

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225360	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/03/2024
NAME OF PROVIDER OR SUPPLIER  Poet's Seat Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  359 High Street Greenfield, MA 01301	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>37227</p> <p>Based on records reviewed and interviews, for two of three sampled residents (Resident #1), who was severely cognitively impaired and had a history of disrobing in public and intrusive wandering, and (Resident #2) who was severely cognitively impaired and had a history of inappropriate touching, the Facility failed to ensure they developed and implemented a Comprehensive Plan of Care that identified goals, interventions and outcomes related to Resident #1 and Resident #2's behaviors.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Care Plans, Comprehensive Person-Centered, dated as revised March 2022, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Policy indicated assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change.</p> <p>Review of the Facility Policy titled Wandering and Elopements, dated as revised March 2019, indicated if identified as a risk for wandering, elopement or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.</p> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 09/25/24, indicated that on 09/23/24 at approximately 3:45 A.M., Nurse #1 found Resident #1 in Resident #2's bed with his/her pull-up brief around his/her ankles. The Report indicated Resident #2 was standing facing the bed with his/her pants and underwear down around his/her ankles. The Report indicated no physical contact was witnessed between Resident #1 and Resident #2.</p> <p>A) Resident #1 was admitted to the Facility in March of 2022, diagnoses included dementia, insomnia and anxiety.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 07/03/24, indicated Resident #1 was severely cognitively impaired with a score of 2 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact.) The Assessment also indicated Resident #1 ambulated with supervision or touch assistance from staff, and he/she exhibited wandering, physical, verbal and other behaviors 4 to 6 days per week, during the assessment period.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Behavior Care Plan, reviewed and renewed with Quarterly MDS completed 07/03/24, indicated he/she exhibited intrusive behavior such as entering other resident rooms. Further review indicated there was no documentation to support that any of Resident #1's care plans addressed goals or interventions specific to his/her intrusive wandering or disrobing in public behaviors.</p> <p>Review of Resident #1's Care Card (Certified Nurse Aide reference guide, identifies residents specific care needs, including number of staff required to provide assistance during tasks), undated, indicated Resident #1 required supervision when ambulating on and off the unit.</p> <p>Review of Resident #1's Behavioral Health Note, dated 07/26/24, indicated that nursing reported that he/she had increased behaviors, including (but not limited to) pacing, wandering and disrobing in public. The Note indicated that the Behavioral Health Provider observed Resident #1 disrobing in public during the evaluation.</p> <p>Review of Resident #1's Behavioral Health Note, dated 08/02/24, indicated that the Social Worker reported he/she had been physically aggressive, disrobing in public, exit seeking, anxious, pacing, wandering and screaming with disruptive sounds and repetitive motions.</p> <p>During an interview on 10/03/24 at 1:20 P.M., Nurse #2 said Resident #1 wandered between both the North and South units and often wandered in and out of other resident rooms.</p> <p>During an interview on 10/04/24 at 8:20 A.M., CNA #2 said that Resident #1 frequently wandered on both units during the 11:00 P.M. to 7:00 A.M. shift when he/she could not sleep. CNA #2 said that Resident #1 sometimes disrobed or pulled off his/her urine-soaked incontinent brief at night.</p> <p>During a telephone interview on 10/09/24 at 2:38 P.M., the Director of Nurses (DON) said Resident #1 wandered in and out of all areas of the facility, including other resident's rooms. The DON said she was not aware that Resident #1's Care Plan did not address his/her intrusive wandering and disrobing behaviors.</p> <p>B) Resident #2 was admitted to the Facility in March of 2022, diagnoses included dementia with other behavioral disturbance, and other symptoms and signs involving cognitive functions and awareness.</p> <p>Review of a Facility Investigation Summary, undated, indicated that on 07/25/24 at around 10:45 A.M., Resident #2 was found in another resident's room, and he/she was observed with his/her hand on the incontinent brief of a resident (of the opposite sex) who was in bed.</p> <p>Review of Resident #2's Physician Progress Note, dated 07/29/24, indicated Resident #2 was referred to the physician for inappropriate contact with a resident (of the opposite sex).</p> <p>During an interview on 10/03/24 at 9:30 A.M., the Physician said he was aware of the incident on 07/25/24 when Resident #2 inappropriately touched another resident. The Physician said that Resident #2 had dementia, was very confused, and had the physical ability to roam.</p> <p>The Physician said Resident #2's inappropriate behaviors were related to his/her dementia and would be better managed with staff interventions, like redirection and supervision, rather than pharmacological interventions.