for another resident and that she (CNA #1) was caring for Resident #1 by herself when he/she fell out of bed.Resident #1 was admitted to the Facility in February 2022, diagnoses included unspecified dementia with agitation and adjustment disorder with mixed disturbance of emotions and conduct.Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 10/07/25, indicated he/she was severely cognitively impaired with a score of zero 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 his/her MDS Assessment indicated he/she had impairment to both his/her lower extremities, and was dependent on staff for hygiene, dressing, bed mobility, transfers, and positioning. Review of Resident #1's Activities of Daily Living (ADL) Care Plan, reviewed and renewed with his/her Annual MDS Assessment, dated 10/07/25, indicated he/she was dependent on two staff members for transfers (via mechanical lift), and two staff members for positioning in and out of bed.Review of Resident #1's current CNA Care Card (reference tool for CNAs to obtain critical patient information that includes their care needs and level of staff assistance required to meet those needs), last updated 02/23/25, indicated he/she was dependent on two staff members for positioning in bed.During a telephone interview on 12/23/25 at 11:16 A.M., CNA #1 said she was working on 12/05/25 and was caring for Resident #1 without the assistance of another caregiver when he/she fell out of bed.CNA #1 said she had cared for Resident #1 one or two times previously when he/she was on a different unit, but that she was not familiar with his/her care needs. CNA #1 said every resident in the facility has a CNA Care Card, located in the CNA assignment books kept at the Nursing Station. CNA #1 said the Care Card includes information about the type of care a resident would need, including how many staff members are required to complete care.CNA #1 said she did not check Resident #1's Care Card prior to caring for him/her, that she did not know Resident #1 required two caregivers for bed mobility and said if she had checked his/her Care Card she would have seen he/she required two caregivers and would have gotten assistance from another staff member prior to providing care.During a telephone interview on 12/23/25 at 12:05 P.M., CNA #2 said she was working the morning of 12/05/25 when Resident #1 fell out of bed. CNA #2 said she was caring for Resident #1's roommate, that CNA #1 was caring for Resident #1 by herself, and that she did not see him/her fall.During an interview on 12/23/25 at 2:00 P.M., Unit Manager #1 said Resident #1 was completely dependent on staff for all his/her care needs, and that his/her Care Card indicated he/she required assistance from two staff members for care, including bed mobility and positioning.Unit Manager #1 said all CNAs should check the Care Card prior to providing care to a resident, and that the Care Cards are easily accessible in the CNA Book located at the Nursing Station.During an interview on 12/23/25 at 4:20 P.M., the Director of Nurses (DON) said she was aware Resident #1 had fallen on 12/05/25 and that the Administrator interviewed the two CNAs that were present in Resident #1's room during the fall (CNA #1 and CNA #2). The

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews for one of three sampled residents (Resident #1), who required the assistance of two staff members for bed mobility and positioning, the Facility failed to ensure he/she was provided with the necessary level of staff assistance to maintain his/her safety to prevent an incident/accident, when on 12/05/25, during the provision of care, CNA #1 provided care to Resident #1 without having another staff member present to assist her, and Resident #1 fell out of bed.Findings include:Review of the Facility policy titled Fall Prevention, dated as revised 09/04/25, indicated the following:-Preventative care planning for the resident at risk for falls should involve all relevant disciplines.-All team members should be aware of the risks and benefits of interventions chosen, and preventative interventions will be entered into the resident care plan and will be updated as indicated.-Ensure caregivers, resident and family are aware of care plan interventions to promote continuity of care.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 12/08/25, indicated that during morning care on 12/05/25, Resident #1 was sliding off an air mattress, could not be retrieved to midline of the bed, was lowered to the floor, and did not have any injuries.Review of the Facility's Internal Investigation indicated the following:-Resident #1 sustained a witnessed fall on 12/05/25.-Certified Nurse Aide (CNA) #1 was providing care to Resident #1 (who was on an air mattress), his/her legs slid towards the edge of the bed, CNA #1 repositioned him/her back to the center of the bed, turned to obtain linens and when she turned her head back to Resident #1, he/she was sliding off the bed.-CNA #1 grabbed Resident #1's midsection to reposition him/her, but he/she continued to slide with his/her weight being more than CNA #1 could manage, and he/she subsequently fell to the floor.-On 12/08/25 after Resident #1 experienced pain and discomfort with care, the Administrator began an internal investigation and interviewed CNA #1 about the fall. Review of the Administrator's interview with CNA #1, dated 12/08/25, indicated CNA #1 said she had cared for Resident #1 in the past (on a different unit), that she did not know that Resident #1 required two persons to assist with his/her care, and while there was another CNA (CNA #2) present in the room, that CNA was caring for another resident and that she (CNA #1) was caring for Resident #1 by herself when he/she fell out of bed.Resident #1 was admitted to the Facility in February 2022, diagnoses included unspecified dementia with agitation and adjustment disorder with mixed disturbance of emotions and conduct. Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 10/07/25, indicated he/she was severely cognitively impaired with a score of zero 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 his/her MDS Assessment indicated he/she had impairment to both his/her lower extremities, and was dependent on staff for hygiene, dressing, bed mobility, transfers, and positioning. Review of Resident #1's Fall Risk Care Plan, reviewed and renewed with his/her Annual MDS Assessment, dated 10/07/25, indicated that he/she was at increased risk for falls.Review of Resident #1's Activities of Daily Living (ADL) Care Plan, reviewed and renewed with his/her Annual MDS Assessment, dated 10/07/25, indicated he/she was dependent on two staff members for transfers (via mechanical lift), and two staff members for positioning in and out of bed.Review of Resident #1's current CNA Care Card (reference tool for CNAs to obtain critical patient information that includes their care needs and level of staff assistance required to meet those needs), last updated 02/23/25, indicated he/she was dependent on two staff members for positioning in bed.Review of a Nursing Post Fall Evaluation Note, dated 12/05/25 at 6:57 A.M. (written by Nurse #1), indicated Resident #1 experienced a witnessed fall on 12/05/25 at 6:15 A.M. during morning care and upon assessment, had no injuries. Review of Nurse #1's Written Witness Statement, undated, indicated that a CNA (later identified as CNA #2) approached her at 6:15 A.M. on 12/05/25 saying, we need you, he/she fell (referring to Resident #1), that she went to Resident #1's room and found him/her to be lying on his/her back with CNA #1 holding his/her head in her lap.Nurse #1's Statement further indicated CNA #1 told her Resident #1 started to slide out of bed and that she could not stop him/her from falling.The surveyor was unable to interview Nurse #1 as she did not respond to the Department of Public Health's request for an interview.Review of CNA #1's Written Witness Statement, dated 12/05/25, indicated that on 12/05/25, she was changing Resident #1, that she was standing on the left side of the bed, that Resident #1 rolled off the right side of the bed and landed on his/her fall mat on the floor.During a telephone interview on 12/23/25 at 11:16 A.M., CNA #1 said she was working on 12/05/25 and caring for Resident #1 when he/she fell out of bed. CNA #1 said she was getting ready to provide incontinent care to Resident #1, that she rolled