

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Charlene Manor Extended Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 130 Colrain Road Greenfield, MA 01301	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>37227</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who was admitted to the Facility for a short term stay and had a history of aggression, the Facility failed to ensure Resident #1's Comprehensive Care Plan included interventions, goal and outcomes related to his/her inappropriate and aggressive behaviors directed at and involving other residents, and discharge planning.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Resident to Resident Altercation, dated as revised 03/20/09, indicated a system to follow-up on all altercations with an emphasis to prevent future altercations will be in place such as, care plans will be updated to incorporate recommendations from the formal incident review process in addition to immediate updates that may have occurred at the time of or proactively prior to the altercation.</p> <p>Review of the Facility Policy titled Care Planning, dated as revised 02/15/25, indicated that Care Planning includes a standardized discharge process to effectively transition a resident to their next level of care, including home, community, or alternate facility.</p> <p>Resident #1 was admitted to the Facility in November 2024, diagnoses included congestive heart failure, diabetes mellitus and bipolar disorder.</p> <p>Review of Resident #1's Admission Social Service Note, dated 12/02/24, indicated that Resident #1's goal was to be discharged to an apartment.</p> <p>Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 12/03/24, indicated Resident #1's goal was to return to the community.</p> <p>Resident #1's Quarterly MDS Assessment, dated 02/05/25, 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). The MDS indicated that Resident #1 was independent with mobility and Activities of Daily Living (ADLs).</p> <p>(continued on next page)</p>

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
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the MDS Assessment indicated that Resident #1 exhibited physical behavioral symptoms directed toward others on one to three days, and verbal behavioral symptoms directed toward others on four to six days, during the seven-day assessment period.</p> <p>Review of Resident #1's Nurses Notes, from 01/01/25 through 04/10/25, indicated progress notes included several behavioral incidents in which Resident #1 made inappropriate comments, used derogatory language, and directed insults toward residents and their family members in the resident common area, often disrupting the evening meal.</p> <p>Review of a Facility Incident Report, dated 02/18/25, indicated that at approximately 9:15 P.M., Resident #1 turned off Resident #2's television and said, Time to go to bed. The Report indicated that Resident #2 then turned the television back on with the volume muted, and that Resident #1 returned to Resident #2's side of the room and turned his/her television off again. The Report indicated that Resident #1 struck Resident #2 on the shin with the television remote control and that Resident #2's right shin was noted to be red and swollen. The Report further indicated that Resident #1 was sent to the emergency department to be evaluated by behavioral health.</p> <p>Review of Resident #1's Behavior Care Plan, reviewed on 03/20/25, indicated that although he/she had interventions and goals related to physical altercations and accusatory statements specific to staff member interactions, the care plan did not address goals and/or interventions specific to his/her adverse behaviors with other residents, which included resident to resident physical altercations, frequent episodes of verbal aggressive and inappropriate behaviors directed at residents in common areas.</p> <p>The Surveyor was unable to interview with Resident #1, as he/she no longer resided in the facility and was in Police custody after physically assaulting a resident.</p> <p>Further review of Resident #1's Comprehensive Care Plan indicated there was no documentation to support that it addressed goals and interventions specific to his/her potential, preferences and plans for discharge from the facility.</p> <p>During an interview on 05/06/24 at 3:32 P.M., Nurse #1, who worked regularly on Resident #1's Unit during the evening shift, said that Resident #1 often shared sexually explicit stories from his/her past with other residents while in the common areas and during meals. Nurse #1 said that redirecting Resident #1 often did not go well and resulted in him/her targeting the intervening staff member, making a scene and setting the tone for the evening meal.</p> <p>During a telephone interview on 05/08/25 at 10:16 A.M., Certified Nurse Aide (CNA) #1, who worked full time during the evening shift on Resident 1's unit, said that Resident #1 spent a lot of time in the resident common area. CNA #1 said that Resident #1 frequently disrupted mealtimes by calling other residents names or directing insults at them. CNA #1 said that these behaviors were difficult to redirect, often resulting in other residents choosing to remain in their rooms for the evening meal.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/06/25 at 3:03 P.M., the Social Worker said that there had been no formal discharge care plan for Resident #1, and to her understanding, he/she had declined any discharge placement other than section-eight housing, which typically had a waiting period of three years in the community. The Social Worker said that the Case Manager at Resident #1's insurance provider had been looking for placement at other long term care facilities.</p> <p>During an interview on 05/06/25 at 4:30 P.M., the Administrator said that Resident #1 was given a 30-day notice of a facility-initiated discharge on 03/03/25, based on his/her independent functional status, and that the notice was rescinded on 03/21/25 because a discharge location could not be established.</p> <p>During an interview on 05/06/25 at 4:45 P.M., the Director of Nurses (DON) said that Resident #1's Behavioral Care Plan should have addressed goals and interventions related to his/her verbally aggressive and inappropriate behaviors toward other residents and said that it should have been updated following his/her physical altercation with Resident #2, that occurred on 02/18/25.</p> <p>The DON further said that Resident #1 had been admitted for a short term stay and should have had a care plan in place that included goals and interventions to transition back into the community. The DON said that she was unaware that Resident #1's Comprehensive Care Plan did not address his/her discharge plan</p>		