STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225466	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highview of Northampton	222 River Road Leeds, MA 01053

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 48138 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who on 7/15/24 during the provision of care by a staff member, slid out of bed, with his/her feet landing on the floor and his/her upper body being held on the bed by the staff member, and was then lowered to the floor by staff, the facility failed to ensure nursing reported the incident to the Provider, his/her Guardian and administrative staff in a timely manner as required, and per facility policy. Findings include: Review of the Facility's policy, titled Condition: Significant Change, dated April 2015, indicated the following: -Staff will promptly contact and consult the resident's physician, notify the resident's representative when there is a change requiring notification. Review of the Facility's policy, titled Incidents and Accidents, dated April 2015, indicated the following: - Staff will contact the resident's practitioner to inform them of the incident and any other findings and the resident's family or representative will be notified of the incident. Review of the Report submitted by the facility via the Health Care Facility Reporting System (HCFRS), dated 07/17/24, indicated (that on 07/15/24) Resident#1 slid out of bed with his/her feet landing on the floor while being rolled onto his/her side by Certified Nurse Aide (CNA) #1 at approximately 6:30 A.M. The Report indicated, CNA #1 called for assistance and Nurse #1 assisted with lowering Resident #1 to the floor, they obtained a mechanical lift and placed him/her back to bed with the assistance of three staff members. Resident #1 was admitted to the Facility in October 2015, diagnoses include Multiple Sclerosis, Parkinson's disease, Dementia, and Epilepsy. Review of Resident #1's medical record indicated indicated his/her Legal Guardian was responsible for making health care decisions. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Minimum Data Set (MDS) Annual Assessment, dated 05/09/24, indicated he/she was severely cognitively impaired, scored a 4 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. Further review of the MDS Assessment, indicated Resident #1 was totally dependent with care and required assistance from two staff members for hygiene/bathing and bed mobility. Review of Resident #1's medical record indicated there was no Nurse Progress Note or Incident Report written on 7/15/24, and no documentation to support his/her Guardian or Provider were notified of the incident. During a telephone interview on 10/10/24 at 11:38 A.M., Nurse #1 said on 07/15/24 around 6:30 A.M.,(exact time unknown) she was at her medication cart in the hallway and heard CNA #1 calling out for help, she entered Resident #1's room and observed him/her with his/her legs on the floor with CNA #1 holding him/her under the arms, and Resident #1's upper body still partially on the bed. Nurse #1 said she assisted with lowering Resident #1 to the floor and requested CNA #2 to assist them and he/she was placed back in bed using a mechanical lift. Nurse #1 said she did not report the incident to Resident #1's Guardian, Provider, or oncoming nursing staff, or administrative staff. Review of Resident #1's Nurse Progress Note, (dated and time stamped in EMR as written on 7/23/24 at 1:41 P.M. by Nurse #1) as a late entry for 07/15/24, indicated that at 6:30 A.M.,CNA #1 called for help and she observed Resident #1 with his/her legs on the floor and his/her head on the bed. The Note indicated Resident #1 was lowered to the floor and then lifted back to bed via mechanical lift with assist of three staff members. Review of the Facility Investigation Report, dated 07/17/24, which included a witness statement provided by CNA#1 that indicated the following: CNA #1 rolled Resident #1 onto his/her side and his/her legs went over the bed landing on the floor and he/she began sliding off of the bed. CNA #1 grabbed Resident #1 under his/her arms and yelled for help. Nurse #1 entered the room, assisted with lowering Resident #1 to the floor and a mechanical lift was obtained and he/she was placed back into bed. The Investigation indicated that on 7/16/24, the Director of Nurses (DON), was notified by Nurse #2 that Resident #1 had unexplained bruising on his/her upper arms and during the interview with Resident #1 when asked if the bruising was painful he/she pointed to his/her right hip and said that it hurt. The Investigation indicated Resident#1's Provider was notified. Review of Resident #1's Mobile X-ray Report of his/her right hip, dated 07/17/24, indicated he/she had a fracture of the right hip. Review of Resident #1's Hospital Discharge Summary, dated 07/21/24, indicated he/she was admitted to the Hospital 07/17/24, after being diagnosed with a right hip fracture which required an open reduction and internal fixation (ORIF) surgical procedure on 07/18/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/24 at 12:30 P.M., the Director of Nurses (DON) said that when she completed the facility's investigation there had been no report or documentation in the medical record of Resident #1's fall by the staff involved and the unexplained bruising found by the day shift staff resulted in further investigation. The DON said it is her expectation for staff to report falls/accidents/incidents immediately as required and to document the incident. The DON said it is her expectation that staff follow the plan of care and in this case it was not done.

