

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 03/11/2024
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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>42741</p> <p>Based on interview and record review, the facility failed to ensure a Notice of Medicare Non-Coverage (NOMNC) and/or a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) were issued for two Residents (#12 and #36) out of a total sample of three residents.</p> <p>Specifically, the facility failed to issue:</p> <ol style="list-style-type: none"> 1. A NOMNC notice and a SNF ABN notice to Resident #12. 2. A SNF ABN notice to Resident #36. <p>NOMNC notice is issued to a resident who is receiving benefits under Medicare Part A when all covered services end. A resident must be told in advance when changes will occur in their bills, and the facility must fully inform the resident of service-related changes and appeal rights.</p> <p>SNF ABN notice is issued to a resident when a facility determines the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all his/her Medicare benefit days. The SNF ABN provides information to beneficiaries so they can decide if they wish to continue receiving skilled services that may not be paid for by Medicare and the beneficiary assumes financial responsibility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #12 was admitted to the facility in January 2024. <p>Review of the SNF Beneficiary Protection Notification Review, completed by the facility indicated Resident #12 came off (Medicare benefits ended) his/her Medicare benefit on 3/4/24.</p> <p>No NOMNC or SNF ABN notice corresponding with the Resident coming off his/her Medicare benefit on 3/4/24 was provided to the surveyor to review.</p> <ol style="list-style-type: none"> 2. Resident #36 was admitted to the facility in November 2023. <p>Review of the SNF Beneficiary Protection Notification Review completed by the facility indicated Resident #36 came off his/her Medicare benefit on 12/4/23.</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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No SNF ABN notice corresponding with the Resident coming off his/her Medicare benefit on 12/4/23 was provided to the surveyor to review.</p> <p>During an interview on 3/6/24 at 2:55 P.M., the Business Office Manager (BOM) said no NOMNC was issued for Resident #12 when he/she came off his/her Medicare benefit on 3/4/24 and one should have been issued at least two days prior to the Resident's last covered day on Medicare. The BOM further said Resident #12 and Resident #36 remained in the facility after their Medicare benefits ended and a SNF ABN was not issued to either Resident. The BOM said a SNF ABN should have been issued to both Residents when their Medicare benefit ended and it was determined they would remain the facility.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337</p> <p>Based on observation, interview, record and policy review, the facility failed to provide an environment that was free of accidents and hazards for two Residents (#10 and #46) out of a total sample of 15 residents.</p> <p>Specifically, the facility staff failed to:</p> <ol style="list-style-type: none"> 1. For Resident #10, ensure a fall event was investigated and interventions were implemented to prevent further falls for a Resident who was identified as being at risk of falling. 2. For Resident #46, provide maintenance and testing of a wander guard device (a device worn by the Resident, usually in a bracelet form, which alarms when the Resident attempts to leave a secure area of the facility) for a Resident who was identified as being at risk for elopement. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility policy titled Falls-Clinical Protocol, revised March 2018, indicated the following: <ul style="list-style-type: none"> -The staff will evaluate and document falls that occur while the individual is in the facility; for example when and where they happen, any observations of the events etc. -For an individual who has fallen, the staff and Practitioner will begin to try and identify possible causes within 24 hours of the fall. <p>Resident #10 was admitted to the facility in October 2020, with diagnoses including Fracture of the Right Femur (large bone in the thigh), history of Falls, and Hemiparesis (partial paralysis of one side of the body that can affect arms, legs and facial muscles).</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #10 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a total possible score of 15.