STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225331	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Longmeadow Skilled Nursing Center	305 Maple Street East Longmeadow, MA 01028

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on observation, interview and record review, the facility failed to ensure a homelike environment was provided relative to dining for two Residents (#44 and #4) out of a total sample of 27 residents, on two of four units observed (Unit Three and Unit Four). Specifically, the facility failed to ensure: 1. -For Resident #44, that meals were provided timely when he/she was dining with other residents and that blood sugar (glucose) checks were not completed in the dining room. -that residents seated together in a dining area, were served their meals at the same time. 2. For Resident #4, that the Resident's preference for beverages was provided timely with meals. Findings include: 1. Resident #44 was admitted to the facility in February 2023 with diagnoses including Encephalopathy (disease in which the functioning of the brain is affected by some agent or condition such as a viral infection of toxins in the blood), Dementia with agitation (progressive or persistent loss of intellectual functioning and memory) and Type 2 Diabetes Mellitus (DM II: condition in which the body has difficulty controlling blood sugar [glucose] levels in the blood), and resided on Unit Four. Review of the Minimum Data Set (MDS) Assessment, dated 3/5/24, indicated Resident #44: -was severely cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 0 out of possible 15. -had upper and lower bilateral range of motion deficits. -required substantial/maximum assistance with eating. Review of the May 2024 Physician's orders included the following: -Check blood glucose levels with meals, initiated 4/17/24. (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/24 at 12:13 P.M., the surveyor observed Resident #44 seated at a table in the small dining area located on Unit Four with two other residents. The lunch meals were observed on a rack positioned in the hallway and the facility staff were observed passing meal trays. One of the residents seated with Resident #44 was provided with his/her meal, was assisted with set up by the staff and was observed to feed him/herself. Resident #44 and the other resident seated at the table were not provided with their lunch meals. At 12:18 P.M., Resident #44 was provided with his/her lunch meal. The surveyor observed Nurse #6 who was already wearing gloves, approach Resident #44 at this time, and informed the Resident that he/she needed to have a blood sugar check. Resident #44 had his/her lunch tray (which was covered) and was seated with two tablemates, one resident who was eating and the other resident who was still not provided a lunch meal. Nurse #6 was observed to obtain Resident #44's blood sugar reading using a glucometer (device used to measure the concentration of glucose in the blood). After obtaining the blood sugar reading, Nurse #6 said she was going to get some Insulin (medication used to regulate glucose level in the blood) to administer to the Resident. At 12:21 P.M., Nurse #6 returned to the dining room where Resident #44 remained seated with his/her tablemates who were eating lunch, holding a syringe containing Insulin. Resident #44's tray remained covered and was positioned in front of him/her. Nurse #6 told Resident #44 that his/her blood sugar was high and that he/she required Insulin prior to lunch. The Resident was observed refusing to have his/her Insulin administered at this time, was crying and said that he/she wanted to go home. Nurse #5, who was seated next to Resident #44 was observed to comfort him/her, uncover his/her lunch meal and encouraged the Resident to eat and offered assistance. At 12:33 P.M., (20 minutes later) the resident who was seated with Resident #44 was provided with his/her meal and was assisted by facility staff. On 5/2/24 at 12:14 P.M., the surveyor observed the lunch meal distribution on Unit Four. At 12:24 P.M., five residents were observed in the small dining room on the Unit, and Resident #44 was observed seated at a small table with three other residents. One of the residents seated with Resident #44 had his/her lunch meal and was observed to be eating. At 12:27 P.M., lunch trays were provided to Resident #44 and the remaining two residents seated at the table. Resident #44's tray was observed to be positioned in front of him/her and was covered. At 12:38 P.M., (14 minutes later), Nurse #5 was observed to sit next to Resident #44, uncover the lunch tray, and assist him/her with the lunch meal. During an interview on 5/3/24 at 3:28 P.M., Nurse #6 said that she was very familiar with Resident #44 and had provided care to him/her for about a year. Nurse #6 said Resident #44 was diabetic and required blood sugar checks before each meal. When the surveyor asked about the procedure for obtaining blood glucose levels, Nurse #6 said that she would approach the Resident, explain the procedure, conduct hand hygiene, put on gloves, and then proceed with checking the blood glucose level and administration of insulin. Nurse #6 said that this procedure should occur in the Resident's room to provide privacy. Nurse #6 said she should not have checked the Resident's blood glucose when he/she was seated in the dining room with other residents during the lunch meal on 5/1/24 and should have assisted the Resident back to his/her room to complete the task. During an interview on 5/7/24 at 1:40 P.M., the surveyor relayed the mealtime observations of Resident #44 to Unit Manager (UM) #2, who said that the Resident's blood glucose should be checked prior to the meal. UM #2 said the procedure should be completed in a private area, like the Resident's room and not when the Resident was seated at the dining room table with others who were eating. