STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225262	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at West Springfield LLC	42 Prospect Avenue West Springfield, MA 01089

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to determine that a significant change in status/ condition had occurred and ensure that a Significant Change in Status Minimum Data Set [MDS] Assessment (SCSA) was completed for two Residents (#105 and #52) out of a total sample of 23 residents. Specifically, the facility failed to identify and complete a SCSA:1. for Resident #105, when a significant change of functional decline in several ADL areas and bowel and bladder continence occurred for the Resident. 2. for Resident #52, when a significant change in mood, toileting, and activities of daily living (ADLs) occurred for the Resident. Findings include:Review of the facility policy titled Comprehensive Assessments, revised March 2022, indicated: -Comprehensive assessments are conducted to assist in developing person-centered care plans. -Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual. -Significant change in status assessment – the SCSA is a comprehensive assessment for a resident that must be completed when the IDT [Interdisciplinary Team] has determined that a resident meets the significant change guidelines for either major improvement or decline. -A significant change is a major decline or improvement in a resident's status that: >will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. The decline is not considered self-limiting; >impacts more than one area of the resident's health status, and >requires interdisciplinary review and/or revision of the care plan. 1. Resident #105 was admitted to the facility in June 2025 with diagnoses including Vascular Dementia. Review of the admission assessment dated [DATE], indicated Resident #105: -was independent for eating -required supervision for toilet hygiene -required moderate assistance for transfers (continued on next page)

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was independent for bed mobility -required supervision for ambulation -was independent for personal hygiene -was continent of bladder -was continent of bowel Review of the Quarterly MDS assessment dated [DATE], indicated Resident #105: -required moderate assistance for eating (changed from 7/9/25 assessment) -was dependent on staff for toilet hygiene (changed from 7/9/25 assessment) -was dependent on staff for transfers (changed from 7/9/25 assessment) -was dependent on staff for bed mobility (changed from 7/9/25 assessment) -required moderate assistance from staff for ambulation (changed from 7/9/25 assessment) -was dependent on staff for personal hygiene (changed from 7/9/25 assessment) -was frequently incontinent of bladder -was occasionally incontinent of bowel Review of Resident #105's medical record failed to indicate that a SCSA had been completed after the resident had a decline in activities of daily living (ADLs) and continence that was not self-limiting from June 2025 to September 2025. During an interview on 12/10/25 at 11:32 A.M., Unit Manager (UM) #1 said that Resident #105 has had a decline since admission in June 2025 and is requiring more assistance from staff for ADLs. During an interview on 12/10/25 at 12:57 P.M., the MDS Nurse said she should have evaluated Resident #105 for a significant change when she completed the Quarterly Assessment on 9/17/25. The MDS Nurse said that a SCSA should have been completed because the Resident had a functional decline in several ADL areas and continence. 2. Review of the facility policy titled, Comprehensive Care Plan, undated, indicated but was not limited to the following: -An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. -Our facility's Care Planning/Interdisciplinary Team, in accordance with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. -Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Areas Assessment) before interventions are added to the care plan. -Assessment of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. -The Care Planning/Interdisciplinary Team along with the resident/representative is responsible for the review and updating of care plans: <When there has been a significant change in the resident's condition <When the desired outcome is not met <When the resident has been readmitted to the facility from a hospital stay; and <At least quarterly Review of the facility policy titled Functional Impairment Clinical Protocol, revised, September 2012, indicated but was limited to: Upon admission to the facility, at any time a significant change of condition occurs, and periodically during a resident's stay, the physician and staff will assess the resident's physical condition and functional status. <The physician will help identify individuals who have had a recent history of functional decline and those who are at risk for additional decline. <The staff will identify individuals with a significant decline in function, including ability to perform activities of daily living (ADLs). -As appropriate, the physician and other staff will identify and evaluate the individual's co-morbidities, conditions causing functional decline, symptoms, risks, impairments, and disabilities, and investigate their causes. -The physician should order consultation and professional evaluations that are appropriate for the resident's condition. -The physician and staff will evaluate the resident for complications secondary to functional decline and/or immobility, such as: <Incontinence -The physician and staff will review the results and implications of these evaluations and use them to