STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37086 Based on records reviewed and interviews for one of three sampled residents (Resident #1) who was assessed by nursing to be at risk for skin breakdown with actual pressure injuries (localized damage to the skin and underlying soft tissue usually over a bony prominence which can present as intact skin or an open ulcer and may be painful) the Facility failed to ensure nursing adequately assessed, measured and obtained Physician's orders related to wound care to his/her bilateral heels that included specifics related to treatments for offloading, in accordance with professional standards of practice in an effort to promote wound healing. Findings include: Review of the Facility's Policy titled Skin Integrity Management, dated 12/03/23, indicated the following: -Stage 1 Pressure Injury: A persistent area of redness that does not disappear when pressure is removed. Skin is not broken, the site may be tender, painful, firm, or soft, warm, or cool compared to surrounding skin. -Stage 2 Pressure Injury: Partial-thickness skin loss involving the outer layer of the skin and the inner layer, which are either damaged or lost. The wound may look like an abrasion, fluid filled blister, or shallow crater. -It is the policy of the facility, consistent with Centers for Medicare and Medicaid Services (CMS) regulations that any resident with pressure ulcer or injury receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. -Preventative measures to consider as part of resident care planning include (but not limited to) off loading devices such as heel cushions, pillows and pressure relieving device on chair and in bed. -All devices, dressings, nutritional supplements, and preventative skin care will be prescribed by the Medical Practitioner and will be entered in the resident's electronic health record: Physician's orders, electronic medication administration record (eMAR) and electronic treatment administration record (eTAR). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Conduct weekly wound rounds- complete measurements of each wound length x width x depth, description of wound bed, description of wound edges and surrounding skin, type and amount of exudates, type of wound drainage, signs of infection and presence or absence of pain. -Document findings of the weekly wound assessment in the resident's EMR. Review of the National Pressure Injury Advisory Panel (NPIAP) website defined a Deep Tissue Injury (DTI) as a persistent non-blanchable (redness that does not fade when pressure is applied) deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. Resident #1 was readmitted to the Facility in April 2024, diagnoses included Congestive Heart Failure and unspecified protein-calorie malnutrition. Review of Resident #1's Hospital Discharge (DC) Summary, which included the Hospital's Wound Nurse Initial Consult, dated 04/15/24, indicated Resident #1 had the following pressure injuries: -Right heel Stage 1- measured 1.2 centimeters (cm.) x 1.0 cm., non-blanchable erythema (redness). Recommend foam dressing and offloading boots. -Left heel Stage 2- beginning to form a blister, measured 1.3 cm. x 1.1 cm., non-blanchable, central area boggy tissue with slight purple discoloration. Also suspicious for deep tissue injury component. Recommend foam dressing and offloading boots. Review of Resident #1's Re-Admission Nursing Assessment, dated 04/18/24 and completed by Nurse #1, indicated his/her [NAME] Pressure Ulcer Risk Assessment score was 12, (indicating moderate risk for skin breakdown). The Assessment also indicated there was a Stage 2 pressure injury on his/her coccyx that measured 0.8 cm. x 1.2 cm. However, the Assessment did not include any reference to skin breakdown on his/her bilateral heels, despite having been clearly identified on his/her Hospital DC Summary. Review of Resident #1's Nurse Progress Note, dated 04/19/24 and written by Nurse #1, indicated Resident #1 was readmitted to the Facility following a short hospital stay and had a Stage 2 pressure injury to the coccyx and his/her bilateral heels were boggy, non-blanchable, tender to pressure and palpation. The Note indicated a foam dressing was applied to each heel and heels were offloaded on pillows. During a telephone interview on 09/03/24 at 10:06 A.M., Nurse #1 said she did not specifically remember Resident #1. Nurse #1 said when she admits a resident who has a wound(s), she obtains Physician's orders for a treatment and then passes it along to the Unit Manager that the resident has wound(s) and may need other interventions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 said that if there was no Unit Manager in place at the time, she