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 10/08/24 at 3:55 P.M., the Behavioral Health Provider said that Resident #2 required supervision from staff due to a history of behaviors including intrusive wandering and inappropriate touching, and said staff needed to ensure they knew his/her whereabouts.</p> <p>Review of Resident #2's Medical Record indicated there was no documentation to support that any of Resident #2's care plans addressed goals or interventions specific to his/her behavior of inappropriately touching other residents.</p> <p>Review of Resident #2's Care Card, undated, indicated Resident #1 required supervision when ambulating on and off the unit.</p> <p>Review of Resident #2's Quarterly Minimum Data Set Assessment, dated 08/07/24, indicated Resident #1 was severely cognitively impaired with a score of 5 out of 15 on the Brief Interview for Mental Status. The Assessment also indicated Resident #1 ambulated with supervision or touch assistance from staff.</p> <p>During a telephone interview on 10/09/24 at 2:38 P.M., the Director of Nurses (DON) said that she was not aware that Resident #2 did not have interventions on his/her care plan to address his/her history of inappropriate touching.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>37227</p> <p>Based on records reviewed and interviews, for two of three sampled residents (Resident #1, who was known to intrusively wander and disrobed in public areas, and Resident #2 who was known to exhibit inappropriate behaviors to residents of the opposite sex), the Facility failed to ensure Resident #1 and Resident #2 were provided with an adequate level of staff supervision in effort to reduce the potential for a resident to resident altercation.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Wandering and Elopements, dated as revised March 2019, indicated the Facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. The Policy also indicated if identified as a risk for wandering, elopement or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.</p> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 09/25/24, indicated that on 09/23/24 at approximately 3:45 A.M., Nurse #1 found Resident #1 in Resident #2's bed with his/her pull-up brief around his/her ankles. The Report indicated Resident #2 was standing facing the bed with his/her pants and underwear around his/her ankles. The Report indicated no physical contact, between Resident #1 and Resident #2, was witnessed.</p> <p>A) Resident #1 was admitted to the Facility in March of 2022, diagnoses included dementia, insomnia and anxiety.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 07/03/24, indicated Resident #1 was severely cognitively impaired with a score of 2 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact.) The Assessment also indicated Resident #1 ambulated with supervision or touch assistance from staff, and he/she exhibited wandering, physical, verbal and other behaviors 4 to 6 days per week, during the assessment period.</p> <p>Review of Resident #1's Behavior Care Plan, reviewed and renewed with Quarterly MDS completed 07/03/24, indicated he/she exhibited intrusive behavior such as entering other resident rooms.</p> <p>Review of Resident #1's Care Card (Certified Nurse Aide reference guide, identifies residents specific care needs, including number of staff required to provide assistance during tasks), undated, indicated Resident #1 required supervision when ambulating on and off the unit.</p> <p>B) Resident #2 was admitted to the Facility in March of 2022, diagnoses included dementia with other behavioral disturbance, and other symptoms and signs involving cognitive functions and awareness.</p> <p>Review of Resident #2's Quarterly MDS Assessment, dated 08/07/24, indicated Resident #1 was severely cognitively impaired with a score of 5 out of 15 on the BIMS. The Assessment also indicated Resident #1 ambulated with supervision or touch assistance from staff.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's Care Card, undated, indicated Resident #1 required supervision when ambulating on and off the unit.</p> <p>Review of a Facility Investigation Summary, undated, indicated that on 07/25/24 at around 10:45 A.M., Resident #2 was found in another resident's room, and he/she was observed with his/her hand on the incontinent brief of a resident (of the opposite sex) who was in bed.</p> <p>During an interview on 10/03/24 at 9:30 A.M., the Physician said he was aware of the incident on 07/25/24 when Resident #2 inappropriately touched another resident. The Physician said that Resident #2 had dementia, was very confused, and said he/she had the physical ability to roam. The Physician said Resident #2's inappropriate behaviors were related to his/her dementia and would be better managed through staff interventions, like redirection and supervision, than through pharmacological interventions.</p> <p>During a telephone interview on 10/08/24 at 3:55 P.M., the Behavioral Health Provider said that Resident #2 required supervision from staff due to a history of behaviors including intrusive wandering and inappropriate touching, and said staff needed to ensure they knew his/her whereabouts.</p> <p>During a telephone interview on 10/04/24 at 8:20 A.M., Certified Nurse Aide (CNA) #2 said that when she worked the overnight shift on 09/21/24, she observed Resident #1 sitting in a chair outside the doorway to his/her room and Resident #2 was rubbing his/her back. CNA #2 said she separated and redirected Resident #1 and Resident #2 and communicated her observation with the CNAs on the next (7:00 A.M. to 3:00 P.M.) shift. CNA #2 said that Resident #1 often wandered on both units during the overnight shift when he/she could not sleep.