STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225176	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam South Rehab and Nursing	65 Cooper Street Agawam, MA 01001

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 44129 Based on records reviewed and interviews for one of three sampled residents (Resident #1) who had an actual area of skin breakdown and was assessed upon admission by the Registered Dietitian (RD) to be at risk for nutritional decline, the Facility failed to ensure that Resident #1 was adequately monitored by the RD, and nutritional interventions were put in place in a timely manner in an effort to prevent significant weight loss and promote wound healing. Findings include: The Facility Policy titled Weight Assessment and Interventions, last revised 11/19/24 included but was not limited to: -It is the policy of this facility to prevent significant unplanned or unavoidable weight loss for our residents. -The threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria: -One month - 5 percent (%) weight loss is significant, greater than 5% is severe -Any weight change of five pounds or more within 30 days will be retaken the next day for confirmation. If the weight is verified, nursing will notify the Provider and the Dietary Manager/Dietitian. -Recommendations from the Provider and/or Dietitian will be followed. The Facility Policy titled, Skin Prevention, Assessment and Treatment, last revised 10/24/24, included but was not limited to the following: -A nutritional consult should be completed for residents who are at risk for skin alterations -Interventions for prevention or active skin alterations may include but are not limited to: A Registered Dietitian review. (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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was admitted to the Facility in August 2024, diagnoses included Parkinson's disease (a progressive, neurological disorder primarily affecting movement), bacteremia (presence of bacteria in the blood stream), and while at the Facility, he/she developed a pressure injury and experienced a severe weight loss. During an interview on 04/18/25 at 2:50 P.M., Family Member #1 said Resident #1 did not receive the assistance from facility staff he felt he/she required to eat, and as a result he/she lost a lot of weight while he/she was there. Family Member #1 said he brought up his concerns to facility staff, but was told Resident #1 was not eating well, had refused some meals, and said no further information was provided. Family Member #1 said he would plan visits during meal times so he could encourage and provide assistance to Resident #1 to eat, but was not able to be there for all of his/her meals. In addition, Family Member #1 said he could not recall ever speaking to a Dietitian during Resident #1's time at the facility. Review of Resident #1's Initial Dietary Evaluation/Assessment, dated 08/30/24 indicated his/her average food intake was fair (50%), he/she was independent with eating, weight fluctuation was expected due to diuretic use (a medication used to rid the tissues of excess fluids), and that he/she was at risk for malnutrition. Review of Resident #1's Nursing Progress Notes, dated 09/12/24, that indicated he/she had a newly discovered pressure injury. Further review of Resident #1's Consultant Wound Specialist Note, dated 10/16/24, that indicated the following: Resident #1's wound continued to deteriorate and required a surgical consult for wound debridement (a procedure where dead, damaged or infected tissue is removed from a wound to promote healing) and Negative Pressure Wound Therapy (a specialized wound treatment that uses suction to promote healing) on 10/23/24. During a telephone interview on 04/29/25 at 9:00 A.M., the Physician's Assistant (PA) said she did not have Resident #1's clinical information readily available, but she said she remembered him/her, was aware he/she had a pressure injury and significant weight loss, and remembered giving nursing staff a verbal order for nutritional supplements. The PA said she said she could not remember how she learned about the significant weight loss, or exactly what supplement(s) she ordered, when she ordered the supplement(s) or which nurse took the verbal order. Review of Resident #1's Weight Report indicated the following weights: 08/19/24 - 166.8 lbs. 08/26/24 - 168.2 lbs. 09/02/24 - 168.0 lbs. 10/05/24 - 149.4 lbs. (indicates an 11.3% weight loss in one month) (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/22/24 - 146.2 lbs. 10/23/24 - 145.6 lbs. Review of Speech Therapy (ST) documentation for August 2024, indicated that on 08/14/24, his/her diet was changed to 2 gm NA, dysphagia advanced, thin liquids while working, and on 09/04/24, his/her diet was upgraded to 2 gm NA regular diet with thin liquids with added moisture added (gravy, sauces). After working with Speech Therapy and Occupational Therapy Resident #1 was assessed to have improved, and diet was upgraded to regular