STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225265	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Hampden LLC	34 Main Street Hampden, MA 01036

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37400 Based on observation, and interview, the facility failed to ensure a homelike environment for resident dining on three units (South Unit, North Unit and East Unit) of three units observed. Specifically, the facility failed to: -provide meals and/or meal assistance timely to Residents (#23, #59, #3, and #11), who were seated with other residents during meals. -remove resident meals off the meal trays before serving meals during communal dining. Findings include: On 2/4/25 from 8:10 A.M. through 8:48 A.M., the surveyors observed the following: a. On the South Unit: -8:10 A.M., the meal cart arrived and breakfast meal trays were provided to residents seated in the day room. Resident #23 was seated at a table in the day room with another resident who was provided with his/her breakfast meal. Resident #23 was awake, dressed and seated in a modified wheelchair at the time and was not provided with a breakfast tray. -8:30 A.M., Resident #23 was provided with his/her breakfast meal tray (20 minutes after another resident seated at the same table). Staff were observed to sit beside Resident #23 and assist him/her with the breakfast meal. The resident who was seated at the same table with Resident #23 had finished the breakfast meal at this time. -All breakfast meals provided to residents in the day room were served on meal trays. b. On the North Unit: -Approximately 8:35 A.M., numerous residents were observed in the Lounge area and the day room across from the Lounge area. (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
	225265	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Hampden LLC	34 Main Street Hampden, MA 01036

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The breakfast meals for the residents in the Lounge area and the day room were served on meal trays. c. On the East Unit: -8:27 A.M., the first meal cart arrived on the unit. Seven residents were observed in the day room. One of the seven residents received their breakfast meal. Two other residents were observed seated at the same table as the served resident and were not provided with their meals at the time. -8:35 A.M., the second meal cart arrived on the unit. -8:36 A.M. through 8:38 A.M., meals were provided to the two residents who were seated next to the resident previously served his/her meal and was eating (9 and 11 minutes later respectively) -8:48 A.M., all breakfast meals were provided to the remaining residents in the day room. -All of the breakfast meals provided to the residents in the day room were served on meal trays. On 2/5/25 from 12:01 P.M. through 12:18 P.M., the surveyors observed the following: a. On the South Unit: -12:01 P.M., 14 residents were observed in the day room and four residents were seated at a small table in the alcove near the nursing station. Two of the four residents seated at the dining table in the alcove had their lunch meals and were being assisted by staff while the other two residents seated at the table did not have their meals. One of the 14 residents in the day room was observed without a meal and was seated among other residents who were eating and/or being assisted by staff. During an interview at 12:06 P.M., Nurse #2 said the residents without a lunch tray need assistance from staff to eat. Nurse #2 said the residents' lunch trays are on the meal cart at this time. -12:10 P.M., (9 minutes later), the three residents (two residents in the alcove area and one resident in the day room) previously observed without their lunch meals were provided assistance with their lunch meal. -All of the lunch meals provided to the residents in the day room and alcove area were served on meal trays. b. On the North Unit: -12:17 P.M., ten residents were seated in the Lounge area at tables or with tray tables positioned in front of them. -12:18 P.M., seven residents were observed in the day room. Resident #59 and Resident #3 were seated at a table across from each other. Resident #11 was seated next to the table in a modified wheelchair. Resident #59 was provided with his/her lunch tray and was being assisted by a Certified Nurses Aide (CNA). Resident #3 had a covered lunch tray in front of him/her and was not being assisted. Resident #11 did not have a lunch meal provided at the time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225265	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Hampden LLC	34 Main Street Hampden, MA 01036

