STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225286	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam East Rehab and Nursing	464 Main 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had an invoked Health Care Proxy (HCP), the facility failed to ensure they involved his/her Health Care Agent (HCA) in developing a discharge plan and failed to follow through with a referral to the appropriate home care agency.Findings include:Review of the Facility policy titled, Discharge Plan, dated as last revised 11/05/25, indicated the following:-The post-discharge plan will be developed by the care plan team with the assistance of the resident and his or her family.-The discharge plan will include:a description of the resident's and family's preferences for care, a description of how the resident and family will access and pay for such services, a description of how the care should be coordinated if continuing treatment involves multiple caregivers, the identity of specific resident needs after discharge (appropriate referrals are made by social services and documented in the medical record), and a description of how the resident and family need to prepare for the discharge.-Social Services will review the plan with the resident and family before the discharge is to take place.-A copy of the post-discharge plan will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records.Review of the Faility policy titled, Resident Transfer and Discharge, dated 10/16/23, indicated the following:-The Facility shall ensure the discharge or transfer is documented in the medical record and the appropriate information is communicated to the receiving health care institution or provider.-Information provided to the receiving provider shall include the following: Contact information of the practitioner responsible for the care of the resident, resident representative information, advance directive information, comprehensive care plan goals, and all other necessary information, including a copy of the resident's discharge summary and any other documentation to ensure a safe and effective transition of care. Resident #1 was admitted to the Facility in July 2025, diagnoses included Dementia and weakness.Review of Resident #1's Medical Record indicated it included a Physician Progress Note to Activate Health Care Proxy/Durable Power of Attorney for Health Care form, dated 06/11/25 (which indicated he/she was unable to make his/her own health care decisions).Review of Resident #1's Progress Notes indicated the following:-07/22/25, Utilization Review (UR) meeting held today, Resident #1 has refused all therapies and has a last covered day of 07/23/25 which the Health Care Proxy is appealing.- 07/29/25, UR meeting held today. Resident #1 continues to refuse to work with therapy, Blue Cross Blue Shield requested NOMNC (Notice of Medicare Non-Coverage) be issued today with last covered day of 07/31/25.During an interview on 11/21/25 at 2:00 P.M., Family Member #1 said she was Resident #1's HCA and had received both NOMNC letters and appealed both decisions. Family Member #1 said Medicare agreed to cover Resident #1 after the first appeal, but when she was notified the second time, she informed Facility's Social Worker that she could not afford to keep Resident #1 at the Facility and planned on taking him/her home on [DATE]. Family Member #1 said the Facility staff did not involve her in developing a safe discharge plan to determine the level of support Resident #1 would need at home, did not initiate a discharge meeting with her and did not arrange home health services for Resident #1. Family Member #1 said after Resident #1 was sent home, it was apparent he/she needed home health (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services as well as a hospital bed. Family Member #1 said she took it upon herself to contact Resident #1's Primary Care Physician to obtain a referral to a home health agency to arrange for nursing, physical and occupational therapy, and to arrange for Resident #1 to have a hospital bed delivered to his/her home. Family Member #1 said had the Facility involved her in the details of Resident #1's care needs and discharge planning, there would not have been a delay in receiving services post-discharge.Review of Resident #1's Discharge summary, dated [DATE], under the section Home Health, indicated he/she was referred to a Home Health Agency for Nursing, Physical, and Occupational Therapy services, and indicated there was no DME (durable medical equipment, such as a hospital bed) needed.During a telephone interview on 11/25/25 at 1:00 P.M., the Director of Social Services (DSS) said she was the member of the Interdisciplinary Team (IDT) who was responsible for discharge planning. The DSS said her responsibilities included but were not limited to initiating and managing referrals to outside agencies, ensuring a discharge plan of care is developed with the collaboration of the IDT, the resident (if able), and their representative and caregivers. The DSS said a final discharge meeting for a resident should be conducted with the resident and/or their representative prior to discharge to ensure a smooth transition once a resident is discharged from the facility.The DSS said she could not recall when discharge meetings were conducted for Resident #1 and said if there were, documentation of those meetings would be scanned and uploaded to his/her electronic health record (EHR).The DSS said when a resident discharges, the IDT is required to complete a Discharge Summary, and that she was responsible for the completion of the Home Health, DME and Community Services sections of the Discharge Summary.The DSS said she referred Resident #1 to