texture but with added extra moisture (sauce/gravy) and continued to be able to eat independently upon assessment. However review of Resident #1's Medical Record indicated there was no documentation to support the RD was notified of his/her severe weight loss or wound healing needs related to treatment for his/her pressure injury. Review of Resident #1's Nutrition/Wound Progress Note, dated 10/24/24, indicated that as of 10/16/24 wound report, Resident #1 has a Stage 3 wound, no new measurements as of 10/23/24 due to him/her being out on medical leave of absence. Resident #1 was also noted to have significant weight loss (see nutrition/weight note). PO (by mouth) intake variable, 0-100% per staff documentation. Fluids and nutrition intake would not be adequate if he/she eats less than 50% of meals. The Note indicated that on 10/24/24, the RD made the following recommendations: - Discontinue 2-gram Sodium Diet, liberalize to regular diet - Med Pass Supplement 2.0, 4 ounces (oz.) three times per day - Pudding with meals - Probiotic supplement daily (until 11/10/24) - Vitamin C 500 milligrams (mg) twice per day x 30 days (for wound healing) - Zinc Sulfate 200 mg daily x 14 days (for wound healing) - Liquid protein 1 oz three times per day as ordered for additional nutrition/hydration to promote wound healing - Continue to honor dietary preferences - Continue to encourage foods and fluids for nutrition, hydration, wound healing and weight maintenance - Continue to monitor the need for further nutrition intervention (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nutrition/Weight note: Current weight 145.6 lbs. (obtained 10/23/24), One month weight 168 lbs. (obtained 09/02/24). Indicates: 22.4 lb. weight loss in one month (-13.3%) significant. - Director of Nursing and Unit Manager notified. Unclear reasons for significant weight loss unless related to diuretics and/or increased nutrient needs for wound healing. Resident #1 continues on diuretics, weight fluctuations expected. No changes noted to diuretics since admission. - Significant weight loss could be multifactorial due to variable oral intake, diuretics, wounds and antibiotics. During a telephone interview on 04/23/25 at 9:15 A.M., Nurse #2 said weights were obtained by the Certified Nurse Aides (CNAs) and reported to nursing staff to document in the Electronic Health Record (EHR). Nurse #2 said if there was a huge discrepancy between the previously recorded weight and the current weight, a re-weigh would need to be obtained in order to determine whether the weight was valid. Nurse #2 said she documented Resident #1's weight of 149.4 lbs. on 10/04/24, and said if she had noted a large discrepancy from his/her previous weight, she would have had the CNA weigh him/her again to be certain the weight was correct. Nurse #2 said she would not document both weights, only the weight she felt was accurate at the time. Nurse #2 said when a weight is entered into the EHR and there was a large discrepancy, she believed the system would trigger an alert which would be visible to the RD and the Director of Nurses (DON). Nurse #2 said she would notify the Provider if there was a large weight gain or loss if a resident was being closely monitored for cardiac conditions (heart failure) or any other specific condition. During an interview on 04/25/25 at 11:52 A.M., Unit Manager #2 said the CNA's were responsible for obtaining residents' weights and reporting their findings to the nursing staff to record in the EHR. Unit Manager #2 said if the newly obtained weight is five pounds off (either gain or loss), the resident is to be re-weighed to determine whether the weight is accurate. Unit Manager #2 said ideally the Unit Manager should run weekly weight reports to identify trends in weight losses or gains to catch issues early, but said she was only running weight reports monthly. Unit Manager #2 said it is the responsibility of the licensed nurse to report a significant weight change to the Unit Manager, Provider and Resident and/or his/her Representative when they discover the weight gain or loss is significant, and there is no automated process within the EHR that sends out alerts to the interdisciplinary team when there is a significant weight change documented. Unit Manager #2 said Nurse #2 should have notified the Unit Manager, the Provider, and the RD as well as written a progress note identifying the weight loss and who she notified, and said Nurse #2 did not write a progress note. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unit Manager #2 said Resident #1 should have had nutritional interventions (such as added protein for wound healing, dietary modifications and dietary supplements for increased calories) initiated upon discovery of his/her pressure injury on 0912/24, upon discovery of his/her severe weight loss documented 10/05/24, and the interventions initiated by the RD on 10/24/24 were not timely. Unit Manager #2 said there was no evidence the RD was notified of Resident #1's pressure injury or severe weight loss prior to 10/24/24. During a telephone interview on 04/25/25 at 3:44 P.M., Registered Dietitian (RD) #2 said she was the RD at the facility during Resident #1's admission. that she visited the facility one day per week for eight hours, but did not run weekly weight reports when she was in the building due to time constraints, workload, and relied on nursing staff to alert her to any concerns, including residents with pressure injuries and significant weight changes. RD #2 said that nursing staff were aware of when she was in the building, knew where to find her, and said if she was not in the building, said the Unit Managers had her e-mail address. RD #2 said nursing staff would notify her about residents with wounds by sending her the Consultant Wound Provider's notes (if they were involved). RD #2 said she would review the report, determine what the residents' needs would be, initiate interventions (either enter them into the EHR herself or relay them to the Unit Manager), and write a progress note. RD #2 said if nursing staff alerted her to significant weight changes, she would assess the resident to determine the cause of the weight changes (eating poorly, disease process, fluid shifts, medications such as diuretics, etc.) and initiate interventions as needed. RD #2 said if there was no Nutritional Progress Note written until 10/24/24, it was most likely she was not notified of Resident #1's weight loss and wound timely. During an interview on 10/23/24 at 12:55 P.M., the Director of Nurses (DON) said the RD should be notified whenever a resident experiences significant weight gain or loss and/or has treatments for wounds/pressure injuries. The DON said the nurse who documents a weight that indicates a significant change is supposed to notify the Provider and the Unit Manager, then the Unit Manager will notify the RD. The DON said for pressure injuries, the Unit Managers e-mail a copy of the wound log to the RD so they know a resident has a wound. After having an opportunity to review Resident #1's Medical Record, the DON said it did not appear that the RD was aware of Resident #1's pressure injury or severe weight loss until she initiated interventions on 10/24/24 and that there should have been nutritional interventions initiated more timely.

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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. 44129 Based on records reviewed and interviews for one of three sampled Residents (Resident #1), who required wound treatments, had significant weight loss, and required assistance with his/her Activities of Daily Living (ADLs), the facility failed to ensure they maintained a complete and accurate medical record when, 1) Weekly Wound Logs and a Weekly Nursing Skin Review User Defined Assessments (UDA) were not consistently completed by nursing staff, 2) nursing documentation in the Treatment Administration Record (TAR) related to wound care was incomplete with blank spaces, and 3) Certified Nurse Aide (CNA) ADL Flow Sheets for August, September, and October 2023 were incomplete with blank spaces. Findings include: Review of the Facility's policy titled, Skin Prevention, Assessment and Treatment, last revised 10/24/24, indicated but was not limited to: Purpose: To promote a systematic approach and monitoring process for the care of residents with existing wounds and for those at risk for skin breakdown. - Findings from the weekly skin assessments should be documented by the licensed nurse. -Any skin impairments, including pressure ulcers (injuries), non-pressure ulcer wounds, surgical wounds, skin tears, abrasions, etc., should be assessed and documented weekly by the Wound Nurse or designee in the Medical Record. - Documentation should cover all pertinent characteristics of existing ulcers, including location, size, depth, maceration (skin damage attributed to prolonged exposure to moisture), color of the ulcer and surrounding tissues, and a description of any drainage, eschar/necrosis (dead tissue), odor, tunneling (a narrow channel extending from the wound surface deep into the underlying tissue, and undermining (erosion of tissue beneath the wound edges). Review of the Facility's policy titled, Charting and Documentation, last revised 11/05/24, indicated but was not limited to: - Each resident will have an active medical record that contains accurately documented information, systematically organized and readily accessible to authorized persons. - An electronic Treatment Administration Record (TAR) shall be maintained, which records indicate care procedures and/or treatments ordered by the physician that is performed and by whom the procedure/treatment was performed. - Narrative documentation/progress notes will be documented under the premise of charting by exception. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Documentation will include information on assessment, notifications, interventions and evaluation including but not limited to refusals of medications/treatments or recommendations, and education provided to the resident and/or responsible party. 