guide subsequent care planning. <The physician will help identify and explain medical causes of functional decline and/or why (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functional decline might be medically unavoidable. - The physician, nurse or therapist may initiate screening for the potential to benefit from rehabilitative services such as physical and occupational therapy. - Following the screening, the therapist will document whether the resident may benefit from a more detailed rehabilitation evaluation or from unskilled therapy (example (e.g.,) restorative nursing services that can be provided by caregivers or exercises with which family members can assist). - If a potential to benefit from rehabilitation therapies (either skilled or unskilled) is identified, the attending physician will order a relevant therapy evaluation (for example, by the physical or occupational therapist) Resident #52 was admitted to the facility in December 2024 with diagnoses including Cerebral Palsy, Acquired absence of Right Leg Below Knee, Spondylosis, Lumbar Region, Need for Assistance with Personal care and anxiety disorder. Review of Resident #52's Quarterly MDS assessment dated [DATE], indicated that the Resident: -was feeling down or depressed 2 - 6 days -total severity score of 1 for Mood -had no behaviors. -required setup or clean up assist for personal hygiene. -oral hygiene was set-up clean up assistance -was occasionally incontinent of urine. -was always continent of bowels. Review of Resident #52's Annual MDS assessment dated [DATE], indicated that the Resident: -had little interest or pleasure in doing things -was feeling down or depressed 7 – 11 days (increased from 7/23/25) -was feeling tired or having little energy -had trouble concentrating on things such as reading the newspaper or watching the television -was moving or speaking so slowly that other people could have noticed. -total severity score was 11 for Mood (increased significantly from 7/23/25 assessment) -was dependent on staff for oral hygiene. (changed from 7/23/25 assessment) (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was dependent on staff for toilet hygiene. (changed from 7/23/25 assessment) -was dependent on staff for personal hygiene (changed from 7/23/25 assessment) - was always incontinent of urine (changed from 7/23/25 assessment) - was always incontinent of bowels. (changed from 7/23/25 assessment) During an interview on 12/11/25 at 12:56 P.M., the MDS Nurse said that she should have evaluated Resident #52 for a significant change when she completed the Annual assessment for 10/20/25. The MDS Nurse said that SCSA MDS Assessment should have been completed because the Resident had a functional decline in personal hygiene, bed mobility and toilet transfers. The MDS nurse said that she referred to the RAI manual for guidance. During an interview on 12/11/25 at 1:06 P.M., Unit Manager (UM) #2 said that she noticed that Resident #52 had declined in ADL care and required more assistance with care than before. UM #2 said that all care plans, care cards, and change in condition should be completed upon any change in ADL care for residents. UM #2 also said the Rehabilitation Department was notified about the change in ADL care and completed a screen requesting the Resident to be evaluated but the Rehabilitation Department had not completed an evaluation. UM #2 said she would provide evidence of the communication slip between her the Rehabilitation Department. The facility staff failed to provide any additional evidence to the surveyor at the time of survey exit.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to review, revise and implement a person-centered care plan relative to assistance with Activities of Daily Living (ADLs-self-care tasks like bathing, dressing, eating, toileting, transferring and continence which are essential for independence) for one Resident (#52), out of a total sample of 23 residents. Specifically, for Resident #52, the facility failed to assess and implement the Resident's request for the use of a commode for toileting in accordance with the needs, goals of care, and preferences that addressed the identified limitations in his/her ability to perform ADL's. Findings Include: Review of the facility's policy, titled Activities of Daily Living, dated December 2020, included but was not limited to:To provide support, assistance, and encouragement to remain as independent as possible with activities of daily living, including hygiene, mobility, elimination, dining, and communication; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values, and beliefs. -A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good grooming, and personal and oral hygiene. -Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that it was unavoidable. -The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living:<Mobility-transfer and ambulation, including walking<Elimination-toileting and incontinent care Resident #52 was admitted to the facility in July 2024 with diagnoses including need for assistance with personal care, Cerebral Palsy, Major Depressive Disorder with Severe Psychotic Feature, and Acquired Absence of Right Leg Below Knee Amputation. Review of Resident #52's Occupational Therapy (OT) Discharge Summary Records dated 1/3/25, indicated the following:-Toilet transfer not attempted due to medical condition or safety concerns.-Recommendation- toileting needs to be at bed level. Requires mechanical lift transfers. