

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/22/2025
NAME OF PROVIDER OR SUPPLIER  East Longmeadow Skilled Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0552  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments.  (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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review the facility failed to ensure the resident and/or their resident representative was fully informed about treatments being provided to one Resident (#5) out of a total sample of 26 residents. Specifically, for Resident #5, the facility failed to ensure the Resident's activated Health Care Proxy (HCP - representative designated by a resident to make decisions for him/her when he/she is no longer able to do so) was informed of the current dose and frequency of an antipsychotic medication (Seroquel) and an antidepressant medication (Zoloft) that were actively being administered to the Resident. Findings include: Review of the facility policy title Psychotropic Medications, revised 2/24/25, indicated the following: &amp;gt;Purpose: -To ensure psychotropic medication is used appropriately, with written informed consent, as part of the care of the resident's psychiatric/behavioral health care plan. &amp;gt;Procedure: -The written informed consent for each psychotropic medication shall be initiated with any newly prescribed psychotropic medication and renewed annually. Review of the facility policy titled Admission/Discharge Drug Regimen Review, including Medication Reconciliation Policy, implementation date 10/15/21, indicated the following: -As part of medication reconciliation, the facility will obtain and document a complete list of the resident's current medication upon the resident's admission/readmission/discharge to the organization with the involvement of the resident or the family or resident representative. Resident #5 was admitted to the facility in June 2025 with diagnoses including Parkinson's related Dementia with Agitation, Depressive Disorder, and a history of delusional thinking. Review of Resident #5's Massachusetts HCP Form, dated 9/2022 indicated he/she appointed Resident Representative #1 as his/her HCP. Review of Resident #5's Physician Determination Concerning Massachusetts Health Care Proxy Form (HCP Invocation Form) dated 5/5/25, indicated the attending Physician declared Resident #5 unable to make his/her own medical decisions and the duration of Resident #5's incapacity was permanent due to a diagnosis of Dementia. Review of Resident #5's Hospital Discharge Medications dated 6/23/25, indicated the following: -Quetiapine (Seroquel - antipsychotic medication) 25 milligrams (mg) oral tablet When: Daily at Bedtime Instructions: Take around 8:00 A.M. and daily at supper. Hold morning dose as needed if excessive lethargy. {sic} Review of Resident #5's Medication Reconciliation Form dated 6/23/25, indicated the following: -Seroquel 25 mg three times daily. The Medication Reconciliation Form failed to indicate that Resident #5's HCP had been consulted regarding Resident #5's medications. Review of Resident #5's Behavioral Health Note dated 6/26/26 {sic} (correct date 6/25/25), indicated the following recommendation: -Zoloft (brand name for Sertraline - antidepressant medication) 25 mg daily. Review of Resident #5's July 2025 Physician's orders indicated: -Seroquel 25 mg.three times daily.start date of 6/23/25 -Sertraline 25 mg.once daily.start date of 6/27/25 Review of the Nurse Practitioner (NP) Progress Notes dated 6/24/25, 6/27/25, and 6/30/25, indicated behaviors stable on Seroquel 25 twice daily (BID). Review of Resident #5's Medication Administration Record (MAR) for June 2025 and July 2025, indicated Resident #5 was administered:-Seroquel 25 mg three times daily as ordered from 6/23/25 through 7/21/25.-Sertraline 25 mg once daily from 6/27/25 through 7/21/25. Review of Resident #5's Informed Consent for Psychotropic Administration Form, for the administration of Seroquel, dated 3/26/25 (form from Resident #5's previous admission to the facility) indicated the name of the medication and a range of 0mg-800mg daily. No dose of frequency was documented on the form. Review of Resident #5's Informed Consent for Psychotropic Administration Form, for the administration of Sertraline dated 4/11/25 (form from Resident #5's previous admission to the facility) indicated the name of the medication and a range of 0 mg - 200 mg daily. The Informed Consent Form failed to indicate the dose and frequency for the Sertraline medication. During an interview on 7/21/25 at 9:08 A.M., Nurse #4 said Informed Consent for Psychotropic Administration Forms are completed at the time a Resident is admitted to the facility. Nurse #4 said if a Resident discharged home and returned to the facility at a later date a new Informed Consent Form