</p> <p>Review of the clinical record progress notes for Resident #10 indicated:</p> <ul style="list-style-type: none"> -On 2/13/24 at 9:41 P.M., the Resident sustained an unwitnessed fall and hit his/her face on a bedside table and was sent to the hospital. The Resident returned to the facility on [DATE] at 1:00 A.M., with a large right sided facial bruise. -On 2/19/24 at 4:40 A.M., the Resident was found sleeping on the floor next to his/her bed. The Resident remained in the facility. -On 2/29/24 at 2:00 A.M., the Resident was found on the floor, with a bump on head his/her head. The Resident was sent to the hospital. The Resident returned to the facility on [DATE] at 11:45 A.M. <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>-On 3/1/24 at 7:28 A.M., the Resident sustained a witnessed fall while ambulating in the hallway without assistance. The Resident remained in the facility.</p> <p>Review of the fall investigation reports, provided by the facility and pertaining to Resident #10, indicated no evidence that the unwitnessed fall event that occurred on 2/29/24 had been investigated by the facility staff.</p> <p>Review of the Resident's current care plan relative to Falls initiated 4/20/22, and last revised 3/8/24, indicated no evidence the care plan was updated to include additional interventions for falls safety, to prevent the Resident from falling, were implemented after the Resident sustained an unwitnessed fall on 2/29/24.</p> <p>During an interview on 3/11/24 at 10:52 A.M., the Director of Nurses (DON) said that there was no investigation report pertaining to Resident #10's unwitnessed fall that occurred on 2/29/24. The DON said that there was confusion as to whether the fall on 2/29/24 was the same fall that was reported for 3/1/24. The DON said the facility should have investigated the fall that occurred on 2/29/24, and interventions should have been implemented as required.</p> <p>2. Review of the facility policy titled Wandering and Elopements, revised March 2019, indicated the following:</p> <p>-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.</p> <p>-If identified as at 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>Resident #46 was admitted to the facility in March 2022 with diagnoses of Vascular Dementia (Dementia associated with disease in the blood vessels of the brain) and Psychotic Disturbances (a collection of symptoms that affect the mind, where there has been some loss of contact with reality).</p> <p>Review of the MDS assessment dated [DATE] indicated Resident #46 was severely cognitively impaired as evidenced by a BIMS score of three out of a total score of 15.</p> <p>On 3/6/24 at 10:46 A.M., the surveyor observed a wander guard device that was placed on the Resident's right ankle.</p> <p>On 3/6/24 at 3:44 P.M., the surveyor observed Resident #46 ambulating up and down the hallway on the North Unit. The surveyor also observed that the Resident did not require assistance of a device to ambulate, and the Resident had a wander guard device on his/her right ankle.</p> <p>Review of the Nursing Progress Notes in the clinical record, dated 1/5/24, indicated Resident #46 had attempted to leave the facility and the facility staff placed a wander guard device on the Resident after speaking to the Resident's Healthcare Proxy (HCP -the person chosen as the healthcare decision maker when the individual is unable to do so for himself).</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>Further review of the Nursing Progress Notes in the clinical record indicated no evidence that the facility staff had provided scheduled maintenance and testing for the Resident's wander guard device.</p> <p>Review of the March 2024 Physician orders indicated no order for scheduled maintenance and testing for the Resident's wander guard device to ensure proper functioning of the device.</p> <p>Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for January 2024, February 2024 and March 2024 indicated no evidence that the facility staff had provided scheduled maintenance and testing for Resident #46's wander guard device.</p> <p>Review of the current care plan, initiated 8/21/23, indicated Resident #46 wanders aimlessly and an intervention was initiated 1/5/24, for the placement of a wander guard device.</p> <p>Further review of the care plan did not indicate an intervention for scheduled maintenance and testing for the wander guard device to ensure proper functioning of the device in preventing accidental elopement from the facility by the Resident.</p> <p>During an interview on 3/11/24 at 8:05 A.M., the DON said that Resident #46 had a wander guard device placed in January 2024 after he/she attempted to leave the facility. The DON said the wander guard devices come with very expensive batteries and sometimes the batteries last a long time and sometimes they do not last a long time. The DON said that the night Nurses used a special tool to test the wander guard every night to make sure the device was functioning properly; and the Nurses documented wander guard maintenance and testing on the Resident's MAR or TAR. The surveyor and the DON reviewed Resident #46's MAR and TAR, and the DON said that there was no documentation regarding the maintenance and testing of the wander guard device.