STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225386	A. Building B. Wing	02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springside Rehabilitation and Skilled Care Center	255 Lebanon Avenue Pittsfield, MA 01201

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for two of six sampled residents (Resident #1 and Resident #5), who resided on the COVID Unit, and required staff assistance with incontinence care, the Facility failed to ensure they were free from abuse, including neglect with emotional harm, when Resident #1 and Resident #5 reported being in physical pain, emotionally upset and angry, when staff failed to respond to their call lights and requests for assistance with personal care needs. Findings include: Review of the Facility Policy titled Freedom from Abuse, Neglect & Exploitation, dated 4/27/17, indicated that all residents are protected from any form of abuse, which includes neglect. Neglect is the failure of the Facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or mental illness. Prevention included staffing patterns are in place daily to meet the needs of the residents. Review of Resident #1's Impaired Skin Integrity Care Plan, dated 10/30/20, indicated he/she had a potential for skin breakdown due to fragile skin, decreased mobility, deconditioning, and incontinence. Interventions included to keep skin clean and dry, apply house barrier cream to the peri area, coccyx and buttocks during every shift and with each incontinent episode. Review of Resident #1's Significant Change Minimum Data Set (MDS) Assessment, dated 11/16/20, indicated he/she was cognitively intact, had a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . During an interview on 1/30/21 at 2:00 P.M., Family Member #1 said in January 2021 on the COVID Unit, there was inadequate nursing staffing levels to meet the needs of the residents. Family Member #1 said Resident #1 was so upset he/she was crying because he/she was incontinent of urine and feces, and no staff members responded to Resident #1's request for assistance in changing his/her incontinent briefs. Family Member #1 said on one occasion in January 2021 (unable to recall exact date), Resident #1 was left in a soiled incontinence brief from approximately 10:30 P.M. to 6:00 A.M. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/04/21, Resident #1 said that the average call light wait time was at least one hour. Resident #1 said that on the COVID Unit in January 2021, during the evening and night shift on more than one occasion, (unable to recall exact dates) he/she became upset and had been crying because no staff members came to respond to his/her request to be changed out of his/her soiled brief. Resident #1 said his/her peri-area was sore, painful, and said he/she had a rash after remaining in the same soiled brief for long periods of time. Resident #1 said on another occasion, in January 2021, (unable to recall exact date) his/her call light and his/her roommate's call lights were not answered at all, and said they both remained in urine soaked briefs for approximately 7.5 hours. Resident #1 said he/she was extremely upset by not having incontinence care provided by staff. Review of Resident #5's Quarterly MDS, dated [DATE], indicated he/she was cognitively intact, able to make his/her needs known to staff, and required extensive assistance of one staff person with ambulation, transfers and toilet use. During an interview on 2/5/21 at 2:46 P.M., Resident #5 said he/she was angry and upset about the lack of assistance with care by staff. Resident #5 said his/her call light was left unanswered for greater than 45 minutes, on more than one occasion. Resident #5 said he/she had been on the commode, required staff assistance with hygiene, rang his/her call light for assistance and said staff took 45 minutes to respond. Resident #5 said due to being left sitting on the commode for so long, his/her legs became numb and said that once assisted by staff, he/she had difficulty walking. During an interview on 1/29/21 at 1:11 P.M., Witness #1 said on 1/15/21 some of the residents who were incontinent of bladder and bowel at baseline, that required staff assistance to meet all of their personal care needs, were not provided incontinence care for an entire shift and into part of the next shift (approximately 12 hours). During an interview on 2/5/21 at 1:55 P.M., Certified Nurse Aide (CNA) #1 said on 1/11/21 and 1/12/21 on the COVID Unit, during the 3:00 P.M. to 11:00 P.M. shift, there was only one CNA assigned to care for approximately 53 residents. CNA #1 said the residents were angry because they were not taken care of properly. CNA #1 said residents were not assisted by staff with incontinence care needs and remained in soiled briefs for most of the shift. During an interview on 2/4/21 at 7:15 A.M., CNA #2 said the CNA staffing in January 2021, was horrible on the COVID Unit, that there was only one CNA during the 3:00 P.M. to 11:00 P.M. shift and the 11:00 P.M. and 7:00 A.M. shift. CNA #2 said the residents were so ill from COVID, that every single resident required complete care, and said incontinence care could not be performed as needed. CNA #2 said it took eight hours (an entire shift) to perform one round of incontinence care for the residents. CNA #2 said they could not reposition the residents in bed every two hours as required and said there were residents with skin rashes. CNA #2 said there should have been at least three CNAs on that shift to adequately care for these residents. During an interview on 1/29/21 at 11:45 A.M., Nurse #1 said he/she had communicated to the Facility Administration that residents were suffering and laying in their own excrement for eight to twelve hours due to not having enough staff on the COVID Unit.

