STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225253	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam West Rehab and Nursing	61 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 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), the facility failed to ensure they maintained complete and accurate medical record when, 1) nursing documentation in Resident #1's Medication Administration Record (MAR) was incomplete, with spaces for medication administration left blank, and 2) required information in the Controlled Substance Register (record/log book used by the facility for maintaining accurate records of all narcotics and other controlled medications ordered and administered to each resident) related to resident specific medications and physician's orders, was inaccurate and incomplete. Findings include: Review of the facility's policy titled, Administering Medication, revised 10/15/24, indicated: - The individual administering the medication shall sign off on the Electronic Medication Administration Record (eMAR) date for that specific day before administering the medication. - Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication shall chart in the eMAR and sign off for that particular drug and document a rationale. - If it is discovered the person administering medications has forgotten to initial in the appropriate space, the supervisor shall notify that person to investigate if the medication/treatment has been administered/performed. If the response indicates the medication/treatment was administered, the staff member shall return to the facility, sign off on the eMAR to indicate a late entry. A late entry note will be documented indicating the administration of the medication. If the medication was not administered the missed dose/medication error protocol shall be followed. Review of the facility's policy titled, Charting and Documentation, revised 11/05/24, indicated: - Each resident will have an active medical record that contains accurately documented information, systematically organized and readily accessible to authorized persons. - A medication administration record shall be maintained which records the date and time each medication ordered by the physician that is given and by whom the medication was administered. (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
	225253	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam West Rehab and Nursing	61 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) Resident #1 was admitted to the facility in January 2022, diagnoses included other specified disorders of the brain, other malformations of the cerebral (part of the brain) vessels, and anxiety disorder. Review of Resident #1's Physician's Order Summary Report, dated 03/28/25, indicated his/her current and active orders included the following: - Ativan (an anti-anxiety medication), give 0.25 milligrams (mg) by mouth every 24 hours for anxiety with a start date of 02/08/24. - Clonazepam (an anti-anxiety medication), give 0.75 mg by mouth in the evening for anxiety, send half tablets of 0.25 mg each to equal 0.75 mg with a start date of 11/21/22. - Oxycodone HCl (an opioid pain medication) oral tablet, 5 mg, give one tablet by mouth three times a day for pain with a start date of 01/20/24. - Oxycodone HCl oral tablet, 5 mg, give one tablet by mouth every 24 hours for pain with a start date of 02/20/24. - Oxycodone HCl capsule, 5 mg, give one tablet by mouth every six hours as needed for moderate to severe pain with a start date of 02/18/24. Review of Resident #1's January 2025 MAR indicated that for the following scheduled medications, the dates and times were left blank: - Clonazepam 0.75 mg: 01/14/25 at 8:00 P.M. - Oxycodone 5 mg: 01/14/25 at 8:00 P.M. and 01/30/25 at 2:00 P.M. Review of Resident #1's February 2025 MAR indicated that for the following scheduled medications, the date and times were left blank: - Clonazepam: 02/01/25 and 02/22/25 at 8:00 P.M. - Oxycodone: 02/01/25 and 02/22/25 at 8:00 P.M. Review of Resident #1's March 2025 MAR indicated that for the following scheduled medications, the date and times were left blank: - Clonazepam: 03/06/25, 03/24/25, and 03/25/25 at 8:00 P.M. - Oxycodone: 03/01/25 at 2:00 P.M., 03/06/25, 03/24/25 and 03/25/25 at 8:00 P.M. Review of the Controlled Substances Register for Resident #1 indicated that the Clonazepam and Oxycodone were all signed off as being administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225253	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam West Rehab and Nursing	61 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/26/25 at 11:11 A.M., Nurse #1 said when a nurse administers a medication to a resident, they are required to document it in the electronic health record (EHR). Nurse #1 said when they document the administration in the EHR, the MAR will show a checkmark followed by the nurse's initials, and if the MAR is blank, that means that the nurse did not document that they gave the