STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 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. Based on records reviewed and interviews for one of three sampled residents (Resident #1), the facility failed to ensure they maintained a complete and accurate medical record when Certified Nurse Aide (CNA) documentation related to positioning was either incomplete and/or inaccurate.Findings include:Review of the Facility policy titled, Documentation in Medical Record, revised January 2025, indicated the following:-Staff shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. -Documentation shall be accurate, relevant, and complete, containing sufficient details about the residents' care and/or responses to care. Resident #1 was admitted to the Facility July 2025, with diagnoses including but not limited to; cerebral infarct (blood clot blocks an artery in the brain, cutting off blood flow to a specific area), end-stage kidney disease, and pressure ulcers.Review of Resident #1's Minimum Data Set (MDS) admission Assessment, dated 08/05/25, indicated he/she was dependent on staff assistance for bed positioning.Review of Resident #1's ADL Flow Sheet (CNA documentation) dated 08/01/25 through 08/14/25 indicated for the following shifts, documentation was inaccurate or incomplete for positioning:-08/02/25 at 6:00 A.M, 10:00 A.M., 12:00 P.M., and 2:00 P.M. left blank.-08/03/25 at 8:00 A.M, 10:00 A.M., and 2:00 P.M. documented NA (not applicable).-08/05/25 at 6:00 A.M., left blank, 10:00 A.M., 12:00 P.M., and 2:00 P.M. documented NA.-08/08/25 at 8:00 A.M. and 10:00 A.M. documented NA.-08/10/25 at 10:00 A.M. documented NA.During an interview on 09/09/25 at 4:00 P.M., the Director of Nursing (DON) said the CNA assigned the resident is responsible for completing the CNA flow sheet. The DON said the CNA flow sheet documentation on 08/02/25, 08/03/25, 08/05/25, 08/09/25 and 08/10/25 should not be blank or documented as NA. The DON said Resident #1's CNA flow sheet was not complete or accurate.

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