</p> <p>During an interview on 3/11/24 at 11:26 A.M., the Assistant Director of Nurses (ADON) said that the nursing staff were supposed to test wander guard devices every day and document on the MAR and that there was no documented evidence for the maintenance and testing of Resident #46's wander guard device. The ADON further said that the wander guard device had not been maintained and tested as required but the device should have been maintained and tested .</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>42741</p> <p>Based on interview, observation, and record review, the facility failed to ensure that the breakfast meal was served at a palatable temperature on one Unit (South Unit) out of two units observed.</p> <p>Specifically, the facility staff failed to:</p> <ul style="list-style-type: none"> -address Resident Council concerns pertaining to meal temperatures. -ensure that breakfast meals on the South Unit were served to the residents at a palatable and appetizing temperature as indicated by test tray tasting completed for breakfast on South Unit. <p>Findings include:</p> <p>During the initial survey resident interviews conducted on 3/6/23 the following information was provided by residents of the South Unit regarding meal temperatures:</p> <ul style="list-style-type: none"> -Breakfast oatmeal was often cold. -Plates used to keep food warm were not warm so the meals did not stay warm and were cold when received. -The breakfast meal was cold at least once a week. <p>Review of the 12/14/23 Resident Council Meeting Minutes indicated the Residents had a concern that food is cold upon delivery to their rooms.</p> <p>Review of the Activities Communication Sheet (form that provides follow-up to concerns raised in Resident Council), dated 12/15/23, indicated:</p> <ul style="list-style-type: none"> -the Food Service Director (FSD), provided logs of the initial temperature of the food from the kitchen to show that food left the kitchen at a hot temperature. -no further follow-up was done to indicate that the FSD had assessed the food once it arrived to the Units. <p>On 3/7/24, the surveyor requested a test tray for breakfast on the South Unit.</p> <p>On 3/7/24 at 8:03 A.M., the surveyor observed the South Unit breakfast meal carts arrived on the Unit.</p> <p>On 3/7/24 from 8:06 A.M. through 8:21 A.M., staff on the South Unit passed breakfast trays to Residents in their rooms.</p> <p>On 3/7/24 at 8:21 A.M., the test tray came off the breakfast meal cart and Nurse #1 assisted the surveyor with taste testing and obtaining temperatures of the meal.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The following temperatures were obtained and observations were made:</p> <p>-Scrambled Egg: 88 degrees Fahrenheit (F) - Nurse #1 said the eggs were cool to the taste, the surveyor observed the eggs were cool to the taste</p> <p>-Shredded Potatoes: 82 degrees F - Nurse #1 said the shredded potatoes were cool to taste, the surveyor observed the shredded potatoes to be cool to the taste</p> <p>-Oatmeal: 100 degrees F - Nurse #1 said the oatmeal was warm to the taste, the surveyor observed the oatmeal to be warm to the taste</p> <p>During an interview immediately following the test tray tasting, Nurse #1 said she was unsure what temperature food should be when it comes up to the unit.</p> <p>During an interview on 3/7/24 at 12:20 P.M., the surveyor discussed with the FSD, the test tray tasting results for breakfast on the North and South Units and lunch on the South Unit, with findings that the breakfast meal on the South Unit did not meet temperatures that were appetizing and palatable. The FSD said food should come up to the units between 130 -135 degrees F and should be hot to the taste.</p> <p>During a follow-up interview on 3/8/24 at 2:45 P.M., the FSD said he had not conducted any test tray audits recently and the last time test tray audits had been conducted was quite some time ago (the FSD did not provide a time frame of when the last test tray audits were completed).</p> <p>During an interview on 3/11/24 at 12:34 P.M., the Administrator said she was unable to locate any follow-up action or test tray audits that the FSD had completed pertaining to the concerns regarding cold food raised from the 12/14/23 Resident Council Meeting. The Administrator said she would speak with the FSD.</p> <p>The facility did not provide any evidence by end of the survey, that test tray audits or any other action had been done in response to the concerns brought to the facility's attention from the 12/14/23 Resident Council Meeting.