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/24 at 2:30 P.M., Certified Nurses Aide (CNA) #4 said that residents who eat in the dining room on Unit Four required assistance with their meals. CNA #4 said that the residents should not receive their meals unless there was staff there to assist them and that the residents should be served and assisted at the same time if seated together at a table. CNA #4 said that residents should not be seated at a table without a meal or without assistance and watching other residents eat. CNA #4 further said that trays are provided when serving residents their meals in the dining room, that staff do not offer to remove the meals from the trays. CNA #4 said he was not sure why staff do not offer to remove the meals from the trays because for other places he had worked, the staff have removed the trays because it provided a good dining experience. During an interview on 5/7/24 at 3:44 P.M., the Food Service Director (FSD) said that the facility had one dining area located on each unit where residents dine together, but there had not been a large communal dining area since he started in February 2022. The FSD said that residents either eat in their rooms or in the small dining rooms located on each unit. The FSD said he was not a part of the communal dining experience on the units, did not have a part in the dining experience once the food left the kitchen and thought that the unit staff were the ones overseeing the communal dining experience, but that he would like to be a part of the process. The surveyor requested the facility policy relative to the dining experience from the FSD at that time. During a follow-up interview on 5/7/24 at 3:46 P.M., the FSD said the facility did not have a policy relative to the resident dining experience. During an interview on 5/7/24 at 4:20 P.M., the Director of Nurses (DON) said that the nursing staff were responsible for assisting residents who required assistance with their meals. The DON said that residents' meals should be warm and to the residents' liking. The DON further said if residents are seated together in a dining area, they should be served at the same time. During an interview on 5/7/24 at 4:51 P.M., the surveyor relayed observations of the dining service with the Administrator. The Administrator said if meals were provided to residents, were within temperature, and there were no verbalizations from the residents that they wanted assistance with their meal, it would be reasonable to expect that residents may have to wait for their meals and/ or receive assistance with meals. 47901 2. Resident #4 was admitted to the facility in April 2023 with diagnoses including Cerebral Infarction (stroke: damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area) and Hyperlipidemia (elevated cholesterol in the blood) and resided on Unit Three. Review of Resident #4's MDS assessment dated [DATE], indicated the Resident had moderate cognitive impairment as evidenced by a BIMS score of 12 out of total possible 15. During an interview on 4/30/24 at 2:00 P.M., Resident #4 said that most of the time, the facility staff failed to provide him/her with coffee for his/her meals. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/24 at 12:55 P.M., Resident #4 said that he/she did not get coffee for his/her breakfast and lunch. Resident #4 further said that he/she had just finished eating his/her lunch. On 5/2/24 at 12:58 P.M., the surveyor observed CNA #8 walking in the hallway on Unit Three with the coffee/tea/hot chocolate beverage cart. The surveyor observed that CNA #8 went from room to room and passed coffee to the residents. During an interview at the time, CNA #8 said the residents had finished eating but the coffee/tea/hot chocolate beverages had not been passed with the lunch trays. CNA #8 said the facility staff were supposed to serve the coffee/tea/hot chocolate before the residents received their meal tray but this was not done. During an interview on 5/2/24 at 3:13 P.M., Unit Manager (UM) #3 said the coffee/tea/beverage cart should be served before the residents received their meals. During an interview on 5/2/24 at 3:36 P.M., the DON said that coffee/tea/hot chocolate beverages were served before the residents received their meals. On 5/7/24 at 8:50 A.M., the surveyor observed Resident #4 having breakfast in his/her room. The surveyor observed there was orange juice in a cup on the Resident's breakfast tray. Resident #4 said that he/she had asked for his/her coffee when the breakfast tray was delivered and was told the coffee would be delivered. On 5/7/24 at 9:04 A.M., the surveyor observed CNA #3 enter Resident #4's room and pick up and take away the Resident's meal tray. During an interview on 5/7/24 at 9:10 A.M., CNA #9 said there was not enough coffee mugs to finish the coffee/tea/hot chocolate beverage pass and that she could not serve Resident #4 his/her coffee and had informed Nurse #4. During an interview on 5/7/24 at 9:15 A.M., Nurse #4 said she had called down to the kitchen for coffee mugs but did not think Resident #4 drank coffee. Nurse #4 said she went and spoke with Resident #4 and said he/she had been waiting for coffee but never received it.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 47901 Based on interview and record review, the facility failed to coordinate an assessment with the Preadmission Screening and Resident Review (PASARR- a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. PASRR requires that: 1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs [in the community, a nursing facility, or acute care setting]; and 3) receive the services they need in those settings) program for one Resident (#76) out of a total sample of 27 residents. Specifically, the facility failed to complete a new Level I assessment for a change in condition timely and refer Resident #76 for a Resident Review (person-centered assessment taking into account all relevant information) when he/she had a significant change in condition, a new diagnosis of Schizoaffective Disorder (serious chronic mental illness, characterized by symptoms of Schizophrenia such as hallucinations or delusions and symptoms of a mood disorder such as mania and depression) while in the facility, and was being treated with an antipsychotic (used to treat symptoms of mental illness, including delusions, fixed, false conviction in something that is not real or shared by other people) medication. Findings include: Review of the facility's policy titled Preadmission Screening and Resident Review (PASARR) last revised 9/22/23, indicated: -Ensure that Level I screen was completed for all individuals before admission or upon significant change in condition. -Make referrals to the Department of Developmental Services (DDS) and or the Department of Mental Health (DMH)/Designees in a timely manner when required. -Resident significant change, must notify the state mental