STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225697	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elaine Center at Hadley	20 North Maple Street Hadley, MA 01035

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. 48138 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was assessed by nursing as being at risk for falls, with interventions for safety that included the assistance of one staff member with toileting, transfers and mobility, the Facility failed to ensure he/she was provided with an adequate level of staff supervision to maintain his/her safety, when on 06/26/24, Certified Nurse Aide (CNA) #1 left Resident #1 unsupervised and unattended standing with his/her walker in the bathroom, Resident #1 fell backwards to the floor, complained of pain, and was transferred to the Hospital Emergency Department where he/she was diagnosed with a fractured left scapula (shoulder blade), and was also noted to have a right elbow skin tear. Findings include: The Facility's Policy, titled Falls Management, dated 03/15/24, 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. Review of the Report submitted by the facility via the Health Care Facility Reporting System (HCFRS), dated 06/27/24, indicated Resident#1 fell backwards in his/her bathroom while standing with his/her walker. The Report indicated, Resident #1 was left unattended while CNA #1 went to get his/her recliner chair that was out in the hallway. The Report indicated Resident #1 sustained a fractured left scapula and right elbow skin tear and a small cut on his/her right eyebrow. Resident #1 was admitted to the Facility in December 2023, diagnoses included history of falls, abnormalities of gait and mobility, muscle weakness and dementia. Review of Resident #1's Minimum Data Set (MDS) Quarterly Assessment, dated 05/24/24, indicated he/she required maximum assistance with care and required partial to moderate assistance from one staff member for ambulation. Review of Resident #1's Falls Care Plan, reviewed and renewed with his/her May MDS, indicated intervention (dated as initiated on 12/11/23) included for staff to provide extensive assistance of one for transfers and minimum to moderate assistance of one for toileting. (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	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 required limited assistance of one staff member to stand and transfer with his/her walker. Review of Resident #1's Lift Transfer Evaluation, dated 06/01/24, indicated he/she was assessed by the Rehabilitation Department as requiring limited to minimal assist to stand, pivot, and transfer. Review of Resident #1's Occupational Therapy Discharge Summary, dated 06/26/24 indicated he/she was unable to stand without upper extremity support and an assistive device for 10 seconds. Review of Resident #1's Nurse Progress Note, dated 06/27/24, indicated that CNA #1 left Resident #1 standing alone with his/her walker in the bathroom doorway, then a few seconds later Nurse #1 heard a bang and found Resident #1 on the floor in his/her bathroom after he/she had fallen backwards. The Note indicated Resident #1 sustained injuries on his/her left humerus (upper arm bone), right elbow and right forehead and was transferred to the Hospital Emergency Department. Review of Resident #1's Hospital X-ray Report of his/her left shoulder, dated 06/27/24, indicated he/she had a fracture of the left scapula. Review of Resident #1's Hospital Discharge Summary, dated 07/01/24, indicated he/she was admitted to the Hospital 06/27/24, diagnosed with a left scapular fracture requiring an orthotic sling and found to have a chronic pulmonary embolism. During an interview on 08/22/24 at 3:23 P.M., Nurse #1 said on 6/26/24 at approximately 9:05 P.M., she had administered medication to Resident #1's roommate, and as she was exiting the room to return to her medication cart (located just outside the room) she saw Resident #1 and CNA #1 on their way out of the bathroom. Nurse #1 said she heard CNA #1 trying to talk Resident #1 into going into bed instead of sleeping in his/her recliner chair that was in the hallway (and needed to be brought into the room) and he/she declined. Nurse #1 said she heard CNA #1 pulling the recliner chair into the room. Nurse #1 said while she was outside the door to Resident #1's room, at her medication cart, she heard a bang, went back into Resident #1's room and found Resident #1 lying on the floor in the bathroom after falling backwards. Nurse #1 said CNA #1 had left Resident #1 standing in the bathroom doorway, unattended, to bring the recliner chair into the room. Nurse #1 said Resident #1 complained of pain and said my shoulder is broken. Nurse #1 said after assessing Resident #1 for injuries, she and CNA #1 lifted him/her up off the floor, placed him/her in the recliner, and she obtained an order to transfer Resident #1 to the Hospital Emergency Department. During an interview on 08/23/24 at 9:46 A.M., CNA #1 said she knew Resident #1 had a history of falls and that he/she should not have been left standing in the bathroom unsupervised. CNA #1 said she left Resident #1 standing with his/her walker in front of the toilet and left the bathroom to bring a linen bag and a trash bag out in the hall to clear the clutter and said she had asked Nurse #1 to watch Resident #1 and then heard him/her fall. During an interview on 08/22/24 at 2:08 P.M., CNA #2 said Resident #1 required assistance with all Activities of Daily Living (ADL's) and that she would not leave him/her unattended or alone standing in the bathroom. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/22/24 at 2:15 P.M., The Administrator said that when she completed the facility's investigation that there were inconsistencies with CNA #1's statement, related to the details of where she was at the time of the fall and what she was doing. The Administrator said Resident #1 was left unattended by staff standing with his/her walker, but should not have, fell in the bathroom and sustained injuries requiring a hospital stay.