was to be completed. During an interview on 7/21/25 at 9:18 A.M., Nurse #5 said Informed Consent for Psychotropic Administration Forms are completed at the time a Resident is admitted to the facility. Nurse #5 said medication reconciliation is done at the time of admission. Nurse #5 said a medication reconciliation form was completed by the admitting Nurse who reviewed the hospital records and then relayed the information to the attending Physician to verify the orders, and the admitting Nurse then inputs them into the electronic medical record (EMR). During an interview on 7/21/25 at 9:27 A. M., Nurse #2 said medication reconciliation is done at the time of admission. Nurse #2 said she completed Resident #5's medication reconciliation at the time of his/her admission to the facility. Nurse #2 said she</p>		

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F 0605  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.  (continued on next page)		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, and record reviews, the facility failed to ensure that as needed (PRN) orders for antipsychotic medications were limited to 14 days for one Resident (#7), of five applicable residents reviewed for unnecessary medications, out of a total sample of 26 residents. Specifically, for Resident #7, the facility failed to ensure that Physician's orders for PRN Seroquel and Haldol medications were limited to 14 days. Findings include: Review of the facility policy titled Psychotropic Medications, revised 2/24/25, indicated in caring for residents with psychiatric/behavioral health conditions, properly ordered psychotropic medications may be used when non-pharmaceutical interventions are ineffective or inadequate. Psychotropic medications can affect mood and behavior and include but not limited to antipsychotics. The policy further indicated: -As with all medications, psychotropics shall only be administered following an order by a physician. &amp;lt;As needed (PRN) medications will require a 14-day order. -Antipsychotics must be stopped following completion of the PRN 14-day order. A new order may be written if the prescriber deems it appropriate following a direct assessment of the patient including (but not limited to) documentation of improvement of distress based on previous use of as needed (if applicable). Resident #7 was admitted to the facility in March 2023 with diagnoses including Dementia with behavioral disturbance, history of Traumatic Brain Injury (TBI), and Depression with Anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #7: -was severely cognitively impaired as evidenced by Brief Interview for Mental Status (BIMS) score of seven out of 15. -reported mood symptoms of loss of interest, depression, fatigue, thoughts of failure, and trouble concentrating. -rejected care, wandered, and demonstrated physical, verbal, and other behaviors during the seven-day look back period. -was prescribed antipsychotic medications on both a routine and PRN basis. Review of Resident #7's Physician's orders from 4/1/25 through 7/31/25 indicated the following: - Haloperidol (antipsychotic) 2 milligram (mg)/1 milliliter (ml) solution sublingual (under the tongue) 0.5 mg (0.25 ml), every four hours as needed for agitation, initiated 4/18/25. - Haloperidol 2 mg/1 ml solution 1 mg = (0.5 ml) sublingual, every four hours as needed for agitation, initiated 6/3/25. - Haloperidol 2mg/1ml solution 1 mg = (0.5 ml) sublingual, every four hours as needed for agitation, initiated 7/18/25. - Seroquel (antipsychotic) 25 mg tablet, 25 mg oral, every six hours as needed for increased agitation/restlessness, initiated 6/12/25. - Seroquel 25 mg tablet, 25 mg oral, every six hours as needed for increased agitation/restlessness, initiated 7/18/25. Review of Resident #7's Medication Administration Records (MAR) from 4/1/25 through 7/22/25 indicated that the Resident received the following: &amp;gt;Haloperidol 0.5 mg PRN on: -April: 4/19/25, 4/24/25, 4/23/25, 4/27/25, 4/29/25, 4/30/25-May: 5/1/25, 5/10/25, 5/14/25, 5/25/25, 5/28/25, 5/29/25, 5/31/25-June: 6/2/25&amp;gt;Haloperidol 1 mg PRN: -June: 6/3/25, 6/5/25, 6/8/25, 6/12/25, 6/17/25, 6/19/25, 6/20/25, 6/24/25 - 6/26/25, 6/28/25, 6/29/25-July: 7/1/25, 7/4/25, 7/9/25, 7/13/25, 7/14/25&amp;gt;Seroquel 25 mg PRN: -June: 6/13/25, 6/15/25, 6/17/25, 6/24/25, 6/25/24, 6/26/25, 6/28/25 - 6/30/25-July: 7/4/25, 7/9/25 - 7/11/25, 7/14/25. Review of the Resident #7's Pharmacy Medication Regimen Review, dated 5/21/25, indicated the following: -Please reassess the need for PRN Haloperidol every 14 days. Review of Resident #7's Physician's Visit Progress Notes indicated the following: -4/16/25: Follow up, serve as regulatory visit. Medications reconciled. it was recommended . to add PRN Haldol q4h PRN. -7/8/25- LTC NP regulatory visit. Medications were reviewed by