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #52:-has moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of nine out of 15 -had no rejection of evaluation or care-was dependent on staff to get on and off a toilet or commode-was occasionally incontinent of bladder-was always incontinent of bowel, not on toileting program Review of Resident #52's ADL Care plan, initiated 7/17/24 and revised 7/18/25, indicated the following under Toilet Use:-Dependent on staff for toileting, revised 7/18/25-Able to use the commode in room, revised 7/18/25-Commode to be against the wall for stability, revised 7/18/25-Encourage to participate to the fullest extent possible with each interaction, revised 7/18/25-Physical Therapy (PT)/Occupational Therapy (OT) evaluation and treatment as per Medical Doctor (MD) orders. Review of Resident #52's Certified Nurse Aide (CNA) Care Card dated 12/1/25, indicated the following:-Bladder incontinent-Bowel incontinent >Toilet Use -Dependent -Briefs On 10/2/25 at 8:19 A.M., the surveyor observed Resident #52 in his/her bedroom lying in bed. During an interview at the time, the Resident said that he/she was dependent on staff for toileting needs and wishes to use the commode, but staff would always give him/her a bed pan. On 10/2/25 at 12:07 P.M., the surveyor observed Resident #52 in his/her bedroom. Resident #52 said that he/she was dependent on staff to use the bathroom, and staff typically gives him/her a bedpan. Resident #52 also said staff use a mechanical lift to transfer him/her in and out of bed and that staff were unable to assist him/her out of bed in order to use the commode, and he/she wished to use the commode instead of a bed pan. On 12/11/25 at 8:28 A.M., the surveyor observed Resident #52 lying in bed in his/her bedroom. During an interview at the time, the Resident said he/she wished to use the commode when needed, but he/she would be offered a bed pan if he/she wanted to use the bathroom (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and that the bed pan was uncomfortable. On 12/11/25 at 8:40 A.M., the surveyor observed CNA #9 enter Resident #52's room and closed the door behind her.During an interview on 12/11/25 at 9:02 A.M., CNA #9 said that she was unfamiliar with Resident #52 as she was agency staff. CNA #9 said that she typically asks other staff members about the type of assistance Resident #52 required for daily care. CNA #9 said Resident #52 was incontinent of bowel and bladder and used adult briefs. CNA #9 said typically staff would assist Resident #52 with toilet use by using a mechanical lift to transfer the Resident to bed to provide incontinent care and then assist the Resident back to his/her wheelchair using the mechanical lift. CNA #9 also said that Resident #52 was dependent on staff for care. CNA #9 said that she provided ADL care for the Resident because the Resident had an appointment. During an interview on 12/11/25 at 9:15 A.M., Unit Manager (UM) #2 said that Resident #52 was dependent on staff for care. UM #2 said Resident #52 required a mechanical lift and two staff assist for transfers. UM #2 also said that staff should transfer the Resident to the bathroom for toilet use. UM #2 further said that Resident #52 would at times be transferred to bed for incontinent care. During an interview on 12/11/25 at 9:45 A.M., the Rehabilitation Service Director said Resident #52 had not used a commode since he/she had right below the knee amputation surgery in December 2024. The Rehabilitation Service Director said the department attempted the use of a slide board transfer to the chair in January 2025 after the surgery and was unsuccessful. The Rehabilitation Service Director said Resident #52's care plan had not been updated to reflect the Resident's status and should have been. The Rehabilitation Service Director further said that she was unaware Resident #52 had made requests to use the commode. The Rehabilitation Service Director said that the therapy department and/or the Physician were not aware of Resident #52's inability to use the commode and had not attempted to evaluate or assess the Resident's desire to be transferred to a commode for him/her to be able to move his/bowels. During an interview on 12/11/25 at 10:03 A.M., the MDS Nurse said Resident #52 was able to use the commode previously that is why he/she was care planned to use the commode. The MDS Nurse said Resident #52 should have been assessed after his/her amputation by the interdisciplinary team (IDT) but had not done so. The MDS Nurse further said that unit managers were responsible for updating and revising the care plans. During an interview on 12/11/25 at 10:35 A.M., the Resident's Healthcare Proxy (HCP) said that Resident #52 had expressed the wish to use the commode to him/her. The HCP said that the IDT had informed him/her that the Resident required a mechanical lift for transfers and that they could not provide a commode for the Resident's use. The HCP further said that the facility had not discussed any attempts that they had evaluated or attempted to assist the Resident to use the commode. During an interview on 12/11/25 at 1:06 P.M., UM #2 said that she noticed that Resident #52 had declined in ADL care and required more assistance with care than he/she was before. UM #2 further said the Resident was being provided with a brief to defecate or urinate on him/herself so that he/she would call and be cleaned. During an interview on 12/11/25 at 1:33 P.M., the Rehabilitation Service Director said that the department would complete a screen when the department receives notice of a change in function for a Resident. The Rehabilitation Service Director said that therapy should have done an assessment to determine the Resident's functional ability, but they did not.