

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/08/2022
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/29/2021
NAME OF PROVIDER OR SUPPLIER Hillcrest Commons Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 169 Valentine Road 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, for one of three sampled Residents (Resident #1), who was severely cognitively impaired, had a history of [MEDICAL RECORD OR PHYSICIAN ORDER] . Findings include: The Facility's Policy, Physician Notification, dated 11/11/2009, indicated that upon identification of a resident who has clinical changes or a change in condition, a Nurse will perform appropriate clinical observations and data collection, will report to the physician changes in the resident's condition, and will initiate interventions as needed and ordered. Resident #1 was admitted to the Facility in 2/2020 diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of Resident #1's Behavioral Care Plan, dated 4/17/21, indicated he/she had poor safety awareness due to depression and non-compliance, interventions included to notify the Physician of behaviors, medical issues or safety issues. Review of Nurse #1's Progress Note, dated 12/14/21, at 5:53 A.M., indicated Resident #1 required constant supervision to prevent him/her from falling, would not stay in bed, kept taking off his/her clothes and blankets, and he/she was a severe fall risk all night long. Review of the Facility's Internal Investigation, dated 12/13/21, which per the Administrator was dated 12/13/21, to show incident occurred during the 12/13/21 - 12/14/21 night shift, and signed by Nurse #1, indicated that Resident #1 was extremely agitated the entire 11:00 P.M. to 7:00 A.M. shift. Resident #1 needed to be monitored with a staff member within arm's reach for the entire shift. The Investigation indicated pillows and blankets were used in the wheelchair to ensure safety. The Investigation indicated Resident #1 was repeatedly banging his/her head on one of the tables in the dining room. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 225687
		If continuation sheet Page 1 of 7

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Certified Nurse Aide (CNA) #2's written witness statement, dated 12/16/21, indicated the following: Resident #1 had been agitated on 12/13/21 during the 3:00 P.M. to 11:00 P.M. shift and during the 11:00 P.M. to 7:00 A.M. shift. During the 11:00 P.M. to 7:00 A.M. shift., Resident #1 stayed in his/her wheelchair all night due to increased restlessness and agitation. Resident #1 was sitting at a (Dining Room) table (in the Day Room) purposely hitting his/her head on the table. Resident #1 was banging his/her head so hard that you could hear his/her head striking the table. Attempts were made to protect his/her head by putting a pillow and blankets on the table, but he/she kept throwing them on the floor. Review of Nurse #1's written witness statement, dated 12/16/21, indicated the following: On 12/13/21, Resident #1 was agitated right from the start of the 11:00 P.M. to 7:00 A.M. shift, and was purposely banging his/her head on the (Dining Room) table, secondary to agitation. Nurse #1 wrote that conservatively Resident #1 (directly) banged his/her head on the table six or eight times. Pillows were put on the table and many times his/her head hit the pillow, but his/her head also hit the table. Resident #1 struck his/her head significantly hard. Other than the agitation, there was no change in his/her neurological status. The Statement indicated he (Nurse #1) and CNA #1 took turns staying with Resident #1. Review of Resident #1's medical record indicated there was no documentation to support that Nurse #1 notified the physician of Resident #1's extremely agitated behavior. During an interview on 12/29/21 at 2:35 P.M., Nurse #1 said that Resident #1 had a history of [MEDICAL RECORD OR PHYSICIAN ORDER] .M. until 5:00 A.M., Resident #1 intermittently banged his/her head against the table. Nurse #1 said Resident #1's head directly made contact with the table six to eight times, and this was a change in his/her behavior. Nurse #1 said he did not notify the physician of Resident #1's self-injurious behavior. Nurse #1 said that he did not report Resident #1's head banging to the on-coming Nurse at 7:00 A.M., during shift change report. Nurse #1 said he told the on-coming Nurse that she would probably have to send Resident #1 to the Hospital due to his/her change in condition with his/her restlessness. Although Nurse #1 said he assessed Resident #1 and completed neurological checks on him/her, further review of Resident #1's record indicated there was no documentation to support Nurse #1 assessed Resident #1 or reported the acute behavioral change to the physician. Approximately nine hours later, Resident #1 was found seated in the day room, was unresponsive, and was emergently transported to the Hospital, for further evaluation.