a Home Care Agency prior to his/her discharge, said she informed that Agency that Resident #1 required nursing care, physical and occupational therapy, and said she sent pertinent discharge information to the Home Care Agency.The DSS said she could not remember the name of the Home Care Agency and said she had no documentation of the referral or documentation to support she sent Resident #1's discharge information to the Agency. The DSS further said she sent all of Resident #1's referral and discharge information to whichever Agency she documented on his/her discharge summary. During a telephone interview on 11/25/25 at 12:00 P.M., the Intake Specialist at the Home Health Agency listed on Resident #1's Discharge Summary said there was no record of Resident #1 being referred to their agency in July or August 2025.The surveyor informed the DSS that Agency listed on Resident #1's Discharge Summary had no record of having received a referral for Resident #1. The DSS was unable to provide any additional information as to which Home Care Agency she had contacted and/or sent documentation to on behalf of Resident #1, in preparation for his/her planned discharge.During an interview on 11/25/25 at 2:30 P.M., Unit Manager #1 said the DSS coordinates discharges and was responsible for referrals any Home Care Agency and communicating residents' discharge needs to those agencies. Unit Manager #1 said for short term residents, discharge planning begins immediately (upon admission) and the IDT meets weekly to discuss those residents, their progress, their ongoing needs and their anticipated discharge needs. Unit Manager #1 said discharge meetings should be conducted prior to a resident being discharged home and those in attendance should be the resident, their representative and/or caregivers, and members of the IDT, Unit Manager #1 said the meetings are intended to have everybody on the same page and to address any needs the resident may have.Unit Manager #1 said evidence of these meetings are documented, attendees sign the documentation, and the meeting information is then uploaded to the EHR. Unit Manager #1 reviewed Resident #1's EHR and said there was no documentation in the EHR to support that a discharge meeting was conducted for him/her.During an interview on 11/25/25 at 4:45 P.M. with the Administrator and the Director of Nursing (DON), the DON said that Resident #1 was admitted to the Facility for short-term rehabilitation with a plan to discharge to his/her home. The DON said discharge care plans should be developed with the IDT, residents and/or their representatives and discharge meetings should be conducted prior to a resident discharging home. The DON said there was no documentation in his/her EHR to support that a (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge care plan was developed for Resident #1 with the input of Family Member #1, or that a discharge meeting was conducted with the IDT and Family Member #1.The Administrator said the DSS did not document any referrals she made to Home Care Agencies or responses from those agencies and said there was no documentation in Resident #1's EHR to support the DSS sent pertinent discharge information to any Home Care Agencies to facilitate Resident #1's discharge home.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for three of three sampled residents (Resident #1, #2, and #3), the facility failed to ensure that a copy of their transfer discharge notifications were provided to the Office of the State Long Term Care Ombudsman, as required.Findings include:During a telephone interview on 11/21/25 at 11:58 A.M., the Ombudsman said the Facility has not provided copies of discharge and transfer notices to her office in several months. Specifically, the Ombudsman said she has not received any discharge notices since March 2025 and said she has not received any transfer notices since August 2025. Resident #1 was admitted to the Facility in July 2025, diagnoses included Dementia and weakness.Review of Resident #1's Medical Record indicated he/she was discharged home on [DATE].Resident #2 was admitted to the Facility in September 2025, diagnoses included soft tissue disorder and muscle weakness.Review of Resident #2's Medical Record indicated he/she was discharged home on [DATE].Resident #3 was admitted to the Facility in September 2025, diagnoses included Rhabdomyolysis (a medical condition in which damaged skeletal muscle breaks down rapidly), frequent falls and frequent falls.Review of Resident #3's Medical Record indicated he/she was transferred to the Hospital for evaluation and did not return to the Facility after his/her hospitalization.During a telephone interview on 11/25/25 at 1:00 P.M., the Director of Social Services (DSS) said she usually sends transfer notices to the Office of the Long-Term Care Ombudsman, and she said she did not know she was supposed to send copies of discharge notices. The DSS said she did not know if she sent a copy of Resident #3's transfer notice to the Ombudsman. During an interview on 11/25/25 at 4:45 P.M., with the Administrator and the Director of Nursing (DON), the DON said the DSS should be sending copies of discharge and transfer notices to the Long-Term Care Ombudsman office and that the DSS keeps all of the letters on file in a binder in the Social Services office.The DON retrieved and reviewed the binder with the surveyor and said there was a copy of a transfer notice for Resident #3 when he/she was transferred to the hospital but there was no documentation to support that the DSS had sent a copy of the notice to the Ombudsman. The DON said the DSS did not send discharge notices to the Ombudsman for Resident #1, Resident #2, and Resident #3.