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129</p> <p>Based on observation, interview, and policy review, the facility failed to ensure that food served to the residents was prepared in accordance with professional standards for food service and safety.</p> <p>Specifically, the facility staff failed to ensure that the microwave, ovens, food mixer, and ice machine equipment in the facility's main kitchen was maintained in a clean and sanitary manner, to prevent contamination and the risk of foodborne illnesses.</p> <p>Findings include:</p> <p>Review of the facility's Kitchen Sanitation and Infection Control policy, undated, included but was not limited to:</p> <ul style="list-style-type: none"> -The Dietary Manager (Food Service Director) is responsible for supervising all sanitation and housekeeping procedures within the Dietary Department. -The Dietary Manager and Consultant Dietitian will develop a cleaning schedule . -A clean department is essential for good sanitation. The department includes equipment, materials that are used, floors, walls . <p>Review of the facility's Cleaning and Sanitizing Dietary Areas and Equipment, undated, included but was not limited to:</p> <ul style="list-style-type: none"> -All kitchen areas and equipment shall be maintained in a sanitary manner and be free of buildup of food, grease, or other soil. -Procedure for cleaning food mixers: .be sure to wash splash up areas. -Sanitation of ice machine: The ice machine shall be sanitized twice monthly. <p>During an inspection of the main kitchen on 3/7/24 between 7:40 A.M. and 7:50 A.M., the surveyor observed the following:</p> <ul style="list-style-type: none"> >Microwave Oven: Interior door and interior top of microwave covered with dried-on, splattered food particles. >Two side-by-side ovens: -The interior of the oven on the left side contained multiple large pieces and areas of black and gray debris. The oven door was coated with baked on food residue. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The interior of the oven on the right side contained multiple crumbled pieces of aluminum foil and baked on black residue. The oven door was coated with baked on food residue. The exterior bottom panel covering the pilot light switch for both ovens was missing, revealing exposed copper wire and springs and the entire length of the missing panel was covered with a black/orange substance and strings of dust hanging off the edges of the panel.</p> <p>>Commercial Food Mixer: The hub where the mixer attachment connects (facing the mixing bowl) was covered with a sticky, brownish/black/orange substance, which when touched caused particles to drop into the mixing bowl.</p> <p>During an interview on 3/7/24 at 7:50 A.M., the Food Service Director (FSD) said he was not sure when both ovens and he microwave oven were last cleaned. The FSD said he thought the [NAME] mixer was recently cleaned. The FSD said he did not have a cleaning/maintenance schedule for the kitchen, and to his knowledge, there were no facility policies related to kitchen cleaning and sanitation.</p> <p>During an observation and interview on 3/7/24 at 1:05 P.M., Dietary Staff #1 said the staff did not have a cleaning schedule or checklist of items to clean in the kitchen and that staff just cleaned areas of the kitchen if they noticed the areas needed cleaning. The surveyor and Dietary Staff #1 observed both oven interiors and Dietary Staff #1 said both ovens were overdue for a cleaning. When the surveyor and Dietary Staff #1 observed the exposed bottom panel for both ovens, Dietary Staff #1 said the exposed area was where the pilot light was located, that there used to be a cover over the whole area, and was unsure where the panel cover went. Dietary Staff #1 said the whole bottom panel area was very dirty and needed to be cleaned.</p> <p>During an observation with Dietary Staff #1 and Dietary Staff #2, of the ice machine that was in use for the facility residents and located outside the kitchen door in the main service hallway, the surveyor observed a long piece of plastic attached to the interior top of the ice machine, hanging over the ice when the lid to the ice machine was opened. The surveyor also observed approximately a foot long area that contained a brownish/orange, wet substance with vertical streaks and the substance dripping down into the ice. Dietary Staff #1 said it did not appear that the ice machine had been cleaned in a long time. Dietary Staff #2 said judging from the cleaning log sheet attached to the side of the ice machine, it was last cleaned on 12/10/23 and appeared to have been on a monthly cleaning schedule. Dietary Staff #1 said the Director of Maintenance was responsible for cleaning the ice machine.</p> <p>During an interview on 3/7/24 at 1:42 P.M., the Director of Maintenance said he was the staff person responsible for cleaning the ice machine monthly and he was not sure when he last cleaned it, maybe the beginning of January. The Director of Maintenance further said that he did not know what the dark, wet substance in the ice machine was, that the substance appeared to be dripping into the ice, and the ice machine needed to be cleaned because this could make the residents sick.</p> <p>During an interview on 3/8/24 at 2:45 P.M., the FSD provided a cleaning checklist to the surveyor, however the FSD said the cleaning checklist was not being utilized.</p>

