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	06/07/2023

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 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** 37227 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required extensive assistance of two staff members and the use of a mechanical lift for all transfers, the Facility failed to ensure he/she was provided with the necessary level of staff assistance and that assistive equipment (lift pad) was positioned correctly, in an effort to maintain Resident #1's safety during a mechanical lift transfer to prevent incidents/accidents resulting in an injury. On 05/16/23, Certified Nurse Aide (CNA) #1, without another staff member present to assist her, attempted to transfer Resident #1 with a mechanical lift. Per the facility's investigation they also determined that CNA #1 had not positioned the mechanical lift pad properly under Resident #1, so when she (CNA #1) raised Resident #1 up in the lift, his/her body tipped forward, his/her head hit the lift, and he/she toppled out of the lift pad onto the floor. Resident #1 was transferred to the Hospital Emergency Department (ED), where he/she was diagnosed with a right frontal scalp laceration, an acute nondisplaced fracture of the acetabulum (hip socket), an acute nondisplaced type II odontoid (C2, cervical neck) fracture, and an acute nondisplaced fracture of the anterior nasal bones and the anterior nasal septum (nose). Findings include: Review of the Facility Policy titled 2-Mechanical lift, dated as reviewed 09/2022, indicated at least two nursing staff members were needed to safely move a resident with a mechanical lift. The Policy also indicated to lift the resident from the surface to check the stability of the attachments, fit of the lift pad and weight distribution. Review of the Manufacturer Guidelines for the mechanical lift pads, indicated an illustration of the divided leg pad when in use. The Guidelines show the leg straps crossed and flat against the resident's inner thighs when the pad is properly placed and connected to the mechanical lift. Resident #1 was admitted to the Facility in June 2018, diagnoses included dementia with mood disturbance, anxiety disorder and abnormal posture. Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 03/29/22, indicated his/her cognitive skills were severely impaired. The Assessment indicated he/she was dependent for his/her care needs and required the assistance of two staff members for transfers. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Care Card (Certified Nurse Aide, reference guide, identifies residents specific care needs, including number of staff required to provide assistance during tasks), in effect at the time of the fall, indicated he/she was non-ambulatory and required the assistance of two staff members for transfers with a mechanical lift. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 05/22/23, indicated that on 05/16/23 at 5:00 A.M., Resident #1 fell to the floor while being transferred out of bed with a mechanical lift, by Certified Nurse Aide #1. The Report indicated CNA #1 transferred Resident #1 with a mechanical lift, by herself, and didn't cross the leg straps (to secure his/her legs in the mechanical lift pad) when she positioned Resident #1 in the lift. The Report indicated that when CNA #1, raised Resident #1 up in the lift, and pulled the lift from away from the bed (while he/she was suspended three feet above the floor), Resident #1 tipped forward out of the sling, and struck his/her head on the lift and landed on the floor. The Report indicated that CNA #1 had not asked a second staff member for assistance, despite there being a nurse available at the nursing station, and two additional CNAs available upon request, at the time of the fall. The Report indicated that the Facility's investigation concluded that CNA #1 had not followed safe practices when utilizing a mechanical lift for transfers and that staff were available to assist CNA #1, but she did not seek assistance. Review of CNA #1's Witness Statement, dated 05/16/23, indicated that she transferred Resident #1 alone, with the mechanical lift and had not crisscrossed the straps, on the lower half of the lift pad. Resident #1 fell from the mechanical lift, onto the floor during a mechanical lift transfer. During an interview on 06/07/23 at 3:27 P.M., Certified Nurse Aide (CNA) #1 said she worked the 11:00 P.M. to 7:00 A.M. shift on 05/16/23, and Resident #1 was on her assignment. CNA #1 said that around 5:00 A.M., she transferred Resident #1 out of bed, alone, using a mechanical lift, when he/she tipped forward out of the lift pad, hit his/her head on the lift, and landed on the floor. CNA #1 said she had not crossed the straps of the divided leg style lift pad when she fastened them to the lift, prior to initiating the transfer. CNA #1 said she knew that mechanical lift transfers required the assistance of two staff members, per Facility policy, and that she should have asked for help. CNA #1 further said she had not asked anyone else for assistance because she thought they were busy doing their rounds. Review of the Assistant Director of Nurses (ADON's) Written Summary of her interview with CNA #1, dated 05/16/23, indicated that CNA #1 told her she was working alone and did not have the split leg style lift pad donned (put on or placed) properly when she transferred Resident #1. The Summary indicated that CNA #1 said she knew that she was supposed to have a second staff member to assist with the mechanical lift transfer but there was no one around. The Summary also indicated CNA #1 said she had not crossed the legs straps when donning the lift pad. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Nurse #1's Written Witness Statement, dated 05/16/23, indicated that when she responded to Resident #1's fall, she found him/her on the floor and noticed the lift was still positioned about three feet above the floor, the mechanical lift pad was still hanging from the lift, and it was not crisscrossed. The Statement also indicated Nurse #1 was available at the desk for approximately 30 minutes prior to the fall. The Statement indicated Nurse #1 assessed Resident #1 immediately after the fall and sent him/her to the Hospital ED for evaluation. During an interview on 06/07/23 at 2:50 P.M., the Assistant Director of Nurses (ADON) said she arrived at the Facility around 6:30 A.M. on 05/16/23 and was notified by Nurse #1 that Resident #1 had been sent to the ED after a fall during a mechanical lift transfer with CNA #1. The ADON said she immediately interviewed CNA #1, and CNA #1 told her that she had performed the transfer alone and had not crisscrossed the leg straps of the lift pad. Review of Resident #1's Hospital Discharge Summary, dated 05/16/23, indicated that he/she was transferred to the Hospital ED after a fall from a mechanical lift at the Facility. The Summary indicated Resident #1 was diagnosed with a right frontal scalp laceration, an acute nondisplaced fracture of the acetabulum, an acute nondisplaced type II odontoid fracture, an acute nondisplaced fracture of the anterior nasal bones and the anterior nasal septum (nose). Resident #1 was discharged back to the facility on [DATE] with an Aspen cervical collar (rigid collar for neck stabilization) and a five-staple repair of the right forehead laceration. During an interview on 05/07/23 at 3:19 P.M., the Director of Nurses (DON) said that per Facility policy, two staff members were required to be present when performing a mechanical lift transfer, for safety. The DON said Facility policy also indicated the resident should be partially raised up while in the lift pad, to check placement and weight distribution before completing the mechanical lift transfer. The DON further said that Resident #1's Care Card, in place at the time of the fall, also indicated the requirement for two staff members to be present for the mechanical lift transfers. The DON said that the Facility investigation concluded that CNA #1 had not followed Facility policy when she performed the mechanical lift transfer without assistance from a second staff member, and when she had not positioned the lift pad correctly and had not checked the lift pad placement prior to performing the transfer (both required by Facility policy), resulting in Resident #1's fall from the lift and subsequent injury. On 06/07/23, the Facility presented the Surveyor with a plan of correction that addressed the areas of concern identified in this survey, the Plan of Correction provided is as follows: A) On 05/16/23, Resident #1 was immediately assessed by Nursing for any injuries sustained during the fall and sent to the Hospital ED for evaluation and treatment. B) On 05/16/23, CNA #1 was placed on administrative leave pending the investigation. Her contract was terminated with the facility and the agency was notified of the incident. C) On 05/16/23 an Emergency Quality Assurance Performance Improvement (QAPI) meeting was held to determine a plan of correction. Additional meetings were held on 05/22/23 and 05/31/23. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	D) On 05/16/23 through 05/19/23, the DON and Unit Managers completed mechanical lift competencies with return demonstration, including proper application of divided leg lift pads, for all nurses, CNAs and rehabilitation therapists. Staff will not return to work until they have completed the mechanical lift competency. E) Random observations of mechanical lift transfers were initiated on 05/17/23 and completed each shift for 14 days by the DON and/or designee. F) Random mechanical lift transfer quizzes were initiated on 05/17/23 and completed each shift for 14 days by the DON and/or designee. G) On 05/19/23, the DON and Clinical Nurse Consultant completed a facility wide audit of all residents requiring a mechanical lift transfer and updated the Care Plan and Kardex for lift pad size and type as indicated. H) On 05/19/23, the DON compiled a binder containing a list of residents requiring mechanical lift transfers including name, room number, mechanical lift with the assistance of two staff members, lift pad color/type/size. The binder will be kept on the units. I) On 05/19/23, mechanical lift assessments were completed by the Unit Managers or designee, on residents who required mechanical lifts, and were reviewed for accuracy to ensure correct lift pad type/color are noted and correct. J) On 05/19/23, the DON and Unit Managers reached substantial compliance with completing mechanical lift education on the mechanical lift and care plan policy for all nursing and rehabilitation staff. K) The QAPI committee will review the effectiveness of the plan of correction for four weeks, then monthly. L) The Administrator and DON are responsible for overall compliance.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 37227 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure that Certified Nurse Aide (CNA) #1 had the appropriate competency and skill set related to providing safe mechanical lift transfers. On 05/16/23, CNA #1 placed the mechanical lift pad under Resident #1 (per facility investigation the pad was not positioned properly) and when CNA #1 raised Resident #1 up in the lift, without the assist of a second staff member, his/her body tipped forward, his/her head hit the lift, and he/she toppled out of the lift onto the floor. Findings include: Review of the Facility Policy titled 2-Mechanical lift, dated as reviewed 09/2022, indicated at least two nursing staff members were needed to safely move a resident with a mechanical lift. The Policy indicated staff should ensure the lift pad is securely attached to the clips and it is properly balanced, the resident's head, neck and back are properly supported, and before the resident is lifted, double check the security of the lift pad attachment. The Policy also indicated that staff should lift the resident from the surface to check the stability of the attachments, fit of the lift pad and weight distribution. Review of the Manufacturer Guidelines for the mechanical lift pads, indicated an illustration of the divided leg pad when in use. The Guidelines show the leg straps crossed, and flat against the resident's inner thighs, when the pad is properly placed and connected to the mechanical lift. Resident #1 was admitted to the Facility in June 2018, diagnoses included dementia with mood disturbance, anxiety disorder and abnormal posture. Review of Resident #1's Care Card (Certified Nurse Aide, reference guide, identifies residents specific care needs, including number of staff required to provide assistance during tasks), in effect at the time of the fall, indicated he/she was non-ambulatory and required the assistance of two staff members for transfers with a mechanical lift. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 05/22/23, indicated that on 05/16/23 at 5:00 A.M., Resident #1 fell to the floor while being transferred out of bed with a mechanical lift, by CNA #1. The Report indicated CNA #1 transferred Resident #1 with a mechanical lift, by herself, and didn't cross the leg straps (to secure his/her legs in the mechanical lift pad) when she positioned Resident #1 in the lift. The Report indicated that when CNA #1 raised Resident #1 up in the lift, and pulled the lift from away from the bed (while he/she was suspended three feet above the floor), Resident #1 tipped forward out of the sling and struck his/her head on the lift, and landed on the floor. The Report indicated that the Facility's investigation concluded that CNA #1 had not followed safe practices when utilizing a mechanical lift for transfers and that staff were available to assist CNA #1 but she did not seek assistance. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CNA #1's Witness Statement, dated 05/16/23, indicated that CNA #1 transferred Resident #1 alone, with the mechanical lift and did not crisscross the straps, on the lower half of the lift pad. Resident #1 fell from the mechanical lift, onto the floor during a mechanical lift transfer. Review of the Facility's Agency Binder Checklist, that included the Mechanical Lift Policy, indicated CNA #1 signed on 05/10/23, acknowledging review of the policies in the binder. During an interview on 06/07/23 at 3:27 P.M., Certified Nurse Aide (CNA) #1 said she worked the 11:00 P.M. to 7:00 A.M. shift on 05/16/23, and Resident #1 was on her assignment. CNA #1 said that around 5:00 A.M., she transferred Resident #1 out of bed, alone, using a mechanical lift, when he/she tipped forward out of the lift pad, hit his/her head on the lift, and landed on the floor. CNA #1 said she did not cross the straps of the divided leg style lift pad when she fastened them to the lift, prior to initiating the transfer. CNA #1 further said she had started working at the Facility a few nights before the incident, on 05/10/23, as a traveling CNA and said she had not received orientation on the use of the mechanical lift. CNA #1 said she did not recall signing off on the Mechanical Lift policy. During an interview on 05/07/23 at 3:19 P.M., the Director of Nurses (DON) said that although CNA #1 had signed off on the Mechanical Lift policy, said she had no documentation to support that CNA #1 had demonstrated competency to safely operate a mechanical lift, prior to providing care to residents at the Facility. The DON said it was the Facility's expectation that the contracted staffing agencies maintain current competencies on the staff they refer to the Facility. The DON said that when she requested a copy of CNA #1's mechanical lift competency, after the incident on 05/16/23, from the Agency that employed and referred CNA #1, they were unable to provide any documented evidence that CNA #1 had been provided education or testing of her competency for safely using a mechanical lift for resident transfers. On 06/07/23, the Facility presented the Surveyor with a plan of correction that addressed the areas of concern identified in this survey, the Plan of Correction provided is as follows: A) On 05/16/23, Resident #1 was immediately assessed by Nursing for any injuries sustained during the fall and sent to the Hospital ED for evaluation and treatment. B) On 05/16/23, CNA #1 was placed on administrative leave pending the investigation. Her contract was terminated with the facility and the agency was notified of the incident. C) On 05/16/23 an Emergency Quality Assurance Performance Improvement (QAPI) meeting was held to determine a plan of correction. Additional meetings were held on 05/22/23 and 05/31/23. D) On 05/16/23 through 05/19/23, the DON and Unit Managers completed mechanical lift competencies with return demonstration, including proper application of divided leg lift pads, for all nurses, CNAs and rehabilitation therapists (including agency staff). Staff will not return to work until they have completed the mechanical lift competency. All new hires and new agency staff will complete a mechanical lift competency with return demonstration, upon orientation. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E) Random observation of mechanical lift transfers were initiated on 05/17/23 and completed each shift for 14 days by the DON and/or designee. F) Random mechanical lift transfer quizzes were initiated on 05/17/23 and completed each shift for 14 days by the DON and/or designee. G) On 05/19/23 the DON compiled a binder containing a list of residents requiring mechanical lift transfers including name, room number, mechanical lift with assistance from two staff members, lift pad color/type/size. Binder kept on the units. H) On 05/19/23, mechanical lift assessments were completed on residents who required mechanical lifts to review for accuracy and ensure the correct sling type/color are noted and correct. I) On 05/19/23, the DON and Unit Managers reached substantial compliance with completing mechanical lift education on the mechanical lift and care plan policy for all nursing and rehabilitation staff. J) Mechanical Lift Pad guides were posted at the nursing stations on 05/19/23, by the Unit Managers, including an illustration of the proper application of the leg straps on the divided leg mechanical lift pads. K) The QAPI committee will review the effectiveness of the plan of correction for 4 weeks, then monthly. L) The Administrator and DON are responsible for overall compliance.