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that one Resident (#23), out of total sample of 23 residents was provided assistance with personal hygiene. Specifically, for Resident #23, the facility failed to ensure that the Resident, who required ADL assistance was offered and/or provided with grooming assistance for the removal of unwanted facial hair. Findings include:Review of the facility's policy titled, Activities of Daily Living (ADLs), revised December 2022, indicated:-A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.-The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living.-The facility will provide care and services for the following activities of daily living:<hygiene, bathing, dressing, grooming and oral care. Resident #23 was admitted to the facility in November 2024 with diagnoses including Unspecified Dementia and Anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #23:-had moderate cognitive impairment impaired as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 9 out of a possible score of 15.-required assistance with personal hygiene. Review of Resident #23's Certified Nurse Aide (CNA)'s Care Card (identifies the care to be provided to residents), indicated that the Resident needed physical assistance for grooming. Review of Resident #23's Activities of Daily Living (ADLs) Flow Sheet documentation for December 2025 indicated that the Resident was a physical assist for grooming. Review of Resident #23's ADL Care Plan, initiated on 10/9/24, indicated the Resident required assistance with bathing, grooming, dressing, hygiene, toileting tasks, and that staff would continue to provide support/assistance needed for ADL completion. Review of Resident #23's comprehensive medical record indicated an invoked Healthcare Proxy (HCP) (a healthcare decision maker - person who makes important personal and healthcare decisions for an adult who lacks the capacity to make their own decisions) for an incapacitated person, effective 1/12/22. On 10/1/25 at 9:16 A.M., the surveyor observed Resident #23 was dressed for the day and watching television in his/her room. The surveyor observed the Resident to have approximately 1.5 inches length of facial hair spread sparsely on the upper lip and chin. During an interview at the time, Resident #23 said he/she does not like any facial hair and that he/she was waiting for family to assist with the removal of his/her unwanted facial hair. On 12/10/25 at 9:21 A.M., the surveyor observed Resident #23 was dressed for the day and reclining in his/her room. The surveyor observed that the Resident's facial hair was denser and longer than previously observed on 10/1/25 and was now covering the upper lip and the entire chin area. During an interview on 12/10/25 at 9:22 A.M., Certified Nurse Aide (CNA) #2 said she was assigned to the Resident but had not noted Resident #23's facial hair. During an interview on 12/10/25 at 9:25 A.M., Unit Manager (UM) #1 said it was his expectation that the CNAs would provide grooming to Residents which includes removing unwanted facial hair. UM #1 further said that he had not observed Resident #23 to have facial hair. During a telephone interview on 12/10/25 at 10:16 A.M., Resident #23's HCP said he/she had not visited the Resident recently but knew his/her family member would not like any facial hair. During an interview on 12/10/25 at 10:23 A.M., CNA #1 said she had provided ADL care to Resident #23 that morning but had not noticed that the Resident had facial hair. CNA #1 said she would go back to the Resident's room, observe him/her, and check back with the surveyor. During an interview on 12/10/25 at 10:40 A.M., CNA #1 said Resident #23's facial hair was gross. CNA #1 said she had only provided bathing and dressing for Resident #23 that morning and that the Resident was on CNA #2's assignment. During an interview on 12/10/25 at 10:53 A.M., the Director of Nursing (DON) said it was her expectation for all residents to receive the necessary care. The DON further said Resident #23 should have been assisted with his/her facial hair removal but was not.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews and record reviews, the facility failed to ensure that controlled medication (medication that fall under the United States Drug Enforcement Administration (DEA) Schedules II-V, and have a potential for abuse) records were accurately maintained for a Controlled Substance Book on one unit (Unit Two) out of four units Controlled Substance Books reviewed.Specifically, the facility failed to accurately document the transfer, destruction, and removal of controlled substance medications (Oxycodone and Tramadol) for four residents in the Controlled Substance Book for Unit Two. Findings include:Review of the facility policy titled, Disposal of Medications and Medication-Related Supplies: Controlled Substance Disposal, effective January 2024, included but was not limited to:-Policy: Medications included in the DEA classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations.-Procedures:<Disposition is documented on the individual controlled substance Accountability Record/book.<The Administrator, nurse(s) and/or pharmacist witnessing the destruction ensures that the following information is entered on the individual controlled substance accountability record/book:1) Date of destruction2) Resident's name3) Name and strength of medication4) Prescription number5) Amount of medication destroyed6) Signatures of witnesses On 12/11/25 at 2:08 P.M., the surveyor and Nurse #6 observed the Controlled Substance Book on Unit Two and randomly reviewed seven individual controlled substance accountability records within the Controlled Substance Book, with the following findings:-Page #49 indicated a resident had four tablets of Oxycodone (opioid/narcotic pain medication) remaining for administration. Nurse #6 was unable to locate the four tablets in the medication cart's lock box.