Provider. Medication list reviewed included: &amp;lt;Haloperidol 0.25 mls sublingual q4h prn&amp;lt;Seroquel 25 mg po q 6 prn agitation Review of Resident #7's medical record failed to indicate any evidence the PRN Haldol and Seroquel medication orders were limited to 14 days, as required. During an interview on 7/22/25 at 9:38 A.M., the surveyor and Unit Manager (UM) #4 reviewed Resident #7's medical record, and UM #4 said that Resident #7 was receiving Haldol PRN and Seroquel PRN. UM #4 said the process for PRN antipsychotic medications should be to trial the medications for 14 days and then on Day 14, the medication would be reviewed to see if it was utilized. UM #4 said she would then notify the Nurse Practitioner (NP) or Medical Doctor (MD) to review the medication and determine if it was necessary for the Resident. UM #4 said for Resident #7, Haldol 1 mg PRN that was started on 6/3/25, should have been reviewed around 6/17/25, and that the Seroquel PRN started on 6/12/25 should have been reviewed around 6/26/25. UM #4 said that the MD orders for Seroquel PRN and Haldol PRN should have been limited to 14 days and were not. During an interview on 7/22/25 at 11:51 A.M. the Director of Nursing (DON) said that PRN antipsychotic medications are typically ordered for 14 days and that Phvsician's orders for PRN antipsychotic medications should have a re-evaluation date to</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>Based on interview and record review, the facility failed to ensure that a Significant Change in Status Minimum Data Set [MDS] Assessment (SCSA) was completed for one Resident (#22) out of a total sample of 26 residents. Specifically, for Resident #22, the facility failed to ensure that a SCSA was completed when the Resident experienced a decline in the Activity of Daily Living (ADL) function, change in bowel and bladder continence, and experienced a significant weight decline (weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days). Findings Include: Review of the CMS Resident Assessment Instrument (RAI) Version 1.19.1 dated October 2024, indicated the following: -A SCSA is a comprehensive assessment for a resident that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either major improvement or decline. -A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting.2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/ or revision of the care plan. Resident #22 was admitted to the facility in December 2024 with diagnoses including Cerebral Vascular Disease. Review of the MDS Assessment, dated 12/24/24, indicated Resident #22:-required moderate assistance for bathing, dressing, lying to sitting on the side of bed and sit-to-stand ability. -required moderate assistance for ambulation of 10 feet. -required moderate assistance for wheelchair mobility. -was independent to roll from left to right. -had no rejections of care. -was continent of bowel and bladder. -weighed 250 lbs. (pounds). Review of the Quarterly MDS Assessment, dated 3/22/25, indicated Resident #22: -required maximum assistance for bathing, dressing, lying to sitting on side of bed, and sit-to-stand ability. -did not ambulate. -required maximum assistance to roll from left to right. -did not use a wheelchair. -had no rejections of care. -was occasionally incontinent of bowel. -was occasionally incontinent of bladder. -weighed 234lbs., had a significant weight loss, and was not on a Physician prescribed weight loss regimen. Review of Resident #22's medical record failed to indicate that a SCSA had been completed after the Resident had a decline in status that was not self-limiting. During an interview on 7/22/2025 at 9:00 A.M., the MDS Nurse said Resident #22 had a significant change in status from December 2024 to March 2025, and according to the RAI manual a SCSA should have been completed. The MDS Nurse said that a SCSA for the Resident should have been completed when the Quarterly MDS Assessment with an ARD (Assessment Reference Date) of 3/22/25 was completed, but was not.</p>		

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<p>F 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>Based on record review, and interview, the facility failed to ensure the timely completion and transmission of the Minimum Data Set (MDS) Assessments as required for four Residents (#29, #135, #141, #95), out of a total sample of 26 residents. Specifically, the facility failed to ensure that the components of the MDS Assessments were completed and electronically transmitted within the required timeframes when: 1. For Resident #29, the Comprehensive MDS Assessment was transmitted 141 days after the completion of the MDS Assessment. 2. For Resident # 135, the Entry Tracking MDS Assessment was transmitted 140 days after the completion of the MDS Assessment. 