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F 0656 Level of Harm - 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. 48138 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), whose comprehensive plan of care indicated he/she required assistance of two staff members for hygiene (incontinence) care and bed mobility, the Facility failed to ensure staff implemented and followed interventions in his/her care plan, when on 7/15/24, Certified Nurse Aide (CNA) #1, provided incontinent care to Resident #1 which included the need to turn and roll him/her in bed, without another member present for assistance. CNA #1 rolled Resident #1 onto his/her side, and he/she slid out of bed with his/her feet landing on the floor with his/her torso still on the side of the bed. CNA #1 called for and another staff member helped lower Resident #1 to the floor. Resident #1 was transferred back to bed via a mechanical lift, the next day Resident #1 was noted to have new areas of bruising, complained of right hip pain, an x-ray was obtained, he/she was diagnosed with a right hip fracture, and was transferred and admitted to the Hospital, where he/she underwent surgical intervention to stabilize the fracture. Findings include: Review of the Facility's Policy titled, Comprehensive Care Plans, dated November 2017, indicated that: - the Facility provides individualized, person-centered care which is reflected in each resident's care plan. To facilitate the creation of such plans, the Facility performs a comprehensive assessment on all residents, -the care plan will include an assessment of resident's strengths and needs and, -the care plan are oriented toward preventing avoidable decline in clinical and functional levels. Review of the Report submitted by the facility via the Health Care Facility Reporting System (HCFRS), dated 07/17/24, indicated (that on 07/15/24) Resident #1 slid out of bed with his/her feet landing on the floor while being rolled onto his/her side by CNA #1 at approximately 6:30 A.M. The Report indicated, CNA #1 called for assistance and Nurse #1 assisted with lowering Resident #1 to the floor and then mechanically lifted him/her back to bed with 3 staff members. Review of the Facility Investigation Report, dated 07/17/24, which included a witness statement provided by CNA #1, indicated the following: CNA #1 rolled Resident #1 onto his/her side, his/her legs went over the side of the bed landing on the floor and he/she began sliding off of the bed. CNA #1 grabbed Resident #1 (from behind) under his/her arms and yelled for help. Nurse #1 entered the room and assisted CNA #1 with lowering Resident #1 to the floor, a mechanical lift was obtained and he/she was placed back into bed. The investigation indicated the Director of Nursing (DON) was notified by Nurse #2 that Resident #1 had unexplained bruising on his/her upper arms, and during an interview with him/her, when asked if the bruising was painful, Resident #1 pointed to his/her right hip and said that it hurt, the DON notified the Provider and an x-ray was ordered. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Resident #1 was admitted to the Facility in October 2015, diagnoses include Multiple Sclerosis, Parkinson's disease, Dementia, and Epilepsy. Review of Resident #1's Minimum Data Set (MDS) Annual Assessment, dated 05/09/24, indicated he/she was totally dependent with care and required assistance from two staff members for hygiene/bathing and bed mobility. Review of Resident #1's Functional Mobility Care Plan, reviewed and renewed with his/her May 2024 MDS, indicated interventions (dated as initiated on 12/26/17) included for two staff members to assist when turning him/her side to side in bed. Review of Resident #1's Care Kardex Report (utilized by Certified Nurse Aides, provides direct care staff with a brief overview of each resident's needs), indicated he/she was dependent for toileting hygiene (which included incontinence care) rolling left and right in bed, and that he/she required assistance of two staff members. Review of Resident #1's Nurse Progress Note, (dated and time stamped in EMR as written on 07/23/24 at 1:41 P.M. by Nurse #1) as a late entry for 07/15/24, indicated that at 6:30 A.M., CNA #1 called for help and she observed Resident #1 without clothing on and his/her legs on the floor with his/her head on the bed. The Note indicated Resident #1 was lowered to the ground and then lifted back to bed via mechanical lift with assist of three staff members. Review of Resident #1's Mobile X-ray Report of his/her right hip, dated 07/17/24, indicated he/she had a fracture of the right hip. Review of Resident #1's Hospital Discharge Summary, dated 07/21/24, indicated he/she was admitted to the Hospital 07/17/24, after being diagnosed with a right hip fracture which required an open reduction and internal fixation (ORIF) surgical procedure on 07/18/24. During a telephone interview on 10/10/24 at 11:38 