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, for one of three sampled Residents (Resident #1), the Facility failed to ensure staff provided care and services that met professional standards of practice, when on 12/14/21, from 1:00 A.M. to 5:00 A.M., Resident #1 exhibited extreme self-injurious behavior by repeatedly banging his/her head on a table, Nurse #1 did not notify the physician, did not document the behavior, did not report Resident #1's self-injurious behavior to the oncoming shift nurse, and despite Nurse #1 saying he assessed Resident #1 for potential injury, and completed a neurological assessment, there was no documentation to support any assessments were completed. Findings include: The Facility's Policy, Accidents, and Incidents, dated 12/29/2011, indicated that an employee witnessing, and accident or incident must report such occurrences to his/her immediate supervisor as soon as practical. Inform the Nursing Supervisor immediately of accidents or incidents so that medical attention can be provided. According to the Facility's standard of practice resource, Clinical Nursing Skills and Techniques, Perry and Potter, 8th Edition, indicated that: - Health assessments are performed on a regular basis to identify changes in the patient's status for comparison with the previous assessment. - A neurological assessment screens a resident for headache, weakness, dizziness, pain, visual changes or changes in speech, these symptoms commonly result from central nervous system dysfunction. - Monitoring of Neurological signs are for early detection of bleeding into the brain caused by head trauma. - Nurses are often the first to detect changes in the resident's condition. For this reason, the ability to think critically and interpret resident behavior and physiologic changes are essential. - Changes in a resident's behavior, increased irritability, mood swings, changes in energy level, these behavioral changes may result from intracranial pathology. Is the resident's behavior and appearance appropriate for the situation? - Accurate Nursing documentation reflects the quality of care and provides evidence of each health care team members accountability in giving care. Resident #1 was admitted to the Facility in 2/2020 diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] Review of Nurse #1's Progress Note, dated 12/14/21 at 5:53 A.M., indicated Resident #1 required constant supervision to prevent him/her from falling, would not stay in bed, kept taking off his/her clothes and blankets, and he/she was a severe fall risk all night long. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility's Investigation, dated 12/13/21, which per the Administrator was dated 12/13/21, to show incident occurred during the 12/13/21 - 12/14/21 night shift, and signed by Nurse #1, indicated that Resident #1 was extremely agitated the entire 11:00 P.M. to 7:00 A.M. shift. He/she needed to be monitored by a staff member within arm's reach for the entire shift. Pillows and blankets were used in the wheelchair to ensure safety. Resident #1 was repeatedly banging his/her head on the (Dining Room) table. During an interview on 12/29/21 at 2:35 P.M., Nurse #1 said he did not document neurological signs or perform complete neurological checks (the basis for comparison of a neurological deterioration) after Resident #1 repeatedly banged his/her head. Nurse #1 said he did look at Resident #1's pupils, but did not use a flashlight to check for pupillary reflexes (a reflex that controls the diameter of the pupil in response to light, to evaluate neurological integrity, compromised by abnormal responsivity, to identify neurological impairment). Nurse #1 said he checked Resident #1's hand grasps, but said they were weak at baseline due to his/her multiple [CONDITION(S)] (a progressive neurological disease with damage to the nerve cells of the brain and spinal cord). Nurse #1 said he did not report the incident of Resident #1's head banging to a Supervisor on the 11:00 P.M. to 7:00 A.M. shift. Review of Resident #1's medical record indicated there was no documentation to support that any neurological assessments had been performed on 12/13/21 during the 11:00 P.M. to 7:00 A.M. shift or on 12/14/21 from 7:00 A.M. to 10:00 A.M., or that the self-inflicted head banging behavior had been documented in the Nursing Progress Notes or reported to the Supervisor. Review of Unit Manager #1's Nursing Progress Note, dated 12/14/21 at 10:58 A.M., indicated Resident #1 became unresponsive, with a pulse rate of 55 (normal 60 to 100), blood pressure 108/69 (normal 120/80), and oxygen saturation of 97% (normal greater than 95%). During an interview on 12/29/21 at 11:00 A.M., Unit Manager #1 said she did not perform neurological signs on 12/14/21 from 7:00 A.M. to 10:00 A. M, because she was not aware that Resident #1 had been repeatedly banging his/her head on the Dining Room table, during the previous shift. Unit Manager #1 said the Nurse on the 7:00 A.M. to 3:00 P.M. shift, had not been informed by Nurse #1 during the shift report of Resident #1's head banging. Review of Certified Nurse Aide (CNA) #2's Witness Statement, dated 12/16/21, indicated the following: Resident #1 was sitting at a (Dining Room) table (in the Day Room) purposely hitting his/her head on the table. Resident #1 was banging his/her head so hard that you could hear his/her head striking the table. Attempts were made to protect his/her head by putting a pillow and blankets on the table, but he/she kept throwing them on the floor. Review of Nurse #1's Witness Statement, dated 12/16/21, indicated the following: On 12/13/21, Resident #1 was purposely banging his/her head on the (Dining Room) table, secondary to agitation. Nurse #1 wrote that conservatively he/she (directly) banged his/her head on the table six or eight times. Resident #1 struck his/her head significantly hard. Other than the agitation, there was no change in his/her neurological status. Nurse #1 and CNA #2 took turns staying with him/her. There was no documentation in Nurse #1's written statement or progress notes to support that he performed or completed neurological checks on Resident #1 after the episode of self injurious behavior. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/29/21 at 2:35 P.M., Nurse #1 said that he did not communicate to the on-coming Nurse during shift report at 7:00 A.M., that Resident #1 was banging his/her head on the dining room table on 12/14/21 from 1:00 A.M. until 5:00 A.M., but said he knew there was a change in Resident #1's condition and told the Nurse on the next shift that Resident #1 probably needed to be sent out to the Hospital due to his/her extreme agitation. Nurse #1 said he/she did not document Resident #1's new behavior of head banging on a table in a progress note. During an interview on 12/29/21 at 8:10 A.M., the Assistant Administrator said that Neurological signs were not performed as they should have been after Resident #1 repeatedly banged his/her head, and that Nurse #1 did not document the new behavior of head banging in Resident #1's Progress Notes or communicate the self-injurious behavior in shift report to the on-coming Nurse on the 7:00 A.M. to 3:00 P.M. shift, and should have. The Facility's Internal Investigation related to Resident #1's change in status during the day shift on 12/14/21, indicated Resident #1 had decreased responsiveness, while sitting in the Day Room. Resident #1 was transferred to the Hospital Emergency Department and was found to have an (acute) subdural hematoma. The findings of the Investigation were that Resident #1 had a change in his/her condition, the Nurses Notes indicated he/she had episodic agitation, but that interviews with the Nursing Staff indicated that Resident #1 had self-inflicted harm. The findings were that Resident #1 repeatedly struck his/her head against a (Dining Room) table despite the staff being with the resident, and it was difficult to determine the cause of the subdural hematoma.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews for one of three sampled (Resident #1), the Facility failed to ensure they maintained complete and accurate medical/clinical records, that his/her record included nursing documentation related to an incident and events that occurred during the night shift on 12/13/21 into 12/14/21, including but not limited to a change in condition with extreme agitation, new behavior of head banging from 1:00 A.M. to 5:00 A.M., and/or assessments of the resident for potential injury. Findings include: The Facility's Policy, Clinical Documentation, dated 1/30/2017, indicated that clinical documentation will be accurate and complete, a resident change in condition or incident requires complete documentation for changes in the resident's condition, interventions, and resident response. According to the Facility's standard of practice resource, Clinical Nursing Skills and Techniques, Perry and Potter, 8th Edition, indicated that the Nursing documentation provides a detailed account of a patient's plan of care, important assessment, and treatment, which must be an accurate and timely evaluation of information. Progress notes provide a format for documenting a patient's health status and progress. All caregivers need to be able to read the progress note and have a clear picture of the problem and level of care required and results of interventions. After each resident contact, identify information that needs to be documented such as change in status, new problem identified, and findings. Resident #1 was admitted to the Facility in 2/2020 diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] Review of Nurse #1's Nursing Progress Note, dated 12/14/21 at 5:53 A.M., indicated Resident #1 required constant supervision to prevent him/her from falling, and he/she would not stay in bed, kept taking off his/her clothes and blankets, and he/she was a severe fall risk all night long. Review of Resident #1's Nurse Progress Notes written by Nurse #1 on 12/13/21 and 12/14/21, indicated there was no documentation regarding Resident #1's repeated self-injurious behavior, of him/her banging his/her head on a dining room table or of the inability to redirect the resident. During an interview on 12/28/21 at 2:35 P.M., Nurse #1 said he did not document in the Resident #1's Progress Notes, his/her new behavior of banging his/her head on a table in the Dining Room. Nurse #1 said he did assess Resident #1's status. Nurse #1 said he did not document his assessment of Resident #1, including neurological signs in the medical record, and said he did not perform complete neurological checks (the basis for comparison of a neurological deterioration) after Resident #1 repeatedly banged his/her head. Nurse #1 said he did not report the incident of Resident #1's head banging to a Supervisor on the 11:00 P.M. to 7:00 A.M. shift. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation in Nurse #1's written statement or nursing progress notes to support that he completed any sort of neurological checks on Resident #1 after the episode of self injurious behavior. During an interview on 12/29/21 at 8:10 A.M., the Assistant Administrator said her expectations were that Nurse #1 would document the head banging behavior in the progress notes and communicate this behavior to the next shift.		