-Page #54 indicated a resident had seven tablets of Tramadol (opioid/ analgesic pain medication) remaining for administration. Nurse #6 was unable to locate the seven tablets in the medication cart's lock box.-Page #70 indicated a resident had 27 tablets of Oxycodone remaining for administration. Nurse #6 was unable to locate the 27 tablets in the medication cart's lock box.-Page #73 indicated a resident had 27 tablets of Oxycodone remaining for administration. Nurse #6 was unable to locate the 27 tablets in the medication cart's lock box.During an interview at the time, Nurse #6 said that these four identified controlled substances should have been in the medication cart's lock box according to the documentation on the designated pages in the Controlled Substance Book, but the medications were not found in the lock box. During an interview on 12/11/25 at 2:20 P.M., Nurse #5 said that according to the Controlled Substance Book index on Unit 2, two of the four identified controlled substances had been destroyed. Nurse #5 said that the controlled substances designated pages in the Controlled Substance Book should have had documentation to reflect the destruction of these controlled substances and did not have the documentation. Nurse #5 said that two of the identified controlled substances were likely transferred to another Controlled Substance Book in the facility because the residents had moved to another unit. Nurse #5 said that when a controlled substance was destroyed, destruction was indicated in the index of the Controlled Substance Book, as well as on the controlled substance's designated page in the Controlled Substance Book. Nurse #5 said that an x was written across the entirety of the designated page, and two Nurses signed under the section titled Medication Destroyed located at the bottom of the page. During an interview on 12/11/25 at 3:15 P.M., the Director of Nursing (DON) said that an investigation had been performed to determine the status of the four identified controlled substances on Unit Two. The DON said the findings of the investigation were as follows:-The four tablets of Oxycodone on page #49 had been destroyed on 9/24/25.-The seven tablets of Tramadol on page #54 had been destroyed on 9/24/25.-The 27 tablets of Oxycodone on page #70 had been transferred to another medication cart's lock box.-The 27 tablets of Oxycodone on page #73 had been removed from the medication cart's lock box for destruction.The DON further said documentation was not completed for the four identified controlled substances on (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the designated pages in the Controlled Substance Book and should have been completed. The DON said the expectation was that when a controlled substance was removed from the medication cart's lock box, both the index and the designated page in the Controlled Substance Book were updated to reflect whether the controlled substance had been removed from the medication cart's lock box or destroyed. The DON said the documentation on the designated page in the Controlled Substance Book should have included the date of the removal or destruction, along with two Nurses' signatures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225262	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at West Springfield LLC	42 Prospect Avenue West Springfield, MA 01089

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure that medications were labeled and stored in accordance with currently accepted professional principles on one unit medication cart (Unit 4) out of a total of four medication carts reviewed. Specifically, the facility failed to ensure that four pre-poured medication tablets observed in a plastic medication cup and stored in the top drawer of the medication cart on Unit 4 was appropriately labeled to prevent accidental administration of the medication. Findings include: Review of the facility policy titled Storage of Medications, undated, included but was not limited to:-Medications and biologicals are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. -The provider pharmacy dispenses medications in containers that meet regulatory requirements, medications are kept in these containers.-All medications dispensed by the pharmacy are stored in the container with the pharmacy label. On 10/2/25 at 8:54 A.M., the surveyor and Nurse #4 observed the following on the Unit 4 medication cart: -One plastic medication cup with 4 tablets of medications in the cup that had no name and label. During an interview at the time, Nurse #4 said a resident had refused the medications earlier. Nurse #4 said that the resident wanted her to leave the medication on his/her bedside table. Nurse #4 said that she kept the medications in the medication cart to re-administer to the resident at a later time. Nurse #4 said the medication cart was locked and it was safe to leave the pre-poured medications inside the medication cart. During an interview on 10/2/25 at 9:05 A.M., Unit Manager (UM) #2 said that the Nurse should immediately destroy the medications if the resident had refused. UM #2 said that pre-pouring medications and leaving in the medication cart would lead to medication errors. During an interview on 10/2/25 at 10:20 A.M., the Director of Nursing (DON) said that the Nurse should have destroyed the medication when the resident refused and not leave pre-poured medications inside the medication cart. The DON said Nurses are not to pre-pour medication and leave inside the medication cart to prevent medication errors.