health authority or state intellectual disability authority, as applicable promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability (ID) for resident review. Resident #76 was admitted to the facility in February 2023, with diagnoses including Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and Anxiety (intense, excessive, and persistent worry and fear about everyday situations). Review of Resident #76's Level I PASARR evaluation dated 2/18/23, did not indicate that the Resident had diagnosis of Schizophrenia. Review of Resident #76's Psychiatric Evaluation dated 2/8/24, indicated that the Resident had a new diagnosis of Schizoaffective Disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/24 at 10:50 A.M., Social Worker (SW) #1 said Resident #76 needed a new PASRR Level I to be completed. During a follow-up interview on 5/1/24 at 11:07 A.M., SW #1 said Resident #76 had a new diagnosis of Schizoaffective Disorder on 2/8/24. SW #1 also said a new Level I PASARR should be completed, and a Resident Review should be requested from the PASARR office for Resident #76. SW #1 said the new Level I assessment had not been done, as required.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563 Based on observation, interview and record review, the facility failed to communicate and implement a Physician's recommendation to start medication for one Resident (#2) out of a total sample of 27 residents. Specifically, for Resident #2, the facility failed to verify the ordered dosage and frequency and appropriately communicate the Physician recommendation of Tylenol medication for pain management for the Resident, resulting in potential delay in treatment. Findings include: Resident #2 was admitted to the facility in October 2019 with the following diagnoses: Vascular Dementia (dementia resulting from impaired blood flow to the brain), Spinal Meningioma (a tumor in the thin membranes that cover the spinal cord), Idiopathic Peripheral Neuropathy (sensory disturbances in the limbs causing numbness, tingling, burning and/or weakness with no known cause) and Renal Mass (an undefined abnormal growth in the kidney that may or may not be cancerous). Review of Lippincott Manual of Nursing Practice - 11th Ed. (2019), Box 2-1 Common Legal Claims for Departure from Standards of Care included the following: -Failure to act as a patient advocate, such as not questioning illegible or incomplete medical orders Review of Resident #2's Minimum Data Set (MDS) assessment dated [DATE], indicated: -that the Resident was rarely/never understood -was severely cognitively impaired -had frequent physical, verbal and other behavioral symptoms Review of the Resident's Provider Progress Note dated 2/15/24, indicated that Resident #2 was noted repetitively biting his/her blanket and pulling the blanket through his/her mouth with no clear cause, and a recommendation was made to try scheduled Tylenol (medication to treat pain or fever) in the event that the Resident was experiencing pain that could not be conveyed (to caregivers). Review of the Resident's Provider Progress Note dated 4/25/24, indicated a recommendation had been given to try scheduled Tylenol for Resident #2 for a question of pain that could not be communicated (by the Resident). Review of the Resident's Physician's orders from February 2024 to May 2024 indicated no active or discontinued orders for Tylenol. Review of the Resident's Nursing Notes from February 2024 through May 2024 did not indicate any documented evidence that the Physician made a recommendation for scheduled Tylenol. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 3:54 P.M., the surveyor observed Resident #2 lying in bed, chewing on his/her blanket, then removing the blanket from his/her mouth and making grunting repetitive noises. On 5/3/24 at 10:55 A.M., the surveyor observed Resident #2 lying in bed fidgeting with the bedsheet. On 5/3/24 at 3:07 P.M., the surveyor observed the Resident lying in bed fidgeting with his/her blankets. On 5/7/24 at 8:06 A.M., the surveyor observed the Resident lying in bed, and grinding his/her teeth. During an interview on 5/7/24 at 9:47 A.M., Certified Nurses Aide (CNA) #6 said she had provided the Resident with a blanket with a device on it used for excessive chewing. CNA #6 said that the Resident did not use the blanket and instead continued to use his/her sheet or shirt to bite on repetitively. During an interview on 5/7/24 at 10:32 A.M., Nurse #8 said that he was familiar with Resident #2 and his/her care. Nurse #8 said when the Resident's Primary Care Physician (Physician #1) communicates with the nursing staff related to obtaining orders, she does not provide written orders, but relays the orders verbally to the nursing staff. Nurse #8 further said that Physician #1's visit progress notes were sometimes faxed to the facility, but orders were given verbally. During an interview on 5/7/24 at 3:59 P.M., Unit Manager (UM) #2 said typically when Physician #1 was in the facility, she sees the Resident, asks questions of the nursing staff if needed, then leaves and calls facility staff later in the day if there were orders or recommendations to implement. UM #2 said she could not say if Physician #1's recommendation to start scheduled Tylenol for Resident #2 was addressed. UM #2 said that the expectation relative to obtaining Physician orders was that the Nurse who received the order would enter the order into the Resident's medical record, and then would write a progress note indicating that a new order for the Resident was received. The surveyor and UM #2 reviewed Physician #1's Progress Note dated 2/15/24. UM #2 said that typically Physician #1's progress notes were sent to the facility 1-2 days after the visits, and upon receiving the Physician's notes, she would review them for recommendation/orders. UM #2 further said the Physician's Note dated 2/15/24 was not in the Resident's medical record, and if she had seen this specific note, she would have entered an order for Tylenol for Resident #2. During an interview on 5/7/24 at 4:11 P.M., the Director of Nurses (DON) said the recommendation for scheduled Tylenol referenced in Physician #1's Progress Note dated 2/15/24, she would expect the Nurse to clarify with Physician #1 or the on-call Provider the dose and the frequency of the scheduled Tylenol medication recommended for Resident #2. The DON said the dose and the frequency information was not included in the Physician recommendation therefore was not a complete order. The DON said the Nurse would be expected to document the clarification communication with Physician #1 in Resident #2's Nurses Progress Notes.