3. For Resident # 141, the Discharge Tracking MDS Assessment was completed 19 days after the ARD (Assessment Reference Date). 4. For Resident #95, the Entry Tracking MDS Assessment was completed 27 days after the ARD. Findings include: Review of the Center for Medicare &amp; Medicaid Services Resident Assessment Instrument (RAI) Version 1.19.1 dated October 2024, included the following: -ARD refers to the specific endpoint for the observation (or look-back) periods in the MDS assessment process. -Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date. -For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date 1. Resident #29 was admitted to the facility in February 2025. Review of the clinical record indicated: -A Comprehensive MDS Assessment, with an ARD of 2/21/25, was completed on 2/26/25, and transmitted on 7/16/25. -The Comprehensive MDS Assessment electronic transmission occurred 141 days after the MDS completion date of 2/26/25. 2. Resident #135 was admitted to the facility in February 2025. Review of the clinical record indicated: -An Entry Tracking MDS Assessment, with an ARD of 2/22/25, was completed on 2/27/25, and transmitted on 7/16/25. -The Entry Tracking MDS Assessment electronic transmission occurred 140 days after the MDS completion date of 2/27/25. 3. Resident #141 was admitted to the facility in December 2024. Review of the clinical record indicated: -The discharge tracking MDS Assessment, with an ARD of 1/16/25, was completed on 2/3/25. -The discharge tracking MDS Assessment was completed 19 days after the completion date of 2/3/25. 4. Resident #95 was admitted to the facility in December 2024. Review of the clinical record indicated: -An entry MDS Assessment, with an ARD of 12/20/24, was completed on 1/16/25. -The entry MDS Assessment with an ARD of 12/20/24, was completed 27 days after the ARD. During an interview on 7/17/2025 at 10:26 A.M., the MDS Nurse said: -Resident #29's Comprehensive MDS Assessment with an ARD of 1/16/25 should have been electronically transmitted within 14 days of the completion date but was not. -Resident #135's Entry Tracking MDS Assessment with an ARD of 2/22/25 should have been electronically transmitted within 14 days of the completion date but was not. -Resident #141's Discharge Tracking MDS Assessment with an ARD of 1/16/25 should have been completed within 14 days of the ARD but was not. -Resident #95's Entry MDS Assessment with an ARD of 12/20/24 should have been completed within 14 days of the ARD but was not. The MDS Nurse further said the facility followed the RAI Manual for guidance on timeliness for completion of MDS Assessments and timely transmission.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>(continued on next page)</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, interviews, and record reviews, the facility failed to provide care and services related to hearing devices for one Resident (#38), out of a total sample of 26 residents. Specifically, for Resident #38, the facility failed to ensure hearing aids were applied per recommendations from the Audiologist and the Resident's plan of care. Findings include: Review of the facility policy titled Activities of Daily Living (ADL), approved 12/22/16, indicated each resident will receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological wellbeing, consistent with the resident's comprehensive assessment and plan of care. The policy also included the following: -the facility will provide care and services for the following activities of daily living .communication, including speech and language, functional communication systems .-the care and services for ADL will be based on the resident's ability as identified in Minimum Data Set (MDS) assessment, Rehabilitation evaluation, nursing assessment, and person-centered care plan.-assistive devices and adaptive equipment are provided as needed . Resident #38 was admitted to the facility in December 2017, with diagnoses including Dementia, Major Depression, Anxiety, and impacted cerumen-bilaterally. Review of the Consent for Audiology Service Form, dated 6/5/19, indicated the Physician consented to have Resident #38 evaluated due to complaints of newly decreased hearing. Review of the Hearing Aid/Assistive Listening Device Delivery/Purchase Agreement dated 12/16/21, indicated Resident #38 was issued two new hearing aids. Review of the Audiology Consult, dated 9/21/23, indicated Resident #38 was evaluated for a hearing aid check and request to be seen related to complaints of newly decreased hearing. The Consultant Audiologist indicated the following: -Resident #38 had hearing aids for the left and right ears.-the batteries in the hearing aids were changed, the devices were cleaned, and both hearing aids fit well.-a listening check using the hearing aids was good and the Resident was pleased with sound quality.