STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225380	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Westfield LLC	60 East Silver Street Westfield, MA 01085

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed, interviews, and observations, for one of three sampled residents (Resident #1) who required a wheelchairˆaccessible platform scale for weight monitoring, the Facility failed to maintain a safe, hazardˆfree environment, when the dualˆramp platform scale was obstructed on three of four sides, limiting staff access needed to safely assist the resident during weighing. On 12/31/25, Resident #1 began to fall from his/her wheelchair, and due to the obstructed access, Certified Nurse Aide #1 was unable to position herself to provide adequate physical assistance. As a result, Resident #1 fell to the floor and sustained a forehead laceration requiring five sutures.Findings include:Review of the Facility Policy titled Safety and Supervision of Residents, dated as revised in 2007, indicated the Facility strives to make the environment as free from accident hazards as possible. The Policy further indicated that resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Resident #1 was admitted to the Facility in June 2023, diagnoses included dementia with agitation and unspecified osteoarthritis. Resident #1's Quarterly Annual Minimum Data Set (MDS) Assessment, dated 11/06/25, 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) The Assessment also indicated Resident #1 required substantial assistance from staff members for transfers and activities of daily living. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 01/06/26, indicated that on 12/31/25 at 11:20 A.M., Resident #1 was weighed in his/her wheelchair by Certified Nurse Aide (CNA) #1. The Report indicated that when CNA #1 attempted to remove Resident #1 from the scale he/she abruptly lowered his/her feet and leaned forward. The Report further indicated that CNA #1 was unable to prevent Resident #1's momentum from propelling him/her forward out of the wheelchair, landing on the floor and striking his/her head. The Report indicated that Resident #1 was sent to the Emergency Department (ED) for evaluation and was noted to have a three (3) centimeter (cm) laceration which was closed with five sutures. Review of Resident #1's Emergency Department (ED) Discharge summary, dated [DATE], indicated he/she was diagnosed with an acute forehead laceration, due to a mechanical fall, that was closed with five sutures. During an environmental tour of the Unit B Shower Room, on 03/11/26 at 9:18 A.M., the surveyor observed the following:-A platform scale was positioned lengthwise against the left wall of the Shower Room, and a large full-length tub was on the opposite (right) wall of the room. -A very large shower bed was stored between the tub and the scale. -The platform scale had dual integrated ramps (left and right) and a platform that allowed a resident to remain seated in a wheelchair while being weighed. -Both ramps, and the scale platform were covered with a non-skid surface (much like sandpaper). -The ramp on the right side of the platform was obstructed by the back wall of the Shower Room, prohibiting anyone from entering and/or exiting the scale from the right side. -The back side of the platform was positioned against the left wall of the Shower Room. -The front side of the platform scale, where staff might stand to assist a resident, without interfering with the weighing mechanism, was obstructed by a very large shower bed. -The (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	ramp on the left side of the platform was the only side of the scale that was accessible to residents and staff. During an interview on 03/11/26 at 11:45 A.M., Certified Nurse Aide (CNA) #1 said that she had worked regularly at the Facility through a staffing agency for around one year at the time of the incident and was familiar with the scale, periodically weighing residents as needed. During the interview, CNA #1 (while in the Unit B Shower Room accompanied by the surveyor) demonstrated how on 12/31/25, she assisted Resident #1 on and off the platform scale in the wheelchair. CNA #1 said she stood behind the wheelchair, used the handgrips to pull and back up Resident #1 on the small ramp on the left side of the scale, in his/her wheelchair. CNA #1 said that once the wheelchair was positioned on the platform, she was confined up against the wall (behind Resident #1) on the right side of the scale, and that a shower bed obstructed the long edge of the scale, limiting her ability to maneuver. CNA #1 said that after she obtained Resident #1's weight, she pushed him/her in the wheelchair from behind to exit the left side of the platform when Resident #1 unexpectedly put his/her foot down causing him/her to tip forward. CNA #1 said she could not get around in front of the wheelchair quickly to assist Resident #1, due to the obstacles and limited space around the scale. CNA #1 said that Resident #1 fell forward out of the wheelchair and hit his/her head on the floor. During an interview on 03/11/26 at 1:54 P.M., Nurse #1 said that while working the day shift on 12/31/25 at around 11:20 A.M., a CNA notified her of a resident fall in the shower room. Nurse #1 said she responded immediately and observed Resident #1 on the floor in front of the wheelchair near the left side of the scale. Nurse #1 further said that CNA #1 reported Resident #1 unexpectedly placed his/her foot down and fell forward out of the wheelchair while being assisted off the scale. Nurse #1 said that Resident #1 had a laceration on his/her forehead and that orders were obtained to send Resident #1 to the ED for further evaluation. Nurse #1 and CNA #1 reviewed the surveyor's photos of the Unit B Shower Room and said the pictures accurately represented how the scale and the shower bed were positioned on 12/31/25, at the time of the fall. CNA #1 said she was not aware of any residents that required the use of the shower bed. CNA #1 further said that the shower bed was stored in the Unit B shower room, alongside the platform scale, for as long as she had worked at the Facility (approximately one year). During an interview on 03/11/26 at 2:45 P.M., Unit Manager #1 said that she was working on 12/31/25 and responded to the fall. Unit Manager #1 said that upon entering the Unit B Shower Room, she observed Resident #1 lying on his/her right side on the floor while Nurse #1 applied pressure to a forehead laceration to control bleeding. Unit Manager #1 said that CNA #1 told her that Resident #1 placed his/her foot down unexpectedly while being wheeled off the scale platform, causing him/her to be propelled forward out of the wheelchair. Unit Manager #1 said that CNA #1 reported that she was positioned behind Resident #1's wheelchair, pushing it down the ramp on the left side of the scale at the time of the fall. Unit Manager #1 further said that no residents currently required the use of the shower bed and that it had previously been stored in the basement. Review of Resident #1's Skin Assessment, dated 01/01/26 indicated the following from a witnessed fall on 12/31/25: forehead laceration and bruising on the forehead, under both eyes, and left hand. Review of Resident #1's Nurses Note, dated 01/09/26, indicated that he/she had five sutures removed from his/her forehead. During an interview on 03/11/26 at 2:31 P.M., the Director of Nurses (DON) said that she was unaware the shower bed was stored in the Unit B Storage Room, or that it limited staff's ability to navigate around the scale.