A.M., Nurse #1 said on 07/15/24 around 6:30 A.M.,(exact time unknown) she was at her medication cart in the hallway and heard CNA #1 calling out for help, she entered Resident #1's room and observed Resident #1 with his/her legs on the floor with CNA #1 holding him/her under the arms, and Resident #1's upper body still partially on the bed. Nurse #1 said she assisted with lowering Resident #1 to the floor and requested CNA #2 to assist them and he/she was placed back in bed using a mechanical lift. Nurse #1 said Resident #1 was dependent on staff are, required two members to assist during care and that CNA #1 should have had another staff member assisting him. During an interview on 10/10/24 at 10:58 A.M., Nurse #2 said Resident #1 was dependent on staff for all care and required two staff members for bed mobility. During a telephone interview on 10/18/24 at 1:55 P.M., CNA #1 said on 7/15/24, he went to provide incontinence care for Resident #1, had requested help from the other CNA, waited for 10 minutes and couldn't find the nurse, so he provided incontinence care to Resident #1 alone. CNA #1 said that when he rolled Resident #1 onto his/her side, he/she slid off the bed, that he attempted to stop the fall by grabbing Resident #1 under the arms and called for help. CNA #1 said he was aware Resident #1 required assistance of two staff members during call, but said he (CNA #1) couldn't wait any longer. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/10/24 at 10:48 A.M., CNA #2 said Resident #1 required assistance of two staff members with all care and said on 7/15/24, she was called in to assist after the fall to mechanical lift him/her back to bed. During an interview on 10/10/24 at 10:58 A.M., Nurse #2 said that Resident #1 was dependent on staff for all care and required two staff members for bed mobility. During an interview on 10/10/24 at 12:30 P.M., the Director of Nurses (DON) said that based on Resident #1's plan of care, two staff members were required to provide assistance to Resident #1 for bed mobility and during hygiene (incontinence) care. The DON said CNA #1 (who was the CNA providing hygiene care to Resident #1 alone on 7/15/24 at the time of the incident) told her that he rolled Resident #1 onto his/her side without another staff member present for assistance, and he/she slid off the bed. The DON said it is her expectation that staff follow the plan of care and in this case, it was not done.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48138 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who during the provision of care by staff had a witnessed fall on 07/15/24, in which Nurse #1 assisted in lowering Resident #1 to the floor and transferring him/her back to bed, the Facility failed to ensure that nursing followed acceptable standards of professional practice, when although Nurse #1 said she assessed Resident #1 immediately after the fall, there was no documentation to that effect, no incident report, no nursing assessment, and it was also not reported to the Physician, Guardian, Nursing staff on the following shift or to Administrative staff. Findings include: The Facility's Policy, titled Accidents/Incidents, dated April 2015, indicated: - It is the responsibility of the staff to report accidents/incidents to the supervisor and document all accidents/incidents that occur at the facility. Review of the Facility's policy, titled Condition: Significant Change, dated April 2015, indicated the following: -Staff will promptly contact and consult the resident's physician, notify the resident's representative when there is a change requiring notification. Review of the Facility's policy, titled Nursing Documentation, dated February 2016, indicated the following: -Incident/Accident is any unusual happening or situation which could result in bodily injury and must be documented in the nurse's note along with completion of the reportable events form. Review of the Report submitted by the facility via the Health Care Facility Reporting System (HCFRS), dated 07/17/24, indicated (that on 7/15/24) Resident #1 slid out of bed with his/her feet landing on the floor while being rolled onto his/her side by CNA #1 at approximately 6:30 A.M. The Report indicated, CNA #1 called for assistance and Nurse #1 assisted with lowering Resident #1 to the floor, a mechanical lift was obtained along with another staff member (CNA #2) and he/she was transferred back to bed. The Report further indicated staff (Nurse #1) did not report or document the fall and (on 7/16/24) Resident #1 was found to have new areas of bruising under both arms and to his/her left shoulder by the next shift (day shift) staff during care, an investigation was conducted which revealed he/she had unexplained bruising and pain in his/her right hip, an x ray was obtained showing a right hip fracture. Resident #1 was then transferred to the hospital and required surgical intervention. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility Investigation Report, dated 7/17/24, included a witness statement provided by CNA #1, which indicated the following: CNA #1 rolled Resident #1 on his/her side, his/her legs went over the side of the bed landing on the floor and he/she began sliding off the bed. CNA #1 grabbed Resident #1 under his/her arms (from behind) and yelled for help. Nurse #1 entered the room and assisted CNA #1 with lowering Resident #1 to the floor and a mechanical lift was obtained and he/she was placed back in bed. Resident #1 was admitted to the Facility in October 2015, diagnoses include Multiple Sclerosis, Parkinson's disease, Dementia, and Epilepsy. Review of Resident #1's Minimum Data Set (MDS) Annual Assessment, dated 05/09/24, indicated he/she scored a 4 out of 15 on his/her Brief Interview for Mental Status (BIMS) FORM Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact. Further review of the MDS Assessment, indicated Resident #1 was totally dependent on staff and required two staff members for bed mobility and personal hygiene. Review of Resident #1's Nurse Progress Note, (dated and time stamped as written on 7/23/24 at 1:41 P.M., by Nurse #1) as a late entry for 7/15/24, indicated that at approximately 6:30 A.M., CNA #1 called for help from Resident #1's room, she was in the hallway at her medication cart then entered the room and observed Resident #1 with his/her legs on the floor with his/her head on the bed. The Note indicated Resident #1 was lowered to the floor and then lifted back to bed via mechanical lift with an assist of three staff members. Further review of Nurse #1's Progress note indicated there was no documentation to support Nurse #1 notified the Provider, Guardian, or Administration. Review of Resident #1's Mobile X-ray Report of his/her right hip, dated 07/17/24, indicated he/she had a fracture of the right hip. Review of Resident #1's Hospital Discharge Summary, dated 07/21/24, indicated he/she was seen in the emergency room and admitted to the Hospital 07/17/24, diagnosed with a right hip fracture which required an open reduction and internal fixation (ORIF) surgical procedure on 07/18/24. During an interview on 10/10/24 at 10:58 A.M., Nurse #2 said she was notified by a CNA on 07/15/24 at approximately 6:15 P.M., that Resident #1 had bruising noted on his/her bilateral underarms and left shoulder. Nurse #2 said she had not been made aware of any incident from the previous shift on shift report given by Nurse #1 earlier in the day that would have explained the bruises. Nurse #2 said she assessed Resident #1 and immediately reported the bruising to the Director of Nurses. During a telephone interview on 10/10/24 at 11:38 A.M., Nurse #1 said on 07/15/24 around 6:30 A.M. she was at her medication cart in the hallway and heard CNA #1 calling out for help, she entered Resident #1's room and observed that Resident #1's legs were on the floor with CNA #1 behind him/her holding him/her under the arms with Resident #1's upper body against the bed. Nurse #1 said she assisted with lowering Resident #1 to the floor and requested for CNA #2 to assist and he/she was placed back in bed with the mechanical lift. Nurse #1 said after being contacted by the DON, that was when she notified the DON of the incident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 said she did not complete an incident report or document or notify anyone after the incident. Although Nurse #1 said she assessed Resident #1 for any injuries after the incident, there was no documentation in Resident #1's medical record from 7/15/24 to support that Nurse #1 even obtained a set of vital signs before or after Resident #1 was transferred back to bed. During an interview on 10/10/24 at 10:58 A.M., Nurse #2 said she was notified by a CNA on 07/15/24 at approximately 6:15 P.M., that Resident #1 had bruising noted on his/her bilateral underarms and left shoulder. Nurse #2 said she had not been made aware of any incident from the previous shift on shift report given by Nurse #1 earlier in the day that would have explained the bruises. Nurse #2 said she assessed Resident #1 and immediately reported the bruising to the Director of Nurses. During an interview on 10/10/24 at 12:30 P.M., The Director of Nursing (DON) said that when she completed the facility's investigation she determined there had been no report or documentation of Resident #1's fall by the nursing staff on 7/15/24. The DON said the unexplained bruising found by the day shift staff resulted in further assessment of Resident #1, which led to a right hip x-ray which showed he/she sustained a right hip fracture and required surgery and a hospital stay. The DON said it is her expectation for nursing staff to report falls/accidents/incidents immediately to Administration, the Provider, residents responsible party, on-coming shift staff and to document them as well, but in this case, Nurse #1 did not do any of it.