-Hearing aid insertion and removal were reviewed with the Nurse and the Resident.-the Resident required assistance with insertion and manipulation of hearing aids daily.-the Nurse will insert and remove the Resident's hearing aids.-the Nurse will change the hearing aid batteries- please open battery doors when not in use to extend battery life.-Resident should wear hearing aids daily . Review of the Communication Care Plan, initiated 2/8/24, indicated Resident #38 had a communication decline related to hearing loss and Dementia. The plan of care included the following interventions also initiated on 2/8/24: -monitor for declines and report changes to the charge Nurse.-hearing aids as tolerated. Review of the ADL Care Plan dated 3/27/25, indicated Resident #38 had an alteration in ability to provide self-care/perform ADL's related to cognitive deficits and included the following interventions also initiated 3/27/25: -partial to moderate assistance of staff with grooming needs, and-maximum assistance of staff with dressing needs. Review of the Annual MDS Assessment, dated 6/18/25, indicated Resident #38: -had minimal difficulty hearing and did not have hearing devices.-usually makes self-understood.-sometimes understands others.-had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of six out of a possible 15 points.-required substantial to maximum assistance of staff with dressing and personal hygiene. During an interview on 7/16/25 at 9:21 A.M., Resident #38 was observed unable to understand what the surveyor was asking and repeatedly said what? The surveyor observed that Resident #38 was not wearing hearing aids and did not have any hearing devices in use. On 7/16/25 at 3:52 P.M., the surveyor observed Resident #38 was dressed and seated in the common area with other residents. The surveyor observed that Resident #38 was not wearing hearing aids. Review of the Certified Nurse Aide (CNA) Care Card, reviewed on 7/18/25, failed to indicate that Resident #38 had hearing devices/hearing aids. During an interview on 7/18/25 at 12:48 P.M., CNA #4 said Resident #38 required total assistance from staff with ADLs. CNA #4 said Resident #38 was heard of hearing and CNA #4 was not sure if he/she had hearing aids. CNA #4 said she could recall the Resident having hearing aids at one point, but it has been a long time since she had seen him/her wearing the hearing aids. CNA #4 said the Nurse may know more about the Resident's hearing aids. During an interview on 7/18/2025 at 12:56 P.M., Nurse #6 said Resident #38 had difficulty with hearing and was followed by Audiology services. Nurse #6 said she was not aware if Resident #38 had hearing aids, but to the best of her knowledge he/she did not have hearing aids. During an interview on 7/18/25 at 1:19 P.M., Unit Manager (UM) #3 said she had worked at the facility as the UM since 2020. UM #3 said she was not aware if Resident #38 had hearing aids but would look into this. During a follow-up interview on 7/18/25 at 4:47 P.M., UM #3 said she reviewed Resident #38's clinical record and was unable to find evidence of what occurred with his/her hearing aids. UIM #3 said there was an Audiology</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>(continued on next page)</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interviews, and record reviews, the facility failed to ensure that the medication regimen reviews (MRRs) performed by the Consultant Pharmacist were acted upon timely for one Resident (#28) out of a total sample of 26 residents. Specifically, for Resident #28, the Attending Physician failed to document in the Resident's medical record that irregularities identified by the Consultant Pharmacist during the MRRs performed on 6/26/24 and 7/23/24 were reviewed and addressed timely. Findings include: Review of the facility policy titled Drug Regimen Review/Medication Regimen Review dated 11/17/16 and revised on 10/6/22, indicated but was not limited to the following: &amp;gt;Policy:-In accordance with State and Federal Regulations, the Consultant Pharmacist will review each resident's clinical chart monthly, or more frequently depending on the resident's condition and the risks for adverse consequences related to current medications. This review of the clinical chart shall be comprehensive, and findings shall be documented on the Consultant Pharmacist Review/Signature sheet in the chart (or in the electronic medical record (eMR) if applicable). -Apparent irregularities including, but not limited to, the use of any drug that meets the criteria for an unnecessary drug will be reported in writing to the Director of Nursing, Medical Director, Attending Physician, and Administrator. -The facility shall follow-up on Consultant Pharmacist recommendations to ensure all residents maintain the highest practicable level of functioning.