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 37400 Based on observation, interview, record and policy review, the facility failed to ensure that Physician's orders were implemented for one Resident (#10), of seven applicable residents identified with pressure ulcers (injury to underlying tissue resulting from prolonged pressure on the skin), out of a total sample of 27 residents. Specifically, the facility failed to ensure that the Physician orders for the setting of a pressure reducing mattress (air mattress) was implemented for Resident #10, who had an existing pressure ulcer and remained bedbound (confined in bed). Findings include: Review of the Operation Manual for the Relief Alternating Pressure System with Low Air Loss, undated and provided by the facility, included the following: -the alternating pressure system with low air loss was designed to treat and prevent wounds by facilitating blood circulation and decreasing pressure of each tissue's contact area. -Always consult the Physician before using the mattress system. -Press the weight button to adjust the patient's weight from 100 pounds (lbs.) to 325 lbs. according to the patient's weight. Resident #10 was admitted to the facility in May 2022, with diagnoses including Dementia (progressive or persistent loss of intellectual functioning and memory) and Protein Calorie Malnutrition (state of inadequate intake of food including protein, calories and other essential nutrients). Review of the Minimum Data Set (MDS) Assessment, dated 1/3/24, indicated the following: -Resident #10 exhibited moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 9 out of a possible 15 -Required partial/moderate assistance from staff with rolling left/right -Required substantial/maximum assistance from staff with transfers -Was at risk for pressure ulcers -had a pressure-reducing device for the bed Review of the Potential for Skin Breakdown Care Plan, initiated 6/13/22, included the following intervention: -air mattress in place, initiated 3/13/24 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Initial Skin Observation Record, dated 2/8/24, indicated Resident #10 had a Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed or an intact or open/ruptured blister) present on his/her coccyx (small triangular bone at the base of the spinal column). Review of the May 2024 Physician's orders included the following: -Air Mattress every shift, ensure inflation and correct setting every shift. Setting at 100 (lbs.) based on weight and manufacturers' recommendations, initiated 3/13/24 Review of the Treatment Administration Record (TAR) from 4/1/24 through 5/6/24 indicated the Resident's air mattress inflation was checked by the nursing staff and was at the correct setting (100 lbs) every shift. On 4/30/24 at 10:12 A.M., the surveyor observed Resident #10 lying in bed with his/her eyes closed. The surveyor observed that an air mattress was in place and was set to 325 lbs. The sticker observed on the top of the air mattress pump box indicated the setting was to be 100 lbs. On 5/2/24 at 9:22 A.M., the surveyor observed the Resident lying in bed on his/her right side with eyes closed. The surveyor observed that an air mattress was in place and set to 325 lbs. On 5/3/24 at 7:37 A.M., the surveyor observed Resident #10 lying in bed with eyes closed. The air mattress was observed set to 325 lbs. Certified Nurses Aide (CNA) #5 entered the Resident's room during the surveyor observation. During an interview at the time, CNA #5 said that she worked with Resident #10 frequently and was very familiar with his/her care. CNA #5 said the Resident required total assistance from staff, did not typically get out of bed and that his/her family had requested to keep the Resident comfortable and allow him/her to sleep. CNA #5 said Resident #10 spent most of the time in bed sleeping. The surveyor and CNA #5 reviewed the Resident's air mattress setting at this time. CNA #5 said that it was set to 325 lbs. and should be at 100 lbs. per the sticker on the air mattress pump box. CNA #5 said the Nurses would be monitoring the setting of the air mattress to ensure it was at the correct setting, she was not sure why it was set incorrectly and would relay the observation to the Nurse. During an interview on 5/7/24 at 11:29 A.M., Nurse #5 said Resident #10's air mattress was monitored by the nursing staff every shift to ensure that it was set at the correct setting according to what was specified in the Physician's orders and determined by the Resident's weight. Nurse #5 said Resident #10 was ordered to be set at 100 lbs. The surveyor relayed previous observations of the Resident's air mattress set to 325 lbs., and Nurse # 5 said that it should not have been set to 325 lbs. because there was a Physician's order for the air mattress to be set at 100 lbs. During an interview on 5/7/24 at 1:44 P.M., Unit Manager (UM) #2 said Resident #10's air mattress was determined by his/her weight. UM #2 said that stickers were added to the air mattress pump box to remind staff of what the air mattress setting should be set at. UM #2 further said that the nursing staff were responsible for ensuring that the Resident's air mattress was set to the correct settings as ordered by the Physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on observation, interview, and policy review, the facility failed to provide an environment that was free of potential accidents and hazards for one Resident (#384), out of a total sample of 27 residents. Specifically, for Resident #384, the facility staff allowed the Resident to smoke in an undesignated area on the sidewalk in front of the building without any smoking safety equipment available for use in the event of an accidental fire in the vicinity. Findings include: Review of the facility's policy titled Resident Smoking, last revised 7/15/22, indicated the following: -The facility strived to maintain a safe, injury-free environment while respecting those residents who have expressed a desire to smoke. -Smoking is allowed only in designated locations to be determined in collaboration with the facility leadership and local fire chief. -Educate staff regarding