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, and interview, the facility failed to adhere to infection control standards to prevent the transmission of communicable diseases and infections during two medication administration observations on one unit (Unit 4) out of four total units. Specifically, failed to adhere to infection control practices when:1. Nurse #4 was observed picking up a medication tablet that was dropped on the surface of an un-sanitized medication cart with a gloved hand and administered the medication to a resident during medication administration.2. Nurse #1 was observed picking up a medication that was dropped on an un-sanitized medication cart with his ungloved/un-sanitized hands and administering the medication to a resident during medication administration. Findings include: Review of the facility's policy titled Hand Hygiene, revised 2/23/22, indicated: -Use an alcohol-based hand rub before performing an aseptic task. -Before moving from work on a soiled body site to a clean body site. -After touching a patient's immediate environment. Review of the facility's policy titled, Medication Administration – general Guidelines, undated, indicated: -The person administering medications adheres to good hand hygiene, including prior to handling any medication. -Before and after administration of medications. -No medications are kept on top of cart. 1. On 10/2/25 at 8:47 A.M., the surveyor observed a medication administration being conducted by Nurse #4. The surveyor observed the following relevant to the surface of Nurse #4's medication administration cart: -A computer mouse on the surface of the cart -A pen being used by Nurse #4 to write on the surface of the cart -Nurse #4 was leaning and resting her forearms on the surface of the medication cart -Nurse #4 dropped a tablet on the surface of the medication cart when she opened the pill pack. -Nurse #4 donned a pair of gloves, picked up the tablet that was dropped and placed the tablet in a small plastic medication cup. -Nurse #4 administered the medication picked up from the medication cart surface to a resident. During an interview on 10/2/25 at 8:56 A.M., Nurse #4 said that she picked up the tablet that had dropped on the surface of the medication cart with gloves on her hands and administered the medication because it was safe for her to administer the medication. Nurse #4 said that she cleaned (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the surface of the medication cart prior to starting the shift but was unsure whether the medication cart surface was dirty or clean. During an interview on 10/2/25 at 9:05 A.M., Unit Manager (UM) #2 said that Nurse #4 should not have administered the medication that was dropped on the surface of the medication cart to the resident. UM #2 said that the medication cart was contaminated and dirty. UM #2 said that Nurse #4 should have destroyed the medication and removed a new medication from the pyxis to administer to the resident. During an interview on 10/2/25 at 10:20 A.M., the Director of Nursing (DON) said Nurse #4 should have destroyed the medication that was dropped on the surface of the medication cart and not administered the medication to the resident. The DON said that the medication had been contaminated from a dirty surface at the time. 2. On 12/10/25 at 4:06 P.M., the surveyor observed a medication administration being conducted by Nurse #1. The surveyor observed the following on the surface of Nurse #1's medication administration cart: - - Finger stick glucose machine (glucometer) -Lancets - -Test strips for the glucose machine - -Portable blood pressure cuff machine - -Jug of water - -Multiple assorted juices >Nurse #1 proceeded to begin medication administration to a resident and performed the following: -obtained the resident's blood pressure using the portable blood pressure machine. -returned the portable blood pressure machine and placed the machine back on top of the medication administration cart. -did not disinfect the blood pressure machine with any cleaning agent or perform any hand hygiene. -documented the resident's blood pressure reading and placed the blood pressure machine to the right side of the medication cart surface. -opened a medication to place in a medication administration cup. -dropped the medication on the surface of the medication administration cart. -picked up the dropped medication with his fingers and placed the medication in the medication administration cup. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-handed the medication cup to the resident and the resident swallowed the medication. During an interview on 12/10/25 at 4:25 P.M., Nurse #1 said he had dropped the medication and picked the medication up with his bare hands without wearing gloves or sanitizing his hands. Nurse #1 said the medication administration cart was not clean and that he had not disinfected the medication administration cart. Nurse #1 said he should not have administered the dropped medication to the resident, but he did. During an interview on 12/11/25 at 11:02 A.M., the Director of Nursing (DON) said Nurse #1 informed her of the poor infection control practice on 12/10/25. The DON said Nurse #1 should have observed infection control practices during the medication administration process. The DON further said Nurse #1 should not have administered the medication that was dropped on an un-sanitized medication cart, which he picked with his/her ungloved and un-sanitized hands.