&amp;gt;Purpose:-To ensure drug and medication regimen reviews are completed, received, and reviewed by appropriate personnel in a timely manner to promote positive patient outcomes and to prevent or minimize adverse consequences related to medication therapy, to the extent possible.&amp;gt;Procedure:-Consultant Pharmacist identified irregularities may include, but are not limited to one or more of the following: -Unnecessary drugs, which may include: .Without adequate indications for its use. -Any non-urgent recommendation(s)/irregularities must be addressed within 30 days of the consultant pharmacist monthly visit. -Outstanding recommendation(s) not resolved within the expected timeframe will be forwarded for action to the Medical Director and/or Director of Nursing. The Director of Nursing and Medical Director have 30 days to resolve any remaining (Pending/No Response) recommendations unless the Consultant Pharmacist upgrades the recommendation to an urgent clinically significant medication issue. -Clinical justification will be documented in the clinical chart if a recommendation is declined by the prescriber. Resident #28 was admitted to the facility in November 2022, with diagnoses including gastro-esophageal reflux disease (GERD) without esophagitis, anemia in chronic kidney disease, history of repeated falls, and history of rib fracture. Review of Resident #28's June 2024 through July 2025 Physician's orders indicated:-Omeprazole (proton pump inhibitor [PPI] medication to treat acid reflux) 40 milligram (mg) capsule, Delayed Release. One capsule oral twice daily at 6:00 A.M. and 4:00 P.M. Start date 11/28/23, end date 6/23/25. Review of Resident #28's Consultant Pharmacist MRRs, dated 6/26/24 and 7/23/24, indicated the following:-A medication replacement request was made by the Consultant Pharmacist. -Consultant Pharmacist Medication Recommendation:&amp;gt;This Resident is prescribed Omeprazole. Per package insert, this medication is not indicated for long term use. Recent studies have implicated PPIs in increased risk for falls w/fractures, vitamin B12 deficiency, hypomagnesemia, pneumonia and clostridoides difficile (C. diff) infection (bacterial infection that primarily affects the colon, often causing severe diarrhea and inflammation). &amp;gt;Please consider a short-term change (four to six weeks then as needed [PRN]) to a Histamine Type-2 Receptor Antagonist (H2) blocker such as Famotidine 20 mg twice daily (BID) may be an option. If no change is indicated, please note medical necessity of current therapy and potential risk versus current therapeutic benefit in Progress note.&amp;gt;Non-urgent medication recommendation. Must be addressed within 30 days of recommendation.-Nursing/Provider Response: Not documented. Review of Resident #28's Medication Administration Records (MARs) dated June 2024, and July 2024 indicated the Resident was administered Omeprazole 40 mg twice daily. Review of Resident #28's Pharmacist MRR dated 6/9/25, indicated the following:-A medication discontinuation request was made by the Pharmacist.--The Consultant Pharmacist MRR was the same recommendation made on 6/26/24 and 7/23/24 (12 and 11 months prior, respectively).-Nursing/Provider Response: Physician/Prescriber agreed with recommendation. Review of Resident #28's clinical record failed to indicate evidence of the Attending Physician review and response to the Consultant Pharmacist's drug regimen reviews on 6/26/24 and 7/23/24, until another drug regimen review was completed on 6/9/25 that indicated the same recommendations. During an interview on 7/22/25 at 10:17 A.M., the Director of Nursing (DON) said there was no evidence that Resident #28's 6/26/24 and 7/23/24 Pharmacist MRRs had been reviewed by the Attending Physician. The DON said the expectation</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/22/2025
NAME OF PROVIDER OR SUPPLIER  East Longmeadow Skilled Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and records reviewed, the facility failed to maintain complete and accurate medical records for one Resident (#51), out of a total sample of 26 residents. Specifically, for Resident #51, the facility failed to ensure complete and accurate documentation was maintained for urinary catheter output (documentation indicating the volume of urine collected in a urinary drainage bag connected to a urinary catheter) as required. Findings include: Review of the facility policy titled Monitoring of Intake and Output (I &amp; Os), revision date 10/30/18, indicated the following:&gt;Procedure:-Record output amounts (in ccs [cubic centimeter]) including:*Urine-Total shift and daily intake and output records&gt;Document &gt;Intake and output; in resident's medical record Resident #51 was admitted to the facility in July 2025 with diagnoses including Neurologic Neglect Syndrome, Urine Retention, and history of Cerebral