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12:20 P.M., Resident #11 was observed to call out Nurse give me mine. When the surveyor asked Resident #11 what he/she was looking for, the CNA who was assisting Resident #59 said Resident #11 was looking for his/her lunch meal. -12:23 P.M., Resident #11 was provided his/her lunch tray and was assisted by a CNA. Resident #3's covered lunch tray remained positioned in front of him/her, and he/she was observed to be looking around. -12:29 P.M. (11 minutes later), Resident #3 was assisted with his/her lunch meal. -All of the lunch meals provided to the residents in the Lounge area and the day room were served on meal trays. c. On the East Unit: - 12:18 P.M., the residents seated in the day room for lunch were served on meal trays. On 2/7/25 from 7:51 A.M. through 8:34 A.M. the surveyors observed the following: a. On the South Unit: -7:51 A.M., the first meal cart arrived on the unit. Numerous residents were observed in the day room seated at tables or in chairs/wheelchairs with tray tables positioned in front of them. Several residents were also observed at the table in the alcove near the nursing station. -8:19 A.M., all residents were provided their breakfast meals and were eating or being assisted by staff. -All of the breakfast meals provided to residents in the day room and alcove area were served on meal trays. b. On the North Unit: -7:54 A.M., the first meal cart arrived on the unit. Three residents were observed in the day room and eight residents were observed in the Lounge area. Staff were observed starting to distribute the breakfast meals. -8:07 A.M., the second meal cart arrived to the unit. -8:16 A.M., Resident #59 was seated with Resident #3 at a table in the day room. Resident #11 was positioned next to the table in a modified wheelchair. Resident #59 was provided with a covered meal tray at the time. -8:22 A.M., Resident #11 was provided with a covered breakfast tray on an overbed table which was positioned behind him/her. Resident #59 remained seated with the covered breakfast tray positioned in front of him/her. Resident #3 did not have a meal, was awake and observed to be looking around the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225265	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Hampden LLC	34 Main Street Hampden, MA 01036

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8:25 A.M., Resident #11 was provided assistance with his/her breakfast meal. -8:32 A.M., Resident #59 was provided assistance with his/her breakfast meal (16 minutes after being provided the breakfast tray). Resident #3 remained without a meal. -8:34 A.M., Resident #3 was provided with his/her breakfast meal and was assisted by a CNA. -All of the breakfast meals provided to residents seated in the Lounge area and day room were served on meal trays. During an interview on 2/7/25 at 9:20 A.M., CNA #1 who worked regularly at the facility, said the resident meals have always been served on meal trays. During an interview on 2/7/25 at 9:52 A.M., Unit Manager (UM) #1 said the residents who eat in the communal areas on the North and South Units have always been served on meal trays. UM #1 said she was made aware of the concerns about some of the residents who were seated at tables without being provided assistance or without a meal and said this should not occur. UM #1 said a covered meal tray should not be provided to a resident until assistance could be provided. UM #1 further said serving meals on trays was not homelike for the residents and she could understand the concern. During an interview on 2/7/25 at 10:37 A.M., with UM #1, the Assistant Director of Nurses (ADON) and the Director of Nursing (DON), the DON said the residents who eat in the communal areas have been served on meal trays since she could remember. The DON said she was not sure why this was, and that she could understand why this was not homelike and could be a dignity concern. UM #1 said they have also started discussing having assigned seating for the tables so that residents who are able to converse and feed themselves can be seated together and those that need assistance from staff were provided with their meals and assistance at the same time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225265	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Hampden LLC	34 Main Street Hampden, MA 01036