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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. 48138 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was assessed by nursing as being totally dependent on staff for care and at high risk for falls, with interventions for safety that included the assistance of two staff members with bed mobility and during personal hygiene, the Facility failed to ensure he/she was provided with an adequate level of staff assistance to maintain his/her safety, when during the overnight shift 07/15/24, a staff member (later identified as CNA #1) provided incontinence (hygiene) care to Resident #1 without having another staff member present to assist him, CNA #1 rolled Resident #1 on his/her side, he/she started to slide out of bed, CNA #1 grabbed Resident #1 (from behind) under his/her arms in an effort to prevent the fall and then called out for help. Nurse #1 assisted CNA #1 with lowering Resident #1 to the floor, he/she was transferred back to bed with an assist of three staff and a mechanical lift. On the following shift, Resident #1 was found with unexplained new area of bruising, complained of right hip pain, and an x-ray was obtained, which revealed a right hip fracture. Resident #1 was transferred and admitted to the Hospital, where he/she required surgical intervention to stabilize the fracture. Findings include: The Facility's Policy, titled Falls Management, dated April 2015, indicated: - Residents would be assessed for risk for falls and interventions would be implemented as appropriate, including staff providing strategies to minimize risk for falls. -Further review indicated a fall is defined as any incident in which a resident unintentionally has a change in elevation/plane or an incidence where a resident rolls off a bed or mattress close to the floor. The Facility's Policy, titled Accidents/Incidents, dated April 2015, indicated: - It is the responsibility of the staff to report accidents/incidents to the supervisor and document all accidents/incidents that occur at the facility. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 07/17/24, indicated (that on 7/15/24) Resident#1 slid out of bed with his/her feet landing on the floor while being rolled onto his/her side by CNA #1 at approximately 6:30 A.M. The Report indicated, CNA #1 called for assistance and Nurse #1 assisted with lowering Resident #1 to the floor, a mechanical lift was obtained along with another staff member (CNA #2) and he/she was transferred back to bed. The Report further indicated staff did not report or document the fall and Resident #1 was found to have bruising under both arms and to his/her left shoulder by the next shift (day shift) during care and an investigation was conducted. The Report indicated Resident #1 had unexplained bruising and pain in his/her right hip, an x ray was obtained, which indicated a right hip fracture. Resident #1 was then transferred to the hospital and required surgical intervention. (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 - Actual harm Residents Affected - Few	Review of Resident #1's Mobile X-ray Report of his/her right hip, dated 07/17/24, indicated he/she had a fracture of the right hip. Review of Resident #1's Hospital Discharge Summary, dated 07/21/24, indicated he/she was seen in the Emergency Department, admitted to the Hospital 07/17/24, and was diagnosed with a right hip fracture which required an open reduction and internal fixation (ORIF) surgical procedure on 07/18/24. Resident #1 was admitted to the Facility in October 2015, diagnoses include Multiple Sclerosis, Parkinson's disease, Dementia, and Epilepsy. Review of Resident #1's Minimum Data Set (MDS) Annual Assessment, dated 05/09/24, indicated he/she was severely cognitively impaired ,scored a 4 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. Further review of the MDS Assessment, indicated Resident #1 was totally dependent on staff and required two staff members for bed mobility and personal hygiene. Review of Resident #1's Functional Mobility Care Plan, reviewed and renewed with his/her