Infarction (Stroke). Review of Resident #51's July 2025 Physician's Orders indicated the following order:-Foley catheter continuous.start date of 7/10/25. Review of the Nursing assessment dated [DATE], indicated the Resident #51 had a Foley Catheter. Review of Resident #51's Care Plan titled Urinary Catheter, date of 7/11/25, indicated the following interventions:-Empty [urinary] drainage/collection bag every shift, document output, effective date 7/11/25. On 7/17/25 at 11:20 A.M., the surveyor observed Resident #51 lying in bed, with his/her foley catheter tubing visible at the side of the bed. The surveyor further observed the urinary catheter bag was contained in a privacy bag hanging on the side of the Resident's bed. Review of Resident 51's Urinary Review by Day Report, from 7/10/25 through 7/17/25, indicated no documentation of urine output:-during the day shift (7:00 A.M. to 3:00 P.M.) on 7/12/25 and 7/14/25 -during the night shift (11:00 P.M. to 7:00 A.M.) from 7/10/25 through 7/16/25. During an interview on 7/17/25 at 11:46 A.M., Nurse #7 said urine output for residents with urinary catheters was recorded at the end of each shift or when a urinary catheter bag was emptied. Nurse #7 said documentation should be maintained on each shift for total urine output and recorded in the electronic medical record. Nurse #7 further said either the Certified Nurses' Aides, or the Nurse can record the Resident's urine output. During an interview on 7/17/25 at 12:15 P.M., the surveyor and Unit Manager (UM) #1 reviewed Resident #51's Urinary Review by Day Report. UM #1 said Resident #51's urine output documentation was incomplete, and staff should be recording the Resident's total urine output each shift. UM #1 said it was important for staff to document urine output for the Resident so staff could watch for urinary retention, and without this documentation staff could not be sure what the Resident's current output was on the days with no documentation.</p>		

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NAME OF PROVIDER OR SUPPLIER  East Longmeadow Skilled Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  305 Maple Street East Longmeadow, MA 01028	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, and interview, the facility failed to ensure infection control practices for cleaning medical equipment was maintained to prevent the potential spread of infection within the facility on two Units (100s and 400s), out of four units observed. Specifically, 1. On the 100s Unit, the facility failed to ensure staff cleaned and disinfected the portable vital signs machine (medical device that takes temperature, blood pressure, and blood oxygen readings) in between resident use. 2. On the 400s Unit, the facility failed to ensure that staff disinfected the glucometer machine while performing finger sticks, and portable vital signs machine in between residents, increasing the risk for the potential spread of infection between residents. Findings include:</p> <p>1a. Review of the facility policy titled Policy for Environmental Surface Cleaning, approved 12/22/16, indicated the following:</p> <p>-PDI Super Sani Plus (type of disinfecting wipe)&amp;hellip;should be used by nursing staff to clean all equipment used by multiple residents. This includes&amp;hellip;thermometers, blood pressure cuffs&amp;hellip;pulse oximetry monitoring&amp;hellip;</p> <p>On 7/16/25 from 7:47 A.M. to 7:53 A.M., the surveyor observed the following on the 100&amp;rsquo;s unit:</p> <p>-Certified Nurses Aide (CNA) #2 obtained the vital signs of the resident in room [ROOM NUMBER].</p> <p>-CNA #2 exited room [ROOM NUMBER], entered room [ROOM NUMBER], and obtained the vital signs of the resident in room [ROOM NUMBER].</p> <p>- CNA #2 exited room [ROOM NUMBER], entered room [ROOM NUMBER], and obtained the vitals of the resident in room [ROOM NUMBER].</p> <p>-CNA #2 exited room [ROOM NUMBER] and began to enter room [ROOM NUMBER], at which time the surveyor intervened after observing CNA #2 did not disinfect the vital signs machine after each use.</p> <p>During an interview immediately following the observation, CNA #2 said she was taking vital signs from residents and that included taking blood pressures, checking temperatures, and obtaining oxygen saturations. CNA #2 said she only cleaned the vital signs machine after she was done with obtaining all of the resident's vitals and was not cleaning and disinfecting the vital sign machine between residents.</p> <p>1b. On 7/16/25 from 8:12 A.M. to 8:18 A.M., the surveyor observed the following on the 100&amp;rsquo;s unit:</p> <p>-CNA #3 obtained the vital signs of the resident in room [ROOM NUMBER].</p> <p>-CNA #3 exited room [ROOM NUMBER], entered room [ROOM NUMBER], and obtained the vital signs of the resident in room [ROOM NUMBER].