would have passed the information along to the next shift's nurse. Nurse #1 said it was up to the Unit Manager to notify the Facility's Wound Nurse when a resident has a new wound. Review of Resident #1's Treatment Administration Record (TAR) for the month of April 2024 indicated the following: -04/19/24- new Physician's Order to apply a foam dressing to his/her bilateral boggy heels for protection every day, on 7:00 A.M. through 3:00 P.M. (day shift) and offload heels while in bed. -04/27/24- above referenced Physician's Order was discontinued -04/28/24- new Physician's Order to apply skin prep (used to create a barrier to reduce friction) to bilateral boggy heels every day on 3:00 P.M. through 11:00 P.M. shift (evening). However, the Physician's Order and therefore the TAR did not include to off-load pressure to Resident #1's bilateral heels. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 04/25/24, indicated he/she was dependent for bathing, dressing, hygiene and ambulation was not attempted at the time of the assessment due to medical or safety concerns. Review of Resident #1's Care Plan related to skin integrity and potential for skin breakdown, dated 04/23/24, indicated Resident #1 had Stage 1 pressure injuries to bilateral heels and interventions included to follow (the Facility's) skin and wound care protocols. Review of Resident #1's Nurse Progress Note, dated 05/11/24 and written by Nurse #2, indicated Resident #1's bilateral heels each had a small dark scab. Review of Resident #1's Nurse Practitioner (NP) Progress Note, dated 05/13/24, indicated Resident #1 had a Deep Tissue Injury (DTI) on the right heel and a Stage 2 pressure injury on the left heel, foam dressings were to be done daily and heels were to be elevated off of the bed. Review of Resident #1's Nurse Progress Note, dated 05/16/24 and written by Nurse #2, indicated Resident #1's right heel had a scabbed area and the surrounding tissue appeared necrotic. The Note indicated the wound measured 1 cm. x 0.5 cm, was unstageable (depth of the wound undetermined due to dead tissue) and a bootie was applied to his/her right foot and leg. During a telephone interview on 08/29/24 at 9:39 A.M., Nurse #2 said she was very familiar with Resident #1. Nurse #2 said the weekly wound measurements were supposed to be done by the Facility's Wound Care Nurse. Nurse #2 said she did not remember specifically when she noticed the scabs on Resident #1's bilateral heels but said she did notify the Nurse Practitioner at one point and a boot was applied to his/her right foot. Nurse #2 said she did not remember if any additional preventative measure were put in place at the time for Resident #1's left foot. Nurse #2 said that all devices, including boots for offloading should be on the Treatment Administration Record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's NP Progress Note, dated 05/16/24, indicated Resident #1's Stage 2 pressure injury on his/her left heel was worsening and to float bilateral heels with boots. The Progress Note indicated Resident #1 was now Comfort Measures Only (CMO). Review of Resident #1's TAR for the month of May 2024 indicated the following Physician's orders: - 05/01/24 through 05/14/24, Apply skin prep to bilateral boggy heels every evening shift. - 05/15/24 through 05/21/24, Cleanse left heel with normal saline, apply Santyl (chemical agent to remove dead tissue), cover with foam dressing every day shift. - 05/16/24 through 05/20/24, Cleanse right heel with normal saline, apply Santyl, cover with a dry clean dressing and wrap with Kling every day shift. However, there was still no Physician's Order or treatment on the TAR to indicate nursing to ensure to float heels or to apply boots. There was also no documentation on the TAR to support weekly measurements of Resident #1's wounds were completed by nursing, per facility policy. Review of Resident #1's medical record indicated there was no documentation to support that the wounds on his/her bilateral heels were: -measured weekly since his/her re-admission per facility policy -that his/her heels were off loaded every shift when in bed and how (boots, pillows etc.) -that he/she was assessed during weekly wound rounds per facility policy. During an interview on 08/29/24 at 10:31 A.M., the Wound Care Nurse said all pressure injuries, no matter the stage, should be measured on admission to the Facility, weekly, and with any change or upon re-admission. The Wound Care Nurse said that the nurses were supposed to measure Resident #1's wounds weekly. The Wound Care Nurse said that she was responsible to track all wounds in the Facility. The Wound Care Nurse said that she was not notified when Resident #1 was admitted to