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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam West Rehab and Nursing	61 Cooper Street Agawam, MA 01001

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 45435 Based on record review and interview, for one of eight sampled residents (Resident #3), the facility failed to ensure they obtained written informed consent for his/her psychotropic medication prior to administering the medication. Findings include: Review of the facility's policy titled Psychotropic Medication Management, revised 10/24/24, indicated that psychotropic medications will be administered upon a physician's order and informed consent by the resident or the Durable Power of Attorney/Responsible Party. Resident #3 was admitted to the facility in February 2025, diagnoses included bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs), anemia (low red blood cells) osteoarthritis of the right and left knee (cartilage at the ends of bones has worn down), diabetes mellitus (trouble controlling blood sugar), hypertension (high blood pressure), and atrial fibrillation (irregular heart beat). Review of Resident #3's Minimum Data Set (MDS) Admission Assessment, dated 02/09/25, indicated he/she had moderate cognitive impairment with a score of 8 out of 15 on his/her Brief Assessment for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggest a resident is cognitively intact). Further review of the medical record indicated Resident's #3's Health Care Proxy was not activated indicating Resident #3 was able to make his/her own decisions. Review of Resident #3's Medication Administration Record (MAR) for the Month of February 2025, indicated he/she had physician's orders for and was administered the following: 8:00 A.M.-Quetiapine fumerate (anti-psychotic medication) oral tablet 300 milligrams (mg), give three tablets one time a day, start date 02/04/25, end date 02/28/25. 8:00 P.M.-Quetiapine fumerate oral tablet 100 mg, give nine tablets by mouth at bedtime, start date, end date 02/28/25. Review of Resident #3's MAR for the Month of March 2025, he/she had physician's orders for and was administered the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8:00 P.M.-Quetiapine fumerate oral tablet 100 mg, give 900 mg by mouth at bedtime, start date 03/13/25, end date 04/22/25. Review of Resident #3's medical record indicated there was no documentation to support that written informed consent for Quetiapine had been obtained prior to the start of administration on 02/03/25. Further review Resident #3's medical record indicated a written informed consent for quetiapine fumarate had not been obtained until 03/11/25, (37 days after the quetiapine fumerate had been initiated). Review of Resident #3's Informed Consent for Psychotropic Medication, dated 03/11/25, indicated the dosage range of Seroquel (quetiapine fumerate) for which the consent had been obtained, was 0 mg-800 mg, which did not coincide with Resident #3's current medication order of quetiapine fumerate 900 mg at bedtime. During an interview on 05/15/25 at 3:15 P.M., the Director of Nurses (DON) said that she was unable to locate and provide any documentation to support that the Facility had obtained written and signed informed consent for the use of quetiapine fumerate for Resident #3 prior to 03/11/25. The DON said that informed consent for quetiapine fumerate should have been obtained upon admission, prior to quetiapine administration on 02/03/25. In addition, the DON said that the Psychotropic Medication Informed Consent signed on 03/11/25 did not reflect Resident #3's current medication order.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37227 Based on records reviewed and interviews, for one of eight sampled residents (Resident #7), who had an above the knee amputation, and whose Physician Orders and Plan of Care indicated that he/she required the use of bedrails for transfers, turning and positioning, the Facility failed to ensure that he/she had the necessary assistive equipment to maintain his/her safety when the left bedrail had fallen off the bed but was not repaired or replaced timely and on 04/02/25, Resident #7 sat up on the side of his/her bed reached for the bedrail, and when it wasn't there, lost his/her balance and fell . Findings include: Review of the Facility Fall Reduction Policy, dated as revised 10/30/24, indicated its purpose was to identify residents who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent or minimize fall related injuries. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 04/08/25, indicated that Resident #7 had an unwitnessed fall from his/her bed. The Report indicated that Resident #7 reported that as he/she was sitting on edge of bed he/she lost his/her balance and fell forward. The Report indicated that Resident #7 initially denied pain but later complained of right hip pain and was transferred to the emergency department for evaluation and treatment per physician recommendations. The Report indicated that Resident #7 was diagnosed with a pathological, closed sub-capital fracture of the right femur due to secondary osteoporosis. Review of Resident #7's Emergency Medicine Progress Note, dated 04/02/25, indicated that he/she presented at the Emergency Department (ED) after a fall. The Note indicated that Resident #7 reported that when he/she was trying to sit up in bed at the Facility, the bedrail was missing from the bed, he/she fell forward from a sitting position, directly onto the floor, and struck his/her forehead. Resident #7 was admitted to the Facility in July 2022, diagnoses included left leg above the knee amputation (AKA), insomnia, generalized anxiety disorder, and repeated falls. Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 02/13/25, indicated Resident #1 was cognitively intact with a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact). Further review of the MDS indicated Resident #7 was independent with rolling in bed, required substantial assistance to sit on the edge of the bed and to transfer from bed to wheelchair. Review of Resident #7's Mobility Care Plan, reviewed and renewed with Quarterly MDS completed 02/13/25, indicated he/she required assistance with mobility related to his/her AKA. The Care Plan interventions indicated Resident #7 required bedrails to enable transfers from bed to chair and to enable turning and repositioning in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's Nurse Progress Note, dated 03/30/25, indicated Resident #7 self-transferred in and out of bed to his/her wheelchair four times without using the call bell and did not ask for staff assistance. Review of Resident #7's Physician's Orders, for April 2025, indicated he/she had orders dated effective 01/28/24, for two bilateral quarter length bedrails as an enabler for turning and repositioning in bed. Review of Maintenance Work Order #7090, created on 04/02/25 at 7:09 P.M. (after the 2:30 A.M. fall) indicated Resident #7's left bedrail needed urgent repair or replacement. Further review of the work-order indicated it was replaced at 12:00 P.M. During an interview on 05/14/25 at 3:05 P.M., Resident #7 said that he/she used bilateral bedrails to reposition in bed, sit up to the edge of bed, and during transfers. Resident #7 said on 04/02/25, at the time of the fall, the left bedrail was broken and was not on the bed. Resident #7 said he/she could not remember how long the bedrail had been broken but recalled that a CNA (exact name unknown) had been unable to reattach the bedrail because the screws were missing. Resident #7 said the CNA had assured him/her that she would notify the maintenance department. Resident #7 said that he/she sat on the edge of the bed, reached for the left bedrail, lost his/her balance, and fell forward off the bed, striking his/her right knee on the floor and hitting his/her head on the bedside table. During a telephone interview on 05/16/25 at 1:43 P.M., Nurse #5 said that she worked full time on the 11:00 P.M. to 7:00 A.M. shift on Resident #7's unit and was familiar with his/her care needs. Nurse #5 said that Resident #7 frequently sat up to the edge of the bed without assistance and sometimes transferred in and out of bed without ringing for staff assistance, despite re-education. Nurse #5 said that Resident #7 required assistance with transfers due to his/her frequent falls. Nurse #5 said that on 04/01/25 at around 11:00 P.M. during the change of shift a Certified Nurse Aide from the evening shift told her that Resident #7's left bedrail was broken and that he (the CNA) would put a maintenance work order in to have it repaired. Nurse #5 said that early the next morning, on 04/02/25 at approximately 2:30 A.M., Resident #7 had a fall from his/her bed. Nurse #5 said when she responded to Resident #7's fall she observed that he/she had fallen from the left side of his/her bed and landed on the floor in the middle of the room. Nurse #5 said the broken bedrail would have been on the same side as his/her left leg amputation. During a telephone interview on 05/15/25 at 8:23 A.M., Certified Nurse Aide (CNA) #1 said that Resident #7 recently moved onto the unit where he (CNA #1) typically worked, while his/her room was being renovated and that he was familiar with his/her care needs. CNA #1 said that Resident #7 used bilateral bedrails to assist with mobility in bed and during transfers. CNA #1 also said that Resident #7 required assistance with transfers but frequently self-transferred. CNA #1 said that when he responded to a loud crash on 04/02/25 at 2:30 A.M., found Resident #7 on the floor and observed that his/her bedside table was tipped over. CNA #1 said he observed that the bedrail was missing from the left side of Resident #7's bed and was leaning up against the wall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/25, Unit Manager #1 said that Resident #7 required bilateral bedrails for mobility when in bed. Unit Manager #1 said that Resident #1's bedrail was broken prior to the fall and the repair request had not been entered into the maintenance work order system until after the fall. Unit Manager #1 further said she was not sure how long the bedrail had been broken. During an interview on 05/15/25 at 10:37 A.M., the Director of Maintenance said he was not made aware that Resident #7's bedrail needed repair, prior to the fall on 04/02/25. The Director of Maintenance further said that the work order system was available to all staff, on all units. During an interview on 05/15/25 at 3:15 P.M. the Director of Nurses said that the repair request for the bedrail should have been submitted at the time staff discovered the need for repair.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 37227 Based on records reviewed, observations and interviews for one of eight sampled residents (Resident #7) who was alert, oriented and made his/her own medical decisions, the Facility failed to ensure that he/she was assessed for the use of bedrails and that alternatives were trialed, prior to installing bilateral bedrails. Findings include: Review of the Facility Policy titled Side Rail Assessment, dated as revised 11/05/24, indicated the use of bedrails must be first evaluated for their appropriateness in relation to the resident's condition. The Policy indicated the alternatives explored, rationale and reason for use and condition of the resident (including the resident's cognitive ability and understanding of the use of bedrails) must be documented. The Policy further indicated that the continued use of bedrails must be assessed for appropriateness annually or more often if necessary. Resident #7 was admitted to the Facility in July 2022, diagnoses included left leg above the knee amputation (AKA), insomnia, generalized anxiety disorder, and repeated falls. Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 02/13/25, indicated Resident #1 was cognitively intact with a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact). Further review of the MDS indicated Resident #7 was independent with rolling in bed and required substantial assistance to sit on the edge of the bed and to transfer from bed to wheelchair. Review of Resident #7's Mobility Care Plan, reviewed and renewed with Quarterly MDS completed 02/13/25, indicated he/she required assistance with mobility related to his/her AKA. The Care Plan interventions, initiated 01/29/23, indicated Resident #7 required bedrails to enable transfers from bed to chair and to enable turning and repositioning in bed. Review of Resident #7's Physician's Orders, for April 2025, indicated he/she had an order dated effective 01/28/24, for two bilateral quarter length bedrails as enablers for turning and repositioning in bed. Review of Resident #7's Medical Record indicated there was no documentation to support that he/she was assessed for the use of bedrails or that appropriate alternatives to bedrails were trialed prior to their use, and that the continued use of bedrails were assessed for appropriateness annually as per facility policy. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Physical Therapy Screen, dated 04/14/25, indicated that Resident #7's bed frame, mattress and bedrails were appropriate for his/her needs. The Screen did not include an evaluation of alternatives that were attempted prior to installation or use of bed rails, and how those alternatives failed to meet the Resident's assessed needs. On 05/14/25 at 2:15 P.M., the Surveyor observed that Resident #7's bed had bilateral quarter length bedrails in the upright position. During an interview on 05/14/25 at 3:05 P.M., Resident #7 said that he/she used bilateral bedrails when repositioning in bed and during transfers for as long as he/she had been living at the Facility. Resident #7 said he/she felt he/she needed bedrails but did not recall anyone discussing the risks associated with their use. During a telephone interview on 05/15/25 at 8:23 A.M., Certified Nurse Aide (CNA) #1 said that Resident #7 used bilateral bedrails to assist with mobility in bed and during transfers. CNA #1 also said that Resident #7 required assistance with transfers but frequently self-transferred. During an interview on 05/15/25, Unit Manager (UM) #1 said that Resident #7 required bilateral bedrails for mobility when in bed. During an interview on 05/15/25 at 3:15 P.M. the Director of Nurses said that the Facility was unable to provide any documentation to support that Resident #7 had been assessed for the use of bedrails, according to Regulations and Facility Policy.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 45435 Based on record review and interviews, for one of eight sampled residents (Resident #3), whose physician's orders included the administration of a medication to manage his/her bipolar disorder, the Facility failed to ensure he/she was free from significant medication errors, when upon admission, the medication was inaccurately reconciled from his/her Hospital Discharge Summary by nursing and he/she was administered incorrect dosages of the medication for multiple days. Findings include: Review of the Facility's policy titled Administering Medication, dated as revised 10/15/24, indicated the following: -Medications shall be administered according to physician's written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity when no contraindications are identified and the medication is labeled according to accepted standards. -Should a dosage seem excessive considering the resident's age and medical condition, or a medication order seems to be unrelated to the resident's current diagnosis or medical condition, the person preparing/administering the medication shall contact the resident's attending physician or the facility's medical director for further instructions. Review of the Davis's Drug Guide for Nurses-19th edition (2025), indicated the usual dosage of quetiapine is 400 milligrams (mg)-800 mg per day. Resident #3 was admitted to the facility in February 2025, diagnoses included but was not limited to bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs), hypertension (high blood pressure), and atrial fibrillation (irregular heart beat). Review of Resident #3's Medication Administration Record (MAR) for the Month of February 2025, indicated he/she had physician's orders and was administered the following: - 8:00 A.M.-Quetiapine fumerate (anti-psychotic medication) oral tablet 300mg, give three tablets one time a day, start date 02/04/25, end date 02/28/25. - 8:00 P.M.-Quetiapine fumerate oral tablet 100 mg, give nine tablets by mouth at bedtime, start date 02/03/25, end date 02/28/25. Review of the Resident #3 Hospital Discharge Summary, dated 02/02/25, indicated his/her physician's orders were for quetiapine 900 mg (no frequency indicated) Review of Resident #3 Hospital Active Medication List, dated 02/02/25, indicated the following: -Quetiapine 300mg tablet, give 3 tablets (total of 900 mg), per Psych (no frequency indicated). -Quetiapine 900 mg, tablet, by mouth, daily at bedtime. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Hospital Psychiatric Consultation note, dated 02/01/25, indicated to administer quetiapine 900 mg, by mouth, daily at bedtime. During an interview on 05/15/25 at 10:15 A.M., Nurse Practitioner (NP) #1 said Resident #3 should not have been receiving quetiapine 900 mg, twice a day, from 02/03/25 through 02/28/25 (25 days). NP #1 said Resident #3's order for quetiapine should have been for 900 mg once a day at bedtime as indicated in his (NP) progress notes. Review of the Nurse Practitioner's Progress Note, dated 02/05/25, indicated to continue quetiapine 900 mg at HS (bedtime). During an interview on 05/15/25 at 12:50 P.M, Nurse #1 said that she had called the on-call provider on 02/03/25, during the evening shift, to obtain admission medication orders for Resident #3. Nurse #1 said that she had utilized the Hospital Discharge Summary and the Hospital Medication List to obtain telephone orders. Nurse #1 said that 900 mg of quetiapine, twice a day, had sounded like a lot of medication, but that she had reviewed the medications with the on-call provider and proceeded to enter the medication orders into the electronic medical record. Nurse #1 said that she was not sure what the usual dose of quetiapine was, and said she could have called the on-call provider back to clarify the dosage, but that she did not. During an interview on 05/15/25 at 10:00 A.M., Unit Manager #2 said that she had called the Provider on 02/28/25, because Resident #3 was lethargic and his blood pressure and heart rate were not stable. Unit Manager #2 said that during the telephone call with the Provider, she read through the list of medications Resident #3 was currently receiving and that the Provider had said that's a lot of Seroquel (quetiapine). Unit Manager #2 said she then reviewed Resident #3's Hospital Discharge Summary and noticed that the Seroquel (quetiapine) had been transcribed twice a day instead of once a day, by mistake. Review of Resident #3's Med Error report, dated 02/28/25 indicated Unit Manager #2 had called the Provider due to Resident #3's lethargy. The Report indicated that Unit Manager #2 reconciled Resident #3's admission medication orders with his/her current medication orders and obtained new orders to taper Seroquel (quetiapine), discontinue Remeron (anti-depressant), obtain an electrocardiogram (EKG-a test that records the electrical activity of the heart), encourage fluids, and obtain vital signs every four hours for seven days. During an interview on 05/15/25 at 3:15 P.M., the Director of Nurses (DON) said that her expectation was that nursing staff would have read the Psychiatric Consultation note and the Provider note and noticed the medication order discrepancy.

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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. 45435 Based on records reviewed and interviews, for two of eight sampled residents (Resident #2 and Resident #3), who were dependent on assistance from staff for activities of daily living, the facility failed to ensure they maintained complete and accurate medical records. Findings include: Review of the Facility policy titled, Charting and Documentation, revised 11/05/25, indicated that each resident will have an active medical record that contains accurately documented information, systematically organized and readily accessible to authorized person. Resident #2 was admitted to the Facility March 2025, with diagnoses including cerebral infarction (blood flow to the brain is interrupted causing brain tissue damage), diabetes mellitus (difficulty controlling blood sugar), and osteomyelitis (inflammation of bone caused by infection). Review of Resident #2's Minimum Data Set (MDS) Admission Assessment (a comprehensive assessment of each resident's functional capabilities), dated 03/30/25, indicated he/she was dependent on staff assistance for all activities of daily living (ADL), bed positioning, transfer, and mobility. Review of Resident #2's ADL Flow Sheet (CNA documentation), dated 03/25/25 through 03/31/25, indicated for the following shifts, documentation was incomplete: -7:00 A.M. to 3:00 P.M. 1 day (out of 7 days) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M. 2 days (out of 7 days) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M. 5 days (out of 7 days) all ADL care areas were left blank. Review of Resident #2's ADL Flow Sheets dated 04/01/25 through 04/17/25, indicated that for the following shifts, documentation was incomplete: -7:00 A.M. to 3:00 P.M. 3 days (out of 17) all ADL care areas were left blank. -3:00 P.M. to 11 P.M. 5 days (out of 17) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M. 8 days (out of 17) all ADL care areas were left blank. Resident #3 was admitted to the facility in February 2025, diagnoses included anemia (low red blood cells) osteoarthritis of the right and left knee (cartilage at the ends of bones has worn down), diabetes mellitus (trouble controlling blood sugar), bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs), hypertension (high blood pressure), and atrial fibrillation (irregular heart beat). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's Minimum Data Set (MDS) Admission Assessment (a comprehensive assessment of each resident's functional capabilities), dated 02/9/25, indicated he/she was dependent on staff assistance for all ADLs, bed positioning, transfers and mobility. Review of Resident #3's ADL Flow Sheet (CNA documentation) dated 02/03/25 through 02/28/25, indicated for the following shifts, documentation was incomplete: -3:00 P.M. to 11:00 P.M. 11 days (out of 26) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M. 10 days (out of 26) all ADL care areas were left blank. During an interview on 05/15/25 at 9:15 A.M., Unit Manager #1 said the CNAs are responsible for completing documentation on the ADL flow sheet by the end of their shift.