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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	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 and interviews for one of six sampled residents (Resident #3), who was assessed as being at increased risk for falls, was non-ambulatory and totally dependent on staff for all care needs, the Facility failed to maintain his/her safety to prevent an incident/accident with injury, when on 1/19/21 after Resident #3 had attempted to get out of bed unassisted by staff earlier in the shift, Resident #3 was found an hour later on the floor after an unwitnessed fall, he/she had an abrasion to his/her right knee and right shoulder, complained of back pain, and was transferred to the Hospital Emergency Department for further evaluation. Findings include: The Facility's Policy titled, Managing Falls and Fall Risk, dated 02/26/15, indicated that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes and to try to prevent the resident from falling and to try to minimize complications from falling. Resident #3 was admitted to the Facility in September 2019, medical history included non-union of a right periprosthetic distal femur fracture (injury occurred 2019) and he/she was diagnosed with dementia and [CONDITION(S)]. Resident #3's Quarterly Minimum Data Set (MDS), dated [DATE], indicated that he/she was severely cognitively impaired, was non-ambulatory, totally dependent on staff for care, required an assist of two staff members for bed mobility, transfers and toilet use. Resident #3's Falls Care Plan, indicated he/she was at risk for falls due to confusion, gait and balance problems, interventions included use of a wireless bed alarm, floor mat on side of bed near the chair, non-skid strips on floor to right side of bed, to anticipate and meet the resident needs, and he/she required prompt response to all requests for assistance. Review of the Facility's Investigation Report, dated 1/19/21, indicated that at 5:20 A.M., Resident #3 had an unwitnessed fall, was found on the floor beside his/her bed lying on his/her right side, 911 was called, and Emergency Medical Services was activated. The Report indicated Resident #3 was at high risk for falls, had an unsteady gait, and poor balance. The Report indicated Resident #3 had been witnessed by staff, earlier in the shift, trying to get out of bed unassisted. Review of Resident #3's medical record and the Facility's Investigation Report, indicated there was no documentation to support that his/her wireless bed alarm was in place at the time of the unwitnessed fall. Review of Certified Nurse Aide #2's written Witness statement, dated 1/19/21, indicated CNA #2 said prior to the unwitnessed fall (at 5:20 A.M.), at approximately 4:10 A.M., Resident #3 was trying to get out of bed and he/she was assisted back into bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/4/21 at 7:15 A.M., Certified Nurse Aide (CNA) #2 said staffing was horrible on the COVID Unit, and said at one point in January 2021, there was only one CNA during the 3:00 P.M. to 11:00 P. M. shift and the 11:00 P.M. to 7:00 A.M CNA #2 said there was not enough staff to meet resident care needs and to also provided adequate supervision for safety to prevent falls. During an interview on 2/5/21 at 1:55 P.M., CNA #1 said on 1/11/21 and 1/12/21 during the 3:00 P.M. to 11:00 P.M. shift there was only one CNA to care for approximately 53 residents, and residents were not taken care of properly. CNA #1 said some residents needed supervision to prevent falls, and said there just was not enough staff to provide supervision. CNA #1 said one resident did fall on his/her shift because of the lack of required supervision Review of Resident #3's Hospital Orthopedic Report, dated 1/19/21, indicated he/she had a history of non-union of a right periprosthetic distal femur fracture. The Report indicated Resident #3 presented with an abrasion to the right knee status post fall, was non-ambulatory at baseline, complained of back and right shoulder pain, and will be treated with conservative management.