the facility's smoking policy, designated smoking location and smoking schedule. -Adaptive equipment (cigarette holder, etc.) will be provided for the residents. -Protective equipment will be provided in the designated smoking location: fire blanket, safety ashtrays, fire extinguisher . Resident #384 was admitted to the facility in April 2024 with diagnoses including Malignant Neoplasm of the brain (brain cancer), Cerebral Infarction (stroke: damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area) and weakness. Review of Resident #384's Smoking assessment dated [DATE], indicated the Resident lacked adequate judgment towards his/her ability to smoke safely and that the Resident's Responsible Party accompanied when he/she went to smoke. Review of the Nursing Progress Note dated 4/26/24 at 4:57 P.M., indicated that Resident #384 would be allowed to smoke with family members outside of the facility. On 4/30/24 at 1:23 P.M., the surveyor observed Resident #384 seated in a wheelchair smoking on the sidewalk in front of the building with the Resident's Responsible Party holding an umbrella over his/her head while he/she was smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 2:24 P.M., the surveyor observed Resident #384 seated in a wheelchair smoking on the sidewalk in front of the building with the Resident's Responsible Party by his/her side. During an interview on 5/7/24 at 12:59 P.M., Unit Manager (UM) #3 said Resident #384 smoked on the sidewalk in front of the building. UM #3 further said there was no fire extinguisher, fire blanket or ash tray/receptacle in the location where the Resident was smoking. During an interview on 5/7/24 at 1:05 P.M., with UM #3, Resident #384 and his/her Responsible Party, the Resident and his/her Responsible Party said the facility staff had never informed them of the smoking area until today (5/7/24), when the Hospice Nurse educated them about utilizing the gazebo (a designated smoking area) away from the front of the building. During an interview on 5/7/24 at 2:09 P.M., Nurse #3 said Resident #384 had been observed smoking on the sidewalk in the front of the building. Nurse #3 said that she had provided the Resident with a smoking apron for safety, but there was no fire extinguisher or any other safety equipment in that location because the sidewalk was not a designated smoking area. During an interview on 5/7/24 at 2:21 P.M., the Administrator said the sidewalk in front of the building was not a designated smoking area. The Administrator said she had observed Resident #384 seated in that area but had not been made aware that the Resident had been smoking in the same area.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45435 Based on observation, interview and record review the facility failed to ensure they maintained an accurate and complete medical record for five Residents (#53, #99, #384, #42 and #9) out of a total sample of 27 residents. Specifically, the facility staff failed to: 1. For Resident #53, accurately document the Resident's status regarding being transferred to the hospital and returning to the facility after a blood transfusion. 2. For Resident #99, accurately document, and obtain the correct consent and Physician order for the specific type of side rails being utilized by the Resident. 3. For Resident #384, ensure that the indwelling Foley urinary catheter size accurately reflected the Physician ordered size Foley catheter. 4. For Resident #42, accurately document a dental procedure that was performed, and rationale for a prescribed antibiotic that was being administered to the Resident. 5. For Resident #9, document the Resident's refusals to have weekly wound measurements completed. Findings include: Review of the facility policy titled Documentation-Clinical, dated 10/31/23, indicated the following: -This facility meets Department of Public Health (DPH) requirement for weekly summary of resident condition by ensuring documentation of medication and treatment administration every shift, interdisciplinary progress notes as needed, skin evaluations weekly, and functional performance point of care documentation every shift. -Resident status, including change in condition, nursing or other services provided and resident response or progress will be documented as warranted. -If the condition of the resident calls for his/her transfer to an acute care facility, the date, time of admission, name of the healthcare facility and the mode of transportation surrounding the transfer will be documented in the nursing notes. 1. Resident #53 was admitted to the facility in April 2024 with the diagnosis of Congestive Heart Failure (CHF-a condition where the heart does not pump blood as well as it should, and fluid builds up in the lungs that can cause shortness of breath, in addition to arms, feet and other organs). Review of the Laboratory Blood Work Report dated 4/23/24, indicated the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hemoglobin (Hb: a protein in red blood cells that carries oxygen [normal level for males: 13.5 - 17.5 g/dL (grams per deciliter) and females: 11.6 - 15 g/dL]) 5.6 - critical result. This result has been called to the facility on [DATE] . Hematocrit (percentage by volume of red cells in blood [normal range for males: 41 - 50 percent and females: 36 - 44%]) 18.5 - critical result. This result has been called to the facility on [DATE] . Review of the Physician's Progress Note, dated 4/23/24, indicated the Resident had agreed to a blood transfusion but did not want to go to the emergency room (ER). Review of the Physician's orders dated 4/1/24 through 5/1/24, indicated the following: -Send to emergency room for blood transfusion, date initiated 4/26/24. Review of the Nurses Progress Notes dated 4/2/24 through 5/2/24 indicated no documented evidence that the Resident had received a blood transfusion as ordered by the Physician. Further review of the Medical Record indicated no documented evidence that the Resident had received a blood transfusion. During an interview on 5/3/24 at 12:39 P.M., Nurse #5 said the Resident had gone out last Saturday (4/27/24) for a blood transfusion. Nurse #5 said she was not working, but she had received this information in shift-to-shift report. Nurse #5 said the transfer for a blood transfusion should have been documented in the Nurses Progress Notes. During an interview on 5/3/24 at 1:00 P.M., Unit Manager (UM) #2 said the Resident had received the blood transfusion. UM #2 said that initially the Resident did not want to leave the facility for the transfusion but later agreed to go to the hospital. UM #2 said that the transfer to the hospital for blood transfusions and return to the facility should have been documented in the Nurses Progress Notes. UM #2 further said she would locate the documentation regarding the blood transfusion. During an interview on 5/3/24 at 2:10 P.M., UM #2 provided the surveyor with documentation faxed to the facility on [DATE] at 1:34 P.M., from the Hospital Medical Day Stay Unit, dated 4/27/24 indicating the Resident had received two units of packed red blood cells. UM #2 said the Nurse should have written a progress note when the Resident was transferred out of the facility. UM #2 further said the Resident should have had written progress notes that included a respiratory assessment for 48 hours after his/her return to the facility. During an interview on 5/3/24 at 2:16 P.M., the Director of Nurses (DON) said the Nurse should have written a progress note indicating the Resident had been transferred out of the facility for a blood transfusion and returned to the facility. 42690 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #99 was admitted to the facility in October 2023 with the following diagnoses: Parkinson's Disease (a chronic and progressive disorder that affects the nervous system and causes movement problems) and Dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking). Review of the May 2024 Physician's orders indicated: -order for transfer bar side rails on side of bed, initiated on 10/2/23. Review of the admission nursing assessment dated [DATE] indicated: - yes the Resident used side rails. -Section 1z. indicated upright (transfer bar) right side and upright (transfer bar) left side. -Other options available were full rails (right, left), half rails (right, left), quarter rails (left, right) upper, quarter rails (left, right) lower. -None of these options were selected. Review of the Quarterly Side Rail Assessments dated 1/8/24 and 4/8/24, indicated that bilateral upright (transfer bars) were in use. Review of the Side Rail Informed Consent signed by the invoked Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself) on 10/2/23 indicated the HCP consented to upright (transfer bar), right and left side. On 5/1/24 at 9:50 A.M., Resident #99 was observed lying in bed with bilateral upper and middle quarter side rails in place. During an interview on 5/1/24 at 10:37 A.M. Nurse #1 said that the Resident had a special bed with side rails, like a hospital bed. When the surveyor asked what assessments are completed for side rails use, Nurse #1 said that the UM typically would do an assessment to determine if the Resident was safe with the side rails. During an interview on 5/1/24 at 11:22 A.M., with the DON and UM #2, UM#2 said that side rail assessments are completed and documented upon admission, quarterly and annually on a UDA (User Defined Assessment). The DON said that the bars selected on the UDA assessment were called transfer bars. During an interview on 5/1/24 at 3:16 P.M., UM #1 said that she believed the bed rails that were on Resident #99's bed were quarter side rails, not transfer side rails, and that it was not documented correctly on the Admission Nursing Assessment or the other assessments. UM #1 further said that the Resident has had the bed for over two year (at the hospital previously) and to the best of the facility staff's knowledge, the bed rails had never changed. UM #1 said that it was just a coding error as the Resident has had quarter side rails on the upper and middle section of his/her bed since admission and it should have been coded as bilateral upper and middle quarter side rails. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/1/24 at 3:51 P.M., the DON said that the facility would also have to obtain a new consent signed by the HCP that reflected the correct side rails being used on the Resident's bed as the consent that was currently on record does not reflect the correct side rails being used on Resident #99's bed. 47901 3. Resident #384 was admitted to the facility in April 2024 with diagnoses including Malignant Neoplasm of the brain (brain cancer), Cerebral Infarction (stroke: damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area) and weakness. Review of Resident #384's April 2024 Physician's orders indicated: -Foley catheter (also known as a urinary catheter - a medical device that drains urine from the bladder into a collection) care every shift, size 16 French (fr) with retention bulb [balloon]10 milliliters (ml), ordered 4/26/24. -Foley catheter site care every shift, ordered 4/26/24. Review of the Hospice Narrative Progress Note dated 4/26/24, indicated Resident #384 had a Foley catheter that was a size 18 Fr with 5 to 10 ml retention balloon. On 5/2/24 at 11:58 A.M., the surveyor and Nurse #3 observed Resident #384's Foley urinary catheter. The Resident's Foley catheter size was observed to be 18 Fr with 5 to 10 ml balloon. During an interview at the time, Nurse #3 said Resident #384's Foley catheter size did not match the Physician's order in the Resident's record, that was initiated 4/26/24. 37400 4. Resident #42 was admitted to the facility in February 2024, with a diagnosis including Protein Calorie Malnutrition (state of inadequate intake of food including protein, calories and other essential nutrients). Review of the May 2024 Physician's orders included the following: -Keflex (an antibiotic) 500 milligrams (mg) every 8 hours daily (three times daily) for 10 days for infection, initiated 4/23/24 Review of the April 2024 and May 2024 Medication Administration Record (MARs) indicated Keflex 500 mg was administered three times daily to Resident #42 from 4/23/24 through 5/2/24, with the exception of 4/26/24 where an M was documented at 10:00 P.M. Review of the Resident's clinical record did not indicate why the Keflex medication was prescribed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/3/24 at 11:10 A.M., Nurse #6 said Resident #42 was prescribed the Keflex because he/she had a root canal and had an abscess (a swollen area within the body tissue containing an accumulation of pus). During an interview on 5/3/24 at 11:34 A.M., UM #2 said that Resident #42's family member brought him/her to a dental appointment outside