the Facility with wounds. The Wound Care Nurse said by the time she was notified of his/her wounds it was late in the game. The Wound Care Nurse said that all interventions, including off loading with pillows or boots, should be an order and documented on the Treatment Administration Record. During a telephone interview on 08/30/24 at 11:52 A.M., the Director of Nurses said she expected all wounds to be measured weekly and that any interventions or pressure relieving devices should be on the resident's care plan and on the Treatment Administration Record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37086 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was assessed to be at risk for nutritional decline, dehydration, and with the potential slow wound healing due to low albumin (may indicate malnutrition, kidney/liver disease), the Facility failed to ensure Resident #1's nutritional status including body weight, meal percentage and fluid intakes, were accurately assessed and monitored appropriately by nursing and per facility policy. Findings include: Review of the Facility Policy titled Weighing and Measuring Resident, with a revision date of 05/03/11, indicated the following: -Residents will be weighed using consistent scale on admission and at least monthly thereafter. -Reweigh will be obtained if weight is +/- three pounds (lbs.) from previous weight. Review of the Facility Policy titled Nutrition Management, with a revision date of 06/06/22, indicated the following: -Identify residents who have functional limitations which may affect ability to eat or drink independently: confusion, easily distracted, fine and gross motor tremors. -Unplanned weight loss or gain considered (greater than three pounds (lbs.) from last recorded weight and/or 5 % in one month, 7.5 % in three months and 10% in six months). -Document residents' percentage of food intake. Resident #1 was readmitted to the Facility in April 2024, diagnoses included Congestive Heart Failure and unspecified protein-calorie malnutrition. Review of Resident #1's Hospital Discharge Summary, which included a Clinical Nutrition assessment dated [DATE], indicated he/she had an estimated weight of 190 lbs. on 04/13/24. The Assessment also indicated that Ensure Plus (high protein/high calorie) supplement was ordered and provided with each meal. Review of Resident #1's Admission Nursing Assessment, dated 04/18/24, indicated that Nurse #1 entered Resident #1's re-admission weight on 04/19/24 at 10:46 A.M. as 190 lbs. The Assessment indicated Resident #1 was admitted with alterations in skin integrity which included a Stage 2 pressure injury on his/her coccyx and his/her bilateral heels were boggy and non-blanchable. Review of Resident #1's weight record, provided by the Facility, indicated the following: 04/04/24 - 215 lbs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/05/24 - 142 lbs. (later determined by the Facility to be an error) 04/19/24- 190 lbs. Further review of Resident #1's medical record indicated there was no documentation to support a re-weight was obtained, per the Facility policy, despite there being a 25 lb. difference in weight readings in approximately two weeks. During a telephone interview on 09/03/24 at 10:06 A.M., Nurse #1 said she did not specifically remember Resident #1 but that she likely helped to complete his/her re-admission to the Facility. Nurse #1 said that when a resident is readmitted to the Facility, his/her weight is obtained by nursing. Nurse #1 said that if for some reason they were unable to obtain his/her weight, they enter the weight from the Hospital Discharge Summary into the Admission Nursing Assessment. Nurse #1 said nursing did not always have access to a resident's previous weight but if they did and noticed a discrepancy, a re-weight would be done. Nurse #1 said she considered anything greater or less than 10 lbs. from the resident's previous weight to be a big difference that would require nursing to obtain a re-weight, but did not remember if she requested one for Resident #1. Review of Resident #1's Nutrition History and Assessment, dated 04/29/24 and signed by the Registered Dietician (RD), indicated Resident #1 weighed 190 lbs., had a Stage 2 pressure injury on his/her coccyx, and had a low albumin level. The Assessment also indicated that Resident #1 was at risk for nutritional decline due to unplanned weight loss, was at risk for dehydration and delayed wound healing. Review of Resident #1's Nutrition Care Plan, dated 04/29/24, indicated he/she was at risk for dehydration and potential for slow wound healing due to low albumin. Further review of the Care Plan indicated the following: -interventions included to monitor intakes and