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<p>F 0926</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Have policies on smoking.</p> <p>42741</p> <p>Based on interview, policy, and record review, the facility failed to implement smoking policies as required for one Resident (#49) out of one applicable Resident, out of a total sample of 15 residents, and also failed to ensure that the Resident smoking area was maintained in a safe, clean and sanitary manner.</p> <p>Specifically, the facility staff failed to:</p> <ol style="list-style-type: none"> 1. For Resident #49, ensure that smoking assessments and Resident Agreement for safe smoking habits were completed quarterly as required. 2. Establish a cleaning schedule to empty the cigarette disposal receptacles timely and replace a missing cigarette disposal receptable cover to prevent accidental fires and/or burns and unsafe disposal of cigarette butts on the ground in the smoking area. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #49 was admitted to the facility in September 2022 with diagnoses of nicotine dependence and Chronic Obstructive Pulmonary Disease (COPD- a chronic lung disease that causes obstructed airflow and breathing problems). <p>Review of the facility policy titled Smoking Policy and Resident Agreement, undated, indicated the following:</p> <p>-A smoking assessment will be completed upon admission, quarterly, when a resident chooses to change their smoking decision, and when it is warranted.</p> <p>Review of the document titled Smoking, provided to the survey team on 3/6/24, as part of the survey entrance indicated Resident #49 was an independent smoker.</p> <p>Review of the Smoking Policy and Resident Agreement, signed by the Resident on 11/23/22 indicated he/she agreed to the facilities policies and procedures surrounding smoking.</p> <p>Review of Resident #49's medical record indicated his/her smoking abilities and habits had been assessed on the Nursing Evaluation .(Admit, Readmit, Quarterly, Change of Condition (COC)-Version (V) 5 only twice in the last year on 9/25/23 and 3/6/24.</p> <p>During an interview on 3/6/24 at 1:46 P.M., Nurse #2 said she was unsure how often residents who smoked should be evaluated for safe smoking habits.</p> <p>During an interview on 3/7/24 at 10:42 A.M., Nurse #3 said she was unsure how often residents who smoked should be evaluated for safe smoking habits.</p> <p>(continued on next page)</p>		

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<p>F 0926</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 3/7/24 at 11:54 A.M., the Director of Nursing (DON) said residents who smoke should be evaluated quarterly for safe smoking habits. The DON said she had reviewed Resident #49's record and he/she had only been evaluated two times over the past year (from March 2023 until March 2024) on 9/25/23 and 3/6/24, and he/she should have been evaluated quarterly (four times a year) per the facility policy.</p> <p>2. During an observation on 3/7/24 at 11:12 A.M., the surveyor observed the facility's outdoor smoking area to be littered with cigarette butts which were thrown and scattered on the ground in the smoking area. The surveyor also observed that the cigarette disposal receptacle cover in the smoking area was missing, and the receptacle was filled to the brim with cigarette butts.</p> <p>During an observation and interview on 3/7/24 at 11:21 A.M., the surveyor and the Director of Nurses (DON) observed the smoking area. The DON said it did not appear that the smoking area had been cleaned recently. The DON said the cigarette disposal receptacle should not be full and there should be no cigarette butts scattered all around on the ground. The DON further said Maintenance should be maintaining the cleanliness of the area and making sure the cigarette disposal receptacle was emptied regularly.</p> <p>During an interview on 3/7/24 at 1:46 P.M., the Maintenance Director said the Housekeeping Department should be cleaning the smoking area regularly but there was no set schedule for cleaning the smoking area. The Maintenance Director further said he had observed the smoking area and that it had not been cleaned in some time and there were cigarette butts scattered on the ground. The Maintenance Director said the cigarette disposal receptacle should have been covered and also should have been emptied regularly.</p>		