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 37400 Based on observation, interview, and record review, the facility failed to ensure that one Resident (#37) out of a total sample of 19 residents, was free from physical restraints. Specifically, the facility failed to ensure that Resident #37 was assessed for the use of a rectangular cushion, which was positioned on his/her right side of the bed under the fitted sheet, and being used to prevent the Resident from putting his/her feet over the side of the bed. Findings include: Review of the facility policy titled Use of Restraints, dated 2001, indicated restraints shall only be used for the safety and well-being of the resident (s) and only after other alternatives have been tried unsuccessfully. The policy also included the following: -restraints shall only be used to treat the resident's medical symptom (s) and never for discipline or staff convenience, or for the prevention of falls -when the use of a restraint is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. -Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. -if the resident cannot remove a device in the same manner in which the staff applied it given the resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint. -prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions that may improve the symptoms. -restraints should only be used upon the written order of a physician and after obtaining consent from the resident and/or representative . Resident #37 was admitted to the facility in July 2019 with diagnoses including Dementia with behavioral disturbance, lymphedema, abnormal gait and mobility and need for assistance with personal care. Review of the Falls Care Plan, initiated 1/20/20, included the following interventions: -Resident will attempt to self transfer, initiated 5/15/23 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225265	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Hampden LLC	34 Main Street Hampden, MA 01036

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-keep bed in lowest position with brakes locked, initiated 1/20/20 -keep call light and frequently used items within reach at all times, initiated 1/20/20 -non-skid socks on at all times, initiated 4/10/20 -pressure bed alarm while in bed, initiated 10/8/20 Review of Resident #37's Restraint Assessment, last completed on 2/17/21, indicated: -no restraints were in use. -bilateral side rails were in place for transfers and positioning. Review of the Side Rails Care Plan, initiated 3/20/22, indicated the Resident utilized 1/4 side rails for independent bed mobility enablers to feel safe and secure, and included the following intervention: -at no time should full side rails be used that restrict the Resident from being able to get in/out of bed, initiated 3/20/22 Review of the Minimum Data Set (MDS) Assessment, dated 1/14/25, indicated Resident #37: -had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 2 out of 15 -utilized a wheelchair -required substantial/maximum assistance of staff with activities of daily living (ADLs), repositioning and transfers -utilized a bed alarm daily -did not utilize restraints Review of the Nursing Evaluation, dated 1/17/25, indicated Resident #37: -was not independently mobile -had cognitive impairment -was a high risk for falls due to score of 12 (high risk - score of greater than or equal to 10) -1/4 side rails have been requested for use when the Resident was in bed -had periods of agitation and confusion and no alternatives to side rails have been tried -was likely to roll, slip or slide from bed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225265	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Hampden LLC	34 Main Street Hampden, MA 01036

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the February 2025 Physician's orders indicated the following: -pressure bed alarm at hour of sleep (HS) every evening shift, initiated 10/8/20 -two 1/4 side rails when in bed to assist with positioning and transfers, initiated 3/15/22 -elevate lower extremity when in bed every day and evening shift, initiated 5/5/23 -remove ace wraps from bilateral lower extremities at HS every night, initiated 10/30/24 -TEDS (Thrombo-embolic deterrent stockings) stockings or ace wraps after morning care every day for edema, initiated 11/21/24 Review of the Resident #37's current Certified Nurses Aide (CNA) Care Card (instructions for specific care) indicated the following under safety: -will attempt to self transfer -non-skid socks on at all times -pressure bed alarm while in bed On 2/4/25 at 8:51 A.M., the surveyor observed Resident #37 lying upright in bed during the breakfast meal. The surveyor observed the Resident's left side of the bed was against the wall and a bolster was on the Resident's entire right side. The surveyor observed that bilateral 1/4 side rails were positioned on both sides of the bed and a bed alarm was on the bedside table. On 2/5/25 at 9:16 A.M., the surveyor observed the following: -Resident #37 was dressed, and uncovered while lying in bed. -Bilateral 1/4 side rails were in place. -the Resident's left side of the bed was flush against the wall. -a bolster mattress (mattress with raised edges on the upper and lower sections. The middle of the mattress is flat to allow access out the bed) was in place. -a rectangular cushion was observed under the fitted sheet on the Resident's right side of the bed where the flat part of the mattress was. At this time, Unit Manager (UM) #1 entered the Resident's room, and the surveyor asked about the rectangular cushion positioned under the fitted sheet on the right side of the Resident's bed. UM #1 said she thought the rectangular cushion was probably under the fitted sheet so that the Resident was made aware of bed boundaries but she was not sure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225265	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Hampden LLC	34 Main Street Hampden, MA 01036