1) Resident #1 was admitted to the Facility in August 2024, diagnoses included Parkinson's disease (a progressive, neurological disorder primarily affecting movement), bacteremia (presence of bacteria in the blood stream), and while at the Facility, he/she developed a pressure injury (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device), and required assistance with his/her Activities of Daily Living (ADLs). Review of Resident #1's Nursing Progress Notes included a note, dated 09/12/24, that indicated he/she had a newly discovered pressure injury. Review of Resident #1's UDAs in the Electronic Health Record (EHR) indicated there was no evidence to support nursing staff completed the following Assessments: -Weekly Nursing Skin Review on 10/07/24 -Weekly Wound Logs on 10/09/24, 10/16/24, and 10/23/24 During a telephone interview on 04/23/25 at 9:15 A.M., Nurse #2 said the licensed nursing staff is responsible for completing weekly skin assessments for every resident and document their findings in the Weekly Nursing Skin Review Assessment UDA in the computer every week. Nurse #2 said the computer alerts the nurse when assessments were due to be completed. Nurse #2 said that the Unit Managers, usually alongside the Consultant Wound Specialist, perform in depth assessments of residents' wounds weekly. Nurse #2 said that after the rounds have been completed, the information from the wound rounds for each resident should be documented in the Weekly Wound Log UDA in the computer. During an interview on 04/22/25 at 10:40 A.M., Unit Manager #1 said nursing staff are required to perform weekly skin assessments on all residents in the facility and document the information in the Weekly Nursing Skin Review Assessment UDA in the EHR. Unit Manager #1 said Weekly Wound Log UDAs are usually completed after the Unit Managers round with the Consultant Wound Specialist and should be entered in the computer every week. Unit Manager #1 reviewed Resident #1's EHR and said there was not a Weekly Nursing Skin Review UDA documented for 10/07/24 and there were no Weekly Wound Log UDAs documented for 10/09/24,10/16/24 and 10/23/24. During an interview on 04/23/25 at 11:52 A.M., Unit Manager #2 said skin assessments should be performed weekly by licensed nursing staff and documented on the Weekly Nursing Skin Review UDA. Unit Manager #2 said while they are rounding with the Consultant Wound Specialist, they (the Unit Managers) handwrite the assessment information for each resident on a weekly wound tracking (paper) form, and after rounding has been completed, the Unit Managers are supposed to transcribe the data from the handwritten form and enter that information into the Weekly Wound Log UDA in the computer. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unit Manager #2 said for Resident #1, there was not a Weekly Nursing Skin Review UDA for 10/07/24 and said that while weekly wound tracking forms were completed on 10/09/24, 10/16/24, and 10/23/24, the assessment data was never documented in the Weekly Wound Log UDA. Unit Manager #2 further said weekly wound tracking forms were not considered part of the medical record. During an interview on 04/23/25 at 12:55 P.M., the Director of Nursing (DON) said that nursing staff are responsible to perform weekly skin checks on all residents in the facility and enter their findings in the computer under the Weekly Nursing Skin Review UDA. The DON said if a resident has a wound, the wound is assessed weekly by the Unit Managers along with the Consultant Wound Specialist and the results of the assessments should be documented in the computer under the Weekly Wound Log UDA. After reviewing Resident #1's EHR with the surveyor, the DON said that nursing staff did not document the Weekly Nursing Skin Review Assessment UDA for 10/07/24, nor did they document the Weekly Wound Log UDAs for 10/09/24, 10/16/24, and 10/23/24, as required. 2. Review of Resident #1's September 2024 Treatment Administration Record (TAR) indicated wound treatments were not signed off as being completed (left blank) on the following dates and shifts: - 09/20/24 - day shift - 09/23/24 - day shift - 09/29/24 - day shift Review of Resident #1's October 2024 TAR indicated wound treatments were not signed off as being completed on the following dates and shifts. - 10/03/24 - day shift (left blank) - 10/03/24 - evening shift (left blank) - 10/4/24 - code 9 other, see nursing note - 10/06/24 - code 9 other, see nursing note Review of Resident #1's Nursing Progress Notes indicated he/she did not receive his/her wound treatments on 10/04/24 and 10/06/24 because he/she was OOB (out of bed). During a telephone interview on 04/22/25 at 3:56 P.M., Nurse #1 said she was on duty from 7:00 A.M. until 7:00 P.M. on both 10/04/24 and 10/06/24. She said that Resident #1 often sat up in his/her wheelchair visiting with his/her spouse for several hours during