May MDS, indicated interventions (dated as initiated on 12/26/17) included that he/she required two staff members to assist when turning him/her side to side in bed. Review of Resident #1's Care Kardex Report (utilized by Certified Nurse Aides, provides direct care staff with a brief overview of each resident's needs), indicated he/she was dependent for toileting hygiene and rolling left and right in bed requiring assist of two staff members. Review of Resident #1's Nurse Progress Note, (dated and time stamped in EMR as written on 7/23/24 at 1:41 P.M. by Nurse #1) as a late entry for 07/15/24, indicated that at 6:30 A.M., CNA #1 called for help from Resident #1's room, that she was in the hallway at her medication cart entered the room, and observed Resident #1 with his/her legs on the floor with his/her head on the bed. The Note indicated Resident #1 was lowered to the floor and then lifted back to bed via mechanical lift and assist of three staff members. Review of the Facility Investigation Report, dated 07/17/24, included a Witness Statement from CNA #1 which indicated the following: CNA #1 rolled Resident #1 on his/her side, his/her legs went over the bed landing on the floor and he/she began sliding off of the bed. CNA #1 grabbed Resident #1 (from behind) under his/her arms and yelled for help. Nurse #1 entered the room and assisted CNA #1 with lowering Resident #1 to the floor, a mechanical lift was obtained and he/she was placed back in bed. During a telephone interview on 10/18/24 at 1:55 P.M., CNA #1 said on 7/15/24, during the overnight shift, he needed to provide incontinence care to Resident #1, said he requested help from the other CNA, waited for 10 minutes, couldn't find the nurse, so provided incontinence care to Resident #1 alone. CNA #1 said when he rolled Resident#1 onto his/her side, he/she started to slide off the bed, he attempted to stop the fall by grabbing Resident #1 under arms and called for help. CNA #1 said Nurse #1 came in to assist, they lowered Resident #1 to the floor, a mechanical lift was obtained and Resident #1 was placed back in bed with an assist of three. CNA #1 said he was aware Resident #1 required assistance of two staff members during care but said he (CNA #1) couldn't wait any longer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225466	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highview of Northampton	222 River Road Leeds, MA 01053

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	During an interview on 10/10/24 at 10:48 A.M., CNA #2 said Resident #1 required two staff member assists with all care and on 7/15/24 she was called in to assist with a mechanical lift transfer of Resident #1, after the fall had occurred to put him/her back to bed. During a telephone interview on 10/10/24 at 11:38 A.M., Nurse #1 said on 07/15/24 at around 6:30 A.M., (exact time unknown) she was at her medication cart in the hallway and heard CNA #1 calling out for help, she entered Resident #1's room, observed him/her with his/her legs on the floor with CNA #1 holding him/her under the arms. Nurse #1 said she assisted with lowering Resident #1 to the floor then requested for CNA #2 to assist them and he/she was placed back in bed with the mechanical lift. During an interview on 10/10/24 at 10:58 A.M., Nurse #2 said she was notified by a CNA on 07/15/24 at approximately 6:15 P.M., that Resident #1 had bruising noted on his/her bilateral underarms and left shoulder. Nurse #2 said she had not been made aware of any incident from the previous shift nurse during change of shift report given to her by Nurse #1, that might have explained the bruising. Nurse #2 said she assessed Resident #1 for any other injuries and reported the bruising to the DON. During an interview on 10/10/24 at 12:30 P.M., The Director of Nursing (DON) said Resident #1 required two staff members to assist with incontinence (hygiene) care and bed mobility, and the facility's investigation determined that at the time of the fall, CNA #1 was providing care to Resident #1 alone, but should have had another staff member present for assistance.