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 9:28 A.M., CNA #1, who regularly worked with Resident #37, said the Resident required assistance from staff to get in and out of bed. CNA #1 said the Resident no longer attempted to get out of bed anymore, but liked to hang his/her feet/legs over the edge of the bed. CNA #1 said Resident #37 had issues with edema (swelling), so the rectangular cushion was placed under the fitted sheet to prevent the Resident from putting his/her legs over the edge of the bed. CNA #1 said they had tried to use pillows on the bed, but the Resident kicks the pillows off the bed. On 2/7/25 at 8:43 A.M., the surveyor observed Resident #37's left side of the bed was against the wall, bilateral 1/4 side rails were in the up position and a bolster mattress was in place. The surveyor further observed a rectangular cushion was on the floor between the Resident's right side of the bed and the bedside table. The Resident was not in the room at the time. Resident #37 was observed up, dressed and in the common area seated in a wheelchair. During a follow-up interview on 2/7/25 at 9:22 A.M., CNA #1 said she worked the 7:00 A.M. to 3:00 P.M. shift and from 3:00 P.M. to 9:00 P.M. CNA #1 said when she worked the evening shift and assists Resident #37 to bed, she would put the rectangular cushion under the fitted sheet on the Resident's right side of the bed in the middle between the raised edges of the mattress. CNA #1 said when the rectangular cushion was in place, the Resident was unable to put his/her legs over the edge of the bed. CNA #1 said the Resident used to attempt to get out of bed without assistance, so he/she had a bed alarm, but no longer attempted to get out of bed. CNA #1 said the rectangular cushion was put into place about a month ago to prevent the Resident from putting his/her legs over the side of the bed. CNA #1 said it was discussed by the CNAs and relayed to the Nurses who were also in agreement. On 2/7/25 at 9:45 A.M., the surveyor and UM #1 observed the Resident's room and UM #1 said she was unaware that the rectangular cushion was being used for Resident #37 until it was observed on 2/5/25. UM #1 said if the rectangular cushion was put under the fitted sheet to prevent the Resident from putting his/her feet/legs over the side of the bed, it would be considered a restraint because the Resident should be able to move his/her legs at will. UM #1 said the Nurses have been applying wraps to the Resident's lower legs to assist in managing his/her edema, and that the Resident would not be able to remove the rectangular cushion because it was positioned under the fitted sheet. UM #1 said that if the rectangular cushion was an intervention that was going to be used, an assessment would need to be completed to determine if it was necessary and if it could be considered a potential restraint. UM #1 said if the rectangular cushion was assessed and indicated for use, the Resident's care plan would need to include this intervention. Review of the Resident's clinical record indicated no documented evidence for the use of the rectangular cushion, bolster mattress or the Resident's bed placement against the wall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225265	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Hampden LLC	34 Main Street Hampden, MA 01036

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/7/25 at 10:31 A.M., with UM #1, Assistant Director of Nurses (ADON) and the Director of Nursing (DON), the DON said the Resident's bolster mattress has a flattened surface in the middle to allow movement/access in and out of bed. The DON said if the rectangular cushion was placed under the Resident's fitted sheet (where the flattened mattress surface was), it would prevent the Resident's body from moving in and out of bed. The DON said if the rectangular cushion was going to be used as an intervention, it would need to be assessed and care planned. The DON said other interventions, like body pillows placed on top of the fitted sheet, that could be removed easily by the Resident could have been trialed first. The DON further said that a recent fall event had occurred in the facility and that the facility staff have been super aware in ensuring interventions were in place to prevent further resident falls, and that staff may be initiating interventions without communicating with management's awareness. The DON said education needed to be provided to the staff about devices that are going to be utilized for residents so that these devices can be assessed and if other options were more appropriate.