</p> <p>During a telephone interview on 10/04/24 at 11:22 A.M., Nurse #1 said that she worked on 09/22/24 from 3:00 P.M. into 09/23/24 until 7:00 A.M., on the North Unit. Nurse #1 said that during the evening, while she was passing medications, she observed three separate times, Resident #1 wander in and out of Resident #2's room in response to his/her request or invitation, for him/her (Resident #1) to come into his/her (Resident #2's) room.</p> <p>Nurse #1 said she was unable to hear, if anything, what Resident #2 said to Resident #1. Nurse #1 said that she had never observed Resident #2 call Resident #1 into his/her room before, and said she felt his/her (Resident #2) behavior seemed a bit off that evening. Nurse #1 said that although she did not communicate her concern to other staff members, she said that she had planned to watch him/her (Resident #2) closely. Nurse #1 said it was common for Resident #1 to wander between both units during the evening and overnight shifts.</p> <p>During a telephone interview on 10/04/24 at 8:06 A.M., Certified Nurse Aide (CNA) #1 said he last saw Resident #1 wandering on the unit at approximately 2:45 A.M. on 09/23/24. CNA #1 said he supervised Resident #1 to ensure he/she did not wander into any resident rooms, until he had to assist Resident #1's roommate. CNA #1 said that while he assisted Resident #1's roommate, sometime after 3:00 A.M. (exact time unknown), he observed that Resident #1 was not in his/her bed. CNA #1 said he was in Resident #1's room longer than expected because he had to address a clogged toilet in the bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>CNA #1 said that when he exited Resident #1's room, sometime before 3:45 A.M., he became concerned because he did not see Resident #1 in the hallway. CNA #1 said he alerted Nurse #1 that he was unsure of Resident #1's whereabouts, and said he went to check the dining room and the South Unit. CNA #1 said that when he arrived on the South Unit, he heard Nurse #1 call out for assistance.</p> <p>Nurse #1 said that she took a break sometime after 3:30 A.M., at the nurses' station across from Resident #2's room. Nurse #1 said she had only been at the nurses' station for a few minutes when CNA #1 asked if she had seen Resident #1. Nurse #1 said she last saw Resident #1 at approximately 2:00 A.M., sitting in a chair by the nurses' station. Nurse #1 said that she checked Resident #1's room and he/she was not in bed. Nurse #1 said the next room she checked was Resident #2's room, at approximately 3:45 A.M. and found Resident #1 lying in Resident #2's bed.</p> <p>Nurse #1 said that from the doorway of Resident #2's room, she saw him/her standing next to his/her bed with his/her back facing the door. Nurse #1 said Resident #2's jeans and underwear were down around his/her ankles and the lower half of his/her buttocks were exposed below the hem of his/her T-shirt.</p> <p>Nurse #1 said Resident #1 was lying on his/her back, in Resident #2's bed, his/her bedtime garment was lifted up, his/her incontinent brief was wet and pulled down to his/her left ankle, and Resident #1's private area was slightly exposed.</p> <p>CNA #2 said that just before 3:45 A.M. on 09/23/24, CNA #1 asked if she had seen Resident #1. CNA #2 said she then heard Nurse #1 call out for assistance, so she and CNA #1 immediately responded. CNA #2 said that when she got to the North Unit, she found Nurse #1 in Resident #2's room, which was located across from the nurses' station. CNA #2 said that as she entered Resident #2's room, she observed that Resident #1 was lying flat on his/her back on Resident #2's bed, and his/her incontinent brief, which was saturated with urine was pulled down to his/her ankles, but that his/her (Resident #1's) private area was not exposed. CNA #2 said Resident #2 was sitting in a chair next to his/her bed, he/she was fully clothed, and he/she did not appear disheveled.</p> <p>Nurse #1 said that on 09/23/24, CNA #1 was the only staff member that worked with her during the overnight shift on the North Unit. Nurse #1 said one CNA and one nurse were scheduled to float between both units (North and South) during the overnight shift, but that neither she or and #1 had worked on the South Unit leading up to the incident. Nurse #1 said that prior to the incident, she last saw Resident #2 at midnight in his/her room.</p> <p>CNA #1 said he assisted Resident #1 with his/her incontinent brief at 1:00 A.M. and said he last saw him/her around 2:45 A.M., wandering in the hallway.</p> <p>CNA #2 said she did not see Resident #1 on 09/23/24, prior to the incident.</p> <p>During a telephone interview on 10/09/24 at 2:38 P.M., the Director of Nurses (DON) said that both Resident #1 and Resident #2 required supervision by staff due to their behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/03/24 at 2:50 P.M., the Administrator reviewed the staffing for 09/22/24 and said the 63-bed facility had two nursing units that were staffed for the overnight shift with one nurse and one CNA assigned to each nursing unit (1 Nurse and 1 CNA on North, then 1 Nurse and 1 CNA on South) and that an additional nurse and CNA were scheduled to float between both units. The Administrator said it was the responsibility of staff to provide supervision to residents that wandered, especially those that wandered into other resident rooms.</p>		