</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  East Longmeadow Skilled Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Maple Street East Longmeadow, MA 01028	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-CNA #3 exited room [ROOM NUMBER], entered room [ROOM NUMBER], and obtained the vitals of the resident in room [ROOM NUMBER].</p> <p>-CNA# 3 did not disinfect the vital signs machine after each resident use.</p> <p>During an interview immediately following the observations, CNA #3 said she was taking vital signs from residents and that included taking blood pressures, checking temperatures, and obtaining oxygen saturations. CNA #3 said she was supposed to clean the vital signs machine between residents, but she had not cleaned the vital signs machine between taking vitals from the residents who resided in rooms [ROOM NUMBER]. CNA #3 said it was important to clean the vital signs machine between residents as it helped to reduce the spread of infection.</p> <p>During an interview on 7/17/25 at 1:27 P.M., the Infection Preventionist (IP) said the vital signs machines should be cleaned between patients to reduce the risk for spreading infection.</p> <p>2. Review of the facility policy titled Blood Glucose Meter Cleaning and Disinfection, revised 8/3/20, indicated:</p> <p>-Shared blood glucose meters are disinfected after every resident use per manufacturer instructions to prevent carry-over transmission of Bloodborne pathogens and infectious agents.</p> <p>Review of the Assure Prism Blood Glucose Monitoring System for multiple patient use, user instruction manual provided by the facility indicated:</p> <p>&amp;gt;Cleaning and Disinfecting Procedures:</p> <p>-Clorox Healthcare Bleach Germicidal Wipes, Super Sani-Cloth Germicidal Wipes:</p> <p>-Cleaning</p> <ol style="list-style-type: none"> <li>1.Wear appropriate protective gear such as disposable gloves.</li> <li>2.Open the cap of the disinfectant container and pull out one towelette and close the cap.</li> <li>3.Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using one towelette to clean blood and other body fluids.</li> <li>4.Dispose of the used towelette in a trash bin.</li> <li>5.Pull out one new towelette and wipe the entire surface of the meter three times horizontally and three times vertically using a new towelette to remove blood borne pathogens.</li> <li>6.Dispose of the used towelette in a trash bin.</li> <li>7.Allow exteriors to remain wet for the corresponding contact time for each disinfectant.</li> <li>8.After disinfection, the user's gloves should be removed to be thrown away and hands washed before proceeding to the next patient.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/16/25 at 8:08 A.M., the surveyor observed Nurse #2 obtain a resident's blood pressure with the portable vital sign machine. The resident was observed to be on Enhanced Barrier Precaution (EBP). Nurse #2 exited the room after obtaining the vital signs and left the vital signs machine in the hallway. Nurse #2 was not observed disinfecting the vital signs machine, the blood pressure cuff or pulse oximeter finger probe.</p> <p>On 7/16/25 at 9:10 A.M., the surveyor observed Nurse #2 pull the vital signs machine into another resident's room and closed the door. Nurse #2 came out of the room and left the vital signs machine in the hallway. During an interview at the same time, Nurse #2 said she did not have any cleaning wipes on her medication cart and that the vital signs machine should have been disinfected before and after each use but was not.</p> <p>On 7/16/25 at 3:59 P.M., the surveyor observed Nurse #1 entering and exiting three individual residents' rooms with a glucometer machine.</p> <p>On 7/16/25 at 4:17 P.M., the surveyor observed Nurse #1 check a resident's blood sugar via finger stick using a glucometer machine who was seated in the common area across from the Fourth-floor nursing station. Nurse #1 was observed with gloves on and after checking the resident's blood sugar, placed the glucometer machine back in the medication cart, removed his gloves and sanitized his hands.</p> <p>During an interview on 7/16/25 at 4:21 P.M., Nurse #1 said the cleaning agent for the glucometer machine was a hand sanitizer. Nurse #1 said he had checked four residents' blood sugar but had forgotten to clean and disinfect the glucometer machine in between all four residents.</p> <p>During an interview on 7/16/25 at 4:33 P.M., Unit Manager (UM) #2 said the cleaning agent for the glucometer machine was Super Sani-Cloth Germicidal Wipes, that was available at the nurses station.</p> <p>During an interview on 7/18/25 at 1:53 P.M., the Infection Prevention Nurse (IP) said Nurse #1 should have cleaned the glucometer machine and the vital sign machine and equipment with the Super Sani-Cloth Germicidal Wipes and waited two minutes for dry time, but he did not.</p>