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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 0725 Level of Harm - Actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on records reviewed and interviews, for one of two nursing units, the COVID (positive) Unit (A-Wing), during the second week of January 2021 (with an average daily census of 50 residents), the Facility failed to ensure sufficient staffing levels were maintained to safely and adequately meet resident's needs per their plans of care. The Facility failed to ensure that there was sufficient staffing levels to provide the level of assistance needed for residents with physical limitations, failed to ensure call lights were responded to timely, and failed to ensure residents received assistance with toileting and personal hygiene care needs when requested and per the plan of care, which resulted in residents becoming, angry, upset and crying after being left in soiled briefs and unable to obtain assistance from staff for extended periods of time. Findings include: The Facility Policy, titled Staffing, dated 10/2017, indicated that they will provide sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with the resident care plans and the facility assessment. Nurses and Certified Nurse Aides (CNA) are available 24 hours a day to provide direct resident care services. The Continuity of Operations Plan Program, dated 3/2020, indicated that the Administrator, Scheduling Coordinator or Member of the Clinical Team are responsible for the daily assessment of staffing status and needs and will implement back up plans as needed. The Minimum Data Sheet, Summary of Residents care needs, dated 1/12/21, for the 55 residents identified as residing on the COVID Unit indicated: - 6 residents required mechanical lift transfers, with a minimum of two staff member assist - 35 residents required 1 to 2 staff members for assist with bathing - 31 residents required 1 to 2 staff members for assist with dressing - 20 residents required 1 to 2 staff members for assist with toilet use - 17 residents were incontinent of bladder and required a toileting program - 10 residents were incontinent of bowel and required a toileting program During an interview on 2/5/21 at 2:46 P.M., Resident #5 said he/she was angry and upset, said his/her call light was left unanswered for greater than 45 minutes, he/she had a bowel movement while on the commode and required staff assistance with personal care needs. Resident #5 said due to being left sitting on the commode, his/her legs became numb and by the time he/she was finally assisted by staff, it was difficult to stand and walk. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	During an interview on 2/4/21 at 3:30 P.M., Resident #1 said that the average call light wait time was one hour. Resident #1 said on one-night in January 2021 (unable to recall exact date) his/her call light and roommate's call lights were not answered at all, and said they both remained in urine soaked briefs for approximately 7.5 hours. Resident #1 said he/she was so upset by not having incontinence care provided. During an interview on 2/4/21 at 6:15 A.M., Nurse #2 said that the Nursing Staffing on the COVID Unit A-Wing was awful on 1/13/21, 1/14/21 and 1/15/21. Nurse #2 said for a census of approximately 50 Residents, there were usually 2 Certified Nurse Aides (CNA), a ratio of 1:25 residents during the 7:00 A.M. to 3:00 P.M. shift. Nurse #2 said the acuity on the unit was high due to the high volume of COVID positive residents who were acutely ill. Nurse #2 said staff kept asking Administration for staffing assistance, but no additional staff arrived in a timely manner to address the resident's immediate needs. Nurse #2 said, as a result of low staffing, resident vital sign monitoring was not consistently performed every four hours, for early detection of a decline in the resident's condition. During an interview on 2/4/21 at 10:00 A.M., the Acting Director of Nursing said the Facility did not have an acuity tool to identify the resident acuity. During an interview on 2/4/21 at 7:15 A.M., Certified Nurse Aide (CNA) #2 said staffing was horrible on the COVID Unit, and said at one point in January 2021, there was only one CNA during the 3:00 P.M. to 11:00 P. M. shift and the 11:00 P.M. to 7:00 A.M CNA #2 said due to the resident's being so ill from COVID 19, every single resident was complete care, and incontinence care could not be performed as needed. CNA #2 said it took eight hours to perform one round of incontinence care on the unit. CNA #2 said they could not reposition the residents in bed every two hours as required and said there were residents with skin rashes. CNA #2 said with the increased resident census and acuity of the residents, there should have been at least three CNAs to adequately care for these residents. During an interview on 2/5/21 at 1:55 P.M., CNA #1 said on 1/11/21 and 1/12/21 during the 3:00 P.M. to 11:00 P.M. shift there was only one CNA to care for approximately 53 residents, and residents were not taken care of properly. CNA #1 said the Residents were angry because they were not provided incontinence care and remained in urine and feces for most of the shift. CNA #1 said the residents were repositioned and turned only once in eight hours, instead of every two hours. CNA #1 said some residents needed supervision to prevent falls, and said there just was not enough staff to provide supervision. CNA #1 said one resident did fall on his/her shift because of the lack of required supervision. Review of the Facility Assessment, dated 1/20/2020, the staffing plan for CNAs on A-Wing was: - 7:00 A.M. to 3:00 P.M. - 4 CNAs - 3:00 P.M. to 11:00 P.M. - 4 CNAs - 11:00 P.M. to 7:00 A.M. - 2 CNAs During an interview on 2/4/21 at 7:25 A.M., Unit Manager #1 said the COVID Unit, A- Wing was not fully staffed in January 2021, that usually staffing for CNAs was: - 7:00 A.M. to 3:00 P.M. - 3 CNAs (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	- 3:00 P.M. to 11:00 P.M. - 3 CNAs - 11:00 P.M. to 7:00 A.M. - 2 CNAs According to the Facility Census Report for 11 days (1/11/2021 to 1/21/2021), the average daily census was 50 residents (ranging from 45 to 55). During these 11 days, the staffing sheets indicated: - 6 of the 11 days had 2 or fewer CNAs during the 7:00 A.M. to 3:00 P.M. shift - 8 of the 11 days had 2 or fewer CNAs during the 3:00 P.M. to 11:00 P.M. shift - 5 of the 11 days had 1 CNA during the 11:00 P.M. to 7:00 A.M. shift During an interview on 2/16/21 at 10:58 A.M., Nurse #4 said even prior to their COVID outbreak in January 2021, the Facility had inadequate staffing for Certified Nurse Aides on the 3:00 P.M. to 11:00 P.M. shifts and on the 11:00 P.M. to 7:00 A.M. shifts, but with the increased patient acuity due to COVID positive residents and inadequate staffing the COVID Unit, they could not meet the basic care and acute care needs of the residents.