weights. -goals included that Resident #1 would maintain stable weights. Review of Resident #1's Medication Administration Record (MAR) for the month of April 2024, indicated his/her weekly weight was not obtained on 04/12/24 due to his/her hospitalization , and the order for weekly weights was discontinued on 04/18/24 (prior to his/her re-admission). Review of Resident #1's Physician's Orders for the months of April 2024 and May 2024 indicated nursing did not obtain another Physician's order to monitor Resident #1's weights, despite it being an intervention on his/her Care Plan. During a telephone interview on 08/29/24 at 3:24 P.M., the Registered Dietician (RD) said that she completed Resident #1's initial Nutrition Assessment on 04/29/24 (after he/she was readmitted to the facility). The RD said she absolutely would have expected a re-weight to be done for Resident #1 due to the documented 25 lb. weight loss from 04/04/24 through 04/19/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RD said that if Resident #1's weight was recorded from the hospital records, that was not enough, and nursing should have obtained another weight. The RD said she was sure a re-weight was requested and if it was not done immediately it should have been done as soon as possible. The RD said there was no Unit Manager on the Unit Resident #1 resided at that time and that follow through was very difficult without one. The RD said that her expectation was for residents to be weighed upon admission (and/or re-admission) to the facility, then weekly, and if stable at that time could go to monthly. The RD said that it was facility protocol and industry standard, and due to Resident #1's low albumin, wounds and potential weight loss, she would have expected Resident #1 to have been weighed weekly. The RD said that weekly she reviewed an electronic report from the Facility's Electronic Medical Record System (EMRS) that allowed her to view any changes in resident's weights. The RD said the problem in this case, was because the re-weight order for Resident #1 was never entered into the EMRS, so Resident #1 did not appear on her weekly report during his/her stay at the Facility. Therefore, she did not re-assess his/her weight for accuracy or weight loss. The RD said Resident #1 was at high risk for nutritional decline due to his/her low albumin level and wounds, therefore obtaining his/her weights was important. The RD said that Resident #1 was not started on any type of a nutritional supplement until she evaluated him/her on 04/29/24. The RD said if Resident #1 had been on Ensure Plus at the hospital, the order should have been implemented when he/she was readmitted to the Facility, and not ten days later when she (RD) did her initial assessment. During a telephone interview on 08/30/24 at 9:05 A.M., the Nurse Practitioner (NP) said that she was not made aware by nursing that there had been any weight discrepancies for Resident #1. The NP said nursing did weekly weights and if a resident sustained a weight loss, they would notify her. The NP said she found out this week (during survey) that Resident #1's Physician's order for weekly weights had been discontinued when he/she had a brief hospitalization and were not restarted when he/she was readmitted to the Facility. The NP said that if she had been aware that Resident #1 may have had a significant weight loss she could have discussed options with his/her family, such as an appetite stimulant. During an interview on 08/29/24 at 12:59 P.M., the Assistant Director of Nurses (ADON) said that she reviewed Resident #1's Physician's Orders and the order to weigh him/her weekly was discontinued when he/she was hospitalized . The ADON said the order was dropped and should not have been. During a telephone interview on 08/30/24 at 11:52 A.M., the Director of Nurses said that staff should obtain a resident's weight on their own, upon admission (re-admission) to the Facility. The DON said if a resident had a weight discrepancy of 25 lbs. in a two week period, she expected staff to obtain a re-weight as soon as possible. The DON said the CNAs should document resident meal and fluid intakes at each meal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 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. 