medication. Nurse #1 said when there are blank spaces on the MAR, it appears as though the nurse did not administer the medications on those dates and times. During an interview on 03/26/25 at 4:18 P.M., Unit Manager #1 said during medication pass, the nurse is required to sign off (document) on each medication they administer in the EHR, there should be no blank spaces on the MAR and when there were blank spaces, that means the nurse did not document the medication administration. After reviewing Resident #1's January, February, and March 2025 MARs with the surveyor, Unit Manager #1 said there were several blank spaces throughout the MARs and there should not have been. During an interview on 03/26/25 at 5:10 P.M., the Assistant Director of Nursing (ADON) reviewed Resident #1's January, February, and March MARs with the surveyor. The ADON said that when passing medications, the nurse is required to sign off as having given the medications in the computer. The ADON said there should not be any blank spaces on the MARs because that means the nurse who was on duty passing the medications did not document as they should have. 2. Review of the facility's policy titled Medication Ordering and Receiving from Pharmacy: Receiving Controlled Substances, dated November 2021 indicated: - An individual resident's controlled substance record is prepared by the pharmacy or the facility for each controlled substance prescribed for a resident. The following information is completed upon dispensing or upon receipt of the controlled substance: 1) Name of resident 2) Prescription number 3) Drug name, strength (if designated), and dosage form of medication 4) Date received 5) Quantity received 6) Name of person receiving the medication supply Review of the Controlled Substance Register pages specific to Resident #1's medications indicated the following: - Page 1: Ativan, missing the prescription number and prescription date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225253	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam West Rehab and Nursing	61 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Pages 3, 15, and 38: Oxycodone, incomplete dosage directions, missing the prescription number and prescription date. - Pages 19, 22, 27, and 30: Oxycodone, incomplete dosage directions. - Page 7: Clonazepam, missing the prescription number and prescription date. - Page 16 and 37: Clonazepam, incorrect dosage directions. During an interview on 03/26/25 at 3:00 P.M., Nurse #1 reviewed the pages related to Resident #1 in the Controlled Substance Register with the surveyor, and after reviewing, said she noted several problems with them. Nurse #1 said that for every medication, there should be a prescription number and a prescription date, as well as clear medication information such as the name of the medication, the dosage/strength of the medication and and directions for administration. Nurse #1 said that there were several pages that were missing the prescription numbers and dates, that the pages for Clonazepam included directions to administer two half tablets as needed daily (and there was no order for this), and for the Oxycodone, none of the pages showed accurate administration directions for what was ordered by the physician. Nurse #1 said they failed to include a scheduled dose of Oxycodone 5 mg daily at 1:00 A.M., 5 pages failed to include the PRN (as needed) dose and directions, and three pages had no directions at all. During an interview on 03/26/25 at 3:41 P.M., Nurse #3 reviewed the pages of Resident #1's Controlled Substance Register with the surveyor. Nurse #3 said that for every medication listed, there should also be a prescription number, prescription date and that information was missing on many of the pages. In addition, Nurse #3 said Resident #1 did not receive PRN Clonazepam, could not remember him/her ever having that ordered, and it should not have been written on the Clonazepam pages. Nurse #3 said that many of the pages for Resident #1's medications in the Controlled Substance Register were incomplete and/or inaccurate. During an interview on 03/26/25 at 4:18 P.M., Unit Manager #1 reviewed the pages of Resident #1's Controlled Substance Register with the surveyor. Unit Manager #1 said that for the Oxycodone pages, the directions were incomplete, with all of the pages not including an additional scheduled 1:00 A.M. dose, some of the pages did not have any administration directions at all, and some pages failed to include the PRN dosages. Unit Manager #1 also said that every page should have a prescription number and prescription date recorded on the pages, however that information was missing from several of the pages. During an interview on 03/26/25 at 5:10 P.M., the Assistant Director of Nursing (ADON) reviewed the pages of Resident #1's Controlled Substance Register with the surveyor and said that they were missing accurate directions as well as missing prescription numbers and dates, all of which were required.