of the facility, the Resident had a root canal procedure and was put on antibiotics prior to the appointment and the antibiotics were continued after the appointment. The surveyor requested information pertaining to the Resident's dental appointment from UM #2 at this time. During a follow-up interview on 5/3/24 at 11:51 A.M., UM #2 said she reviewed the Resident's clinical record and was unable to find information pertaining to the Resident's dental appointment. UM #2 said there should be documentation, including nursing notes about the Resident going out to the appointment and the results of the appointment including the initiation of the antibiotics. UM #2 further said Resident #42 had an appointment on 4/23/24 and had the root canal procedure on 4/25/24. UM #2 provided the surveyor with an After Completion of Endodontic Therapy form, that was undated and initialed by the Provider, which indicated instructions for aftercare for Resident #42. Further review of the After Completion of Endodontic Therapy form included a handwritten notation that stated called Dentist, did not prescribe antibiotics. The surveyor reviewed the After Completion of Endodontic Therapy form with UM #2, and UM #2 said she was not sure what the handwritten notation meant since the Resident remained on antibiotic therapy. UM #2 said she would have to contact the dental office to follow-up since there was no information about the Resident's dental work since 4/23/24 and there should be. On 5/3/24 at 2:10 P.M., UM #2 said that she would expect to see documentation in Resident #42's clinical record about his/her dental appointments, what occurred at the appointments and any follow-up needed. UM #2 said if the Resident's family makes an appointment outside of the facility for the Resident and no paperwork was provided after the appointment, the facility staff should contact the Provider and request the information about what occurred at the appointment and follow-up instructions if applicable. UM #2 said she requested the information from Resident #42's Dentist today, but it should have been received previously. During a interview on 5/7/24 at 9:49 A.M., UM #2 said she obtained the consult sheets from the Resident's dental appointments on 4/23/24 and 4/25/24. UM #2 said the appointments were with different dental Providers, and the appointment on 4/23/24 was for the Resident's mouth abscess and the appointment on 4/25/24 was for the root canal. 50563 5. Resident #9 was admitted to the facility in January 2010, with the following diagnoses: Stage 3 Pressure Ulcer of the left buttock (a wound caused by prolonged pressure usually over an area where the bone is close to the surface), Lymphedema (swelling due to a buildup of fluid when the lymph nodes do not drain properly), Type II Diabetes (DM II - condition in which the body does not produce enough insulin and has trouble controlling blood sugar levels), Depression, and Anxiety. Review of Resident's Weekly Wound Physician Progress Note dated 7/27/23 indicated, Resident #9 no longer wanted to be evaluated weekly by the Consultant Wound Physician and that wound care would be provided by nursing staff going forward due to the Resident's request. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #9's clinical record indicated no documented evidence that Weekly Wound Assessments including the measurement of the wound were completed from 7/27/23 through 12/27/23. Review of Resident #9's Nursing Progress Notes from August 2023 through December 2023 indicated no documentation of acceptance or refusal of the Weekly Wound Assessments by the Resident. Review of Resident #9's Minimum Data Set (MDS) assessment dated [DATE], indicated that the Resident was interviewable and had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15. The surveyor attempted to interview Resident #9 on the following dates/times, but he/she refused: -4/30/24 at 11:10 A.M. -5/1/24 at 9:29 A.M. -5/2/24 at 9:14 A.M. On 5/7/24 at 8:35 A.M., the surveyor requested wound tracking or wound assessment data for Resident #9 from August 2023 through December 2023 and the facility was able to provide evidence that a Weekly Wound Assessment was completed on 12/28/23. During an interview on 5/7/24 at 10:57 A.M., the Wound Nurse said she could not provide documentation that Resident #9's Weekly Wound Assessments were completed during August 2023 through December 2023, because the Resident refused to have the Weekly Wound Assessments completed. The Wound Nurse said she did not document the Resident's refusals and should have entered a Nurse's note indicating that the Resident refused the Weekly Wound Assessments. During an interview on 5/7/24 at 2:03 P.M., UM #2 said the expectation would be for the Wound Nurse to assess the Resident's wound weekly on the Weekly Wound Assessment form and if the Resident refused, this information would be relayed to the nursing staff and documented within the Resident's clinical record in a progress note.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on observation, interview, record and policy review, the facility failed to ensure that Enhanced Barrier Precautions (EBP- targeted gown and glove use during high contact resident care activities, designed to reduce transmission of infections) were adhered to for three Residents (#12, #17, #42), of five applicable residents, out of a total sample of 27 residents, to prevent the spread of infections. Specifically, the facility staff failed to: 1. For Resident #12, ensure that the required personal protective equipment (PPE) was worn when providing high contact wound care when the Resident was identified as being on EBP. 2. For Resident #17, ensure the required PPE was worn when assisting the Resident with toileting activities. 