the day, he/she would often refuse treatments and medications, and that was likely the case on 10/04/24 and 10/06/24. Nurse #1 said she should have written a more comprehensive note other than just saying Resident #1 was out of bed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 said she was certain at some point during her shifts on 10/04/24 and 10/06/24 that she performed the wound treatment for Resident #1, however she never went back to document that she did so. During an interview on 04/22/25 at 10:40 A.M., Unit Manager #1 reviewed Resident #1's September and October 2024 TARs and said blank spaces appear because the nurse failed to document the wound treatments. Unit Manager #1 said for 10/04/24 and 10/06/24, the nursing note was too vague and there was no way to determine from the documentation if Nurse #1 re-attempted the wound treatment later, or if she provided education to Resident #1 about the need to perform the wound treatment at the scheduled time. Unit Manager #1 also said if Nurse #1 did perform the wound treatments on 10/04/24 and 10/06/24, she should have documented as such. During an interview on 04/23/25 at 12:55 P.M., the DON said there should not be blank spaces on the TAR and the blank spaces indicated the nursing staff failed to document they performed the wound treatments. The DON said Nurse #1 should have written a more comprehensive note relative to the wound treatments for Resident #1 on 10/04/24 and 10/08/24, and that just documenting out of bed was not sufficient. The DON further said that if Nurse #1 did the treatments later in her shift, she should have documented it. 3. Review of Resident #1's CNA Activities of Daily Living Flowsheets (Documentation Survey Report) indicated for the following tasks, documentation was incomplete (with many entries left blank): August 2024: -Oral Hygiene three times per day: 23 out of 60 opportunities left blank; -Nutrition (fluid intake) three times per day: 23 out of 60 opportunities left blank; -Nutrition (amount eaten) three times per day: 30 out of 60 opportunities left blank; September 2024: -Oral Hygiene three times per day: 31 out of 90 opportunities left blank; -Nutrition (fluid intake) three times per day: 31 out of 90 opportunities left blank; -Nutrition (amount eaten) three times per day: 29 out of 90 opportunities left blank; October 2024: -Oral Hygiene three times per day: 10 out of 69 opportunities left blank; -Nutrition (fluid intake) three times per day: 10 out of 69 opportunities left blank; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nutrition (amount eaten) three times per day: 9 out of 69 opportunities left blank; During an interview on 04/22/25 at 2:15 P.M., Nurse Aide (NA) #1 said that they are required to document tasks they perform for all residents throughout the day, and it must be completed by the end of their shift. NA #1 said if a resident refused any care, they are still required to document the refusal and notify the resident's nurse. NA #1 said there should not be any blank spaces on their Flow Sheets and if there were any blank spaces, the documentation was not completed, as required. During an interview on 04/22/25 at 2:15 P.M., NA #2 said they were supposed to complete their documentation by the end of their shift. NA #2 said they use a tablet to document electronically and demonstrated to the surveyor the documentation process. NA #2 said they document all the residents' ADLs, including oral care, meal intake and fluid intake and the amount of assistance a resident requires from staff to complete these tasks. NA #2 said there should not be any blank spaces on the Flow Sheet, and the blank spaces meant the documentation was not completed for those dates and times. During an interview on 04/23/25, CNA #1 said if a resident refused any ADL care, the CNAs were required to document the refusal and notify the nurse. CNA #1 said all their documentation must be completed in the computer by the end of their shift, and the blank spaces on the Flow Sheet meant that the CNAs did not complete their documentation, as required. During an interview on 04/22/25 at 3:10 P.M., Unit Manager #2 reviewed Resident #1's CNA documentation (Documentation Survey Report) and said it was the expectation that CNAs and NAs document the care they provide to the residents throughout the shift and the documentation should be completed by the end of their shift, and the blank spaces in the report meant the documentation was not done. Unit Manager #2 said that the floor nurses were supposed to review CNA documentation at the end of each shift to ensure it had been completed and this did not happen. During an interview on 04/23/25 at 12:55 P.M., the Director of Nurses (DON) reviewed the CNA documentation (Documentation Survey Report) and said there should not be any blank spaces, and the blank spaces meant the CNAs failed to document on those dates and times. The DON said it was the expectation that all documentation was to be completed by the end of the shift.