37086 Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who sustained two unwitnessed falls and whose Comprehensive Care Plan indicated he/she was at risk for dehydration with the potential for slow wound healing due to low albumin (may indicate malnutrition, kidney/liver disease) the Facility failed to ensure they maintained a complete and accurate medical record when 1) nursing did not complete the 72 hour neurological checks following each of his/her unwitnessed falls, and 2) Certified Nurse Aides (CNAs) daily documentation related to Resident #1's fluid and food intake were not consistently recorded on his/her flow sheets. Findings include: Review of the Facility's policy titled Falls Management: Post Fall, with a revision date of 11/02/23, indicated an Incident and Accident Report would be completed after each resident fall. Review of the Facility's Incident and Accident Report Form indicated to initiate neurological checks (assessment used to determine head injury) when a resident sustained an unwitnessed fall or head strike. Review of the Facility's Neurological Check Flowsheet indicated to assess the following with each check: -Level of consciousness -Pupil Response -Motor Response (hand grasps) -Pain Response -Vital Signs (record blood pressure, temperature, pulse and respiration) Further review of the Flowsheet indicated the neurological checks were to be completed every 15 minutes for the first hour, then every 30 minutes for the next four hours, then every hour for two hours, then every shift for 72 hours. Review of the Facility's policy titled Nutrition Management, with a revision date of 06/06/22, indicated to document residents' percentage of food intake. Resident #1 was admitted to the Facility in April 2024, diagnoses included atrial fibrillation, muscle weakness and unspecified protein-calorie malnutrition. 1) Review of Resident #1's Incident and Accident Report, dated 04/28/24 at 3:45 P.M., indicated Resident #1 sustained an unwitnessed fall in his/her room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Neurological Check Flowsheet, dated 04/28/24, indicated Resident #1's neurological checks were initiated on 04/28/24 at 3:45 P.M., and checked again at 4:30 P.M. and 5:00 P.M. However, per facility policy his/her neurological checks were to be obtained every 15 minutes for one hour and were not obtained at 4:00 P.M., 4:15 P.M. and 4:30 P.M., as required Further review of the Flowsheet indicated Resident #1's neurological checks were not documented as being obtained on 4/30/24 for the 7:00 A.M. through 3:00 P.M. (day shift) or 3:00 P.M. through 11:00 P.M. (evening shift) or on 05/01/24 day or evening shifts to complete the 72-hour neurological checks. Review of Resident #1's Accident Report, dated 05/10/24 at 1:35 P.M., indicated Resident #1 sustained an unwitnessed fall in his/her room. Review of Resident #1's Neurological Check Flowsheet, dated 05/10/24, indicated neurological checks were done through 05/12/24 11:00 P.M. through 7:00 A.M. (night shift), but were not documented on 05/12/24 day or evening shifts, or on 05/13/24 day or evening shifts, to complete the 72-hour neurological checks. During an interview on 08/29/24 at 11:47 A.M., the Assistant Director of Nurses (ADON) said that neurological checks should be initiated when a resident sustains an unwitnessed fall or a head strike. The ADON said the neurological checks should be done at the intervals specified on the Flowsheet. During the interview, the ADON reviewed Resident #1's Neurological Check Flow Sheets, dated 04/28/24 and 05/10/24, and said they were not completed accurately. During a telephone interview on 08/30/24 at 11:52 A.M., the Director of Nurses (DON) said that Resident #1's neurological checks should have been completed accurately by nursing and according to facility protocol. 2.) Review of Resident #1's Nutrition Care Plan, dated 04/29/24 , indicated he/she was at risk for dehydration and slow wound healing due to low albumin, interventions included to monitor intakes. Review of Resident #1's Meal Intake by Day report, indicated from 05/01/24 through 05/19/24, that CNAs had not consistently completed his/her flow sheets related to the percentage of the meal consumed or the amount of fluids consumed, and that the following dates and times were left blank; 05/03/24- breakfast, lunch 05/05/24- breakfast, lunch, dinner 05/06/24- dinner 05/07/24- breakfast, lunch 05/08/24- breakfast, lunch 05/11/24- breakfast, lunch, dinner (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/12/24- dinner 05/13/24- dinner 05/17/24- breakfast, lunch, dinner During an interview on 08/28/24 at 3:40 P.M. Certified Nurse Aide (CNA) #2 said the CNAs were supposed to document resident meal intake percentages and fluids consumed for every meal. During an interview on 08/29/24 at 9:19 A.M., Unit Manager #1 said the CNAs were supposed document meal percentages and fluid intakes for every resident at every meal. During a telephone interview on 08/30/24 at 11:52 A.M., the Director of Nurses (DON) said the CNAs were expected to document fluid intake and meal intake percentage for each resident, at every meal.