3. For Resident #42, ensure the required PPE was worn when assisting the Resident with repositioning when in bed. Findings include: Review of the facility policy titled Enhanced Barrier Precautions, dated 1/10/23, indicated: Enhanced Barrier Precautions will be used in these conditions: -Residents with an infection or colonization with Multi Drug Resistant Organism (MDRO - organism that is resistant to one or more classes of antimicrobial agents) when they do not need to be on Contact Precautions. -All Residents on the unit with indwelling medical devices, example central line, urinary catheter, feeding tube, . -All Residents on the unit with wounds. -Enhanced Barrier Precautions (EBP) require gowns and gloves for all high contact care with examples like dressing, bathing/showering, transferring, providing hygiene, changing linens, device care or use such as central line, urinary catheter, feeding tube, wound care. 1. Resident #12 was admitted to the facility in February 2024 with diagnoses including Osteomyelitis (inflammation of bone or bone marrow due to infection) and open leg wound. Review of Resident #12's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of total possible 15. Further review of the MDS Assessment indicated Resident #12 had an infection of the foot and diabetic foot ulcers (an open sore or wound that is commonly located on the bottom of the foot and occurs in patients with Diabetes). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/3/24 at 11:12 A.M., the surveyor observed an EBP sign outside of Resident #12's room. The surveyor observed Nurse #9 performing a leg wound dressing on Resident #12 and Nurse #9 was kneeling on the floor while she performed the leg wound dressing change. Nurse #9 did not don (put on) a gown to perform the leg wound dressing procedure. The surveyor observed that Nurse #9 stood up after completing the Resident's wound dressing, removed her gloves, and walked out of the Resident's room. During an interview on 5/3/24 at 11:18 A.M., Nurse #9 said the EBP sign did not apply to Resident #12. The surveyor and Nurse #9 reviewed the EBP sign outside Resident #12's door and Nurse #9 said she should have worn a gown when she provided the wound care for the Resident, but she did not. 37400 2. Resident #17 was admitted to the facility August 2018, with diagnoses including Cerebral Infarction (Stroke: damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area) with left-sided hemiparesis (paralysis on one side) and resided on Unit Four. Review of the MDS assessment dated [DATE], indicated Resident #17 was severely cognitively impaired as evidenced by staff interview and had a Stage 3 Pressure Ulcer (full thickness tissue loss where subcutaneous fat may be visible) and an unstageable Pressure Ulcer (full-thickness pressure injury in which the wound base is obscured by slough [yellow/white material in the wound bed] and/or eschar [dead tissue that eventually sloughs off healthy skin after an injury]) present. Review of the May 2024 Physician's orders included the following: -Left heel wound . -Coccyx (triangular bone at the base of the spine) wound . On 4/30/24 at 10:03 A.M., the surveyor observed Resident #17 lying in bed with eyes closed. The surveyor observed that EBP signage was posted outside of the Resident's room door and a PPE bin was observed outside of the room and contained gowns and gloves. On 5/2/24 at 9:13 A.M., the surveyor observed Resident #17 awake, lying in bed and leaning against the side rail. The surveyor observed that EBP signage was posted outside of the Resident's room door. During an interview at the time, Resident #17 said he/she was not comfortable with his/her current position in bed. The surveyor relayed to facility staff that the Resident said he/she was not comfortable with their current position in bed. The surveyor observed Certified Nurses Aide (CNA) #4 and Nurse #5 enter the Resident's room shortly after, don gloves (but did not a gown) and assisted Resident #17 with repositioning in his/her bed by using a sheet positioned under the Resident. After the Resident was repositioned, CNA #4 and Nurse #5 removed their gloves, performed hand hygiene and exited the room. During an interview on 5/7/24 at 11:33 A.M., Nurse #5 said that Resident #17 was on EBP because he/she had wounds. Nurse #5 said that anytime direct care was provided to the Resident, a gown and gloves were required to be worn. Nurse #5 further said that repositioning in bed would be considered direct care and when she and CNA #4 assisted the Resident with repositioning, gowns should have been worn. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225331	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Longmeadow Skilled Nursing Center	305 Maple Street East Longmeadow, MA 01028

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/24 at 1:34 P.M., Unit Manager (UM) #2 said facility staff were required to wear a gown in addition to gloves when repositioning Resident #17 in bed, because repositioning would be considered direct care. 3. Resident #42 was admitted to the facility in February 2024, with a diagnosis including Protein Calorie Malnutrition (state of inadequate intake of food, such as protein, calories or other essential nutrients) and resided on Unit Four. Review of the MDS assessment dated [DATE], indicated Resident #42 had moderate cognitive impairment as evidenced by a BIMS score of 10 out of 15, and was at risk for pressure ulcers. Review of the May 2024 Physician's orders included the following: -Left buttock day and night; >cleanse area gently with Normal Saline (mixture of sodium chloride and water) 30 milliliter (ml) and pat dry, >do not remove previous layer of triad (sterile coating used on broken skin to protect from incontinence [inability to control the flow of urine from the bladder] that could adhere to wet skin) present. >Reapply triad over layer present - leave open to air, initiated 4/28/24 On 5/2/24 at 3:44 P.M., the surveyor observed Resident #42 lying in bed with his/her call light initiated. The surveyor observed an EBP sign was posted outside of the Resident's room and a PPE bin was observed near the outside of the room door which contained gloves and gowns. The surveyor observed CNA #10 enter the Resident's room, don gloves (but did not don a gown) and assisted Resident #42 out of bed, into a wheelchair and then into the bathroom. At 3:50 P.M., the surveyor observed CNA #10 exiting the Resident's room after removing her gloves and completing hand hygiene. During an interview on 5/2/24 at 3:52 P.M., CNA #10 said that she was regular staff at the facility and knew Resident #42 very well. CNA #10 said the Resident required assistance with dressing, transfers, and personal hygiene and when assisting the Resident with these tasks, she would wear gloves. The surveyor and CNA #10 reviewed the EBP signage posted outside of the Resident's room, and CNA #10 said Resident #42 currently had an open area so she should have also worn a gown when providing transfer and toileting assistance, but did not.