STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225392	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sixteen Acres Healthcare Center	215 Bicentennial Highway Springfield, MA 01118

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 42690 Based on observation and interview, the facility staff failed to maintain a clean, orderly, homelike environment on one unit (Unit Four) out of three units. Specifically, the facility failed to ensure that the air conditioning (AC) vent located on the ceiling, and the ceiling tiles surrounding the vent in the hallway outside of the resident rooms were maintained in good repair and a clean, homelike environment. Findings include: On 8/20/24 at 9:58 A.M., the surveyor observed the following on Unit Four: -A blue and white disposable incontinence pad (used to absorb urine on the resident's beds) was placed on the floor in the middle of the resident's hallway, topped with a yellow caution sign, indicating a water/slip hazard. -Directly above the disposable incontinence pad and hazard sign was a leaking AC vent with water droplets dripping from the left side of the vent. -The ceiling tiles around the AC vent were dark water-stained, with larger water-stained markings on the right side of the vent, some darker in color and spanning three tiles around the vent. During an interview immediately following the observation, Maintenance Staff #1 and #2 said that the AC vent had looked like this for a while, and they were unsure if anyone had been in to fix the leaking AC vent. The surveyor observed that the disposable incontinence pad, yellow sign and stained ceiling tiles remained in the same condition for the duration of the survey from the initial observation on 8/20/24 through 8/22/24. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225392	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sixteen Acres Healthcare Center	215 Bicentennial Highway Springfield, MA 01118

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/24 at 11:23 A.M., the Director of Maintenance (DOM) said that the ceiling vent for the air-conditioner on the fourth floor does leak due to condensation when the weather is warmer and that it is an ongoing issue. The DOM said that because of this, the ceiling tiles do become stained and require him to frequently change them out, sometimes monthly. The DOM said that the pipes are wrapped to try and reduce the condensation, but it does not stop them from leaking on hot days. The DOM said that it is not homelike having the disposable pad and yellow hazard sign in the hallway as well as the stained tiles and leaking AC vent.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225392	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sixteen Acres Healthcare Center	215 Bicentennial Highway Springfield, MA 01118

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 42690 Based on record and policy review, and interview, the facility failed to ensure that the required transfer documentation was completed and the transfer documentation communicated the appropriate information to the receiving health care institution for one Resident (#13), out of a total sample of 22 residents. Specifically, the facility failed to ensure Resident #13 was transferred to the emergency room with a form that included important information relative to the Resident's medical history and the reason for transfer, putting the Resident at risk for complications and adverse events upon transfer to the hospital. Findings include: Review of the facility policy titled Transfer/Discharge Notifications, revised on September 2022, indicated the following: -Documentation by the physician must be in the medical record and include the following information: A. The basis for the transfer B. The specific resident need(s) that cannot be met, facility attempts to meet the residents needs, and the service available at the receiving facility to meet the need(s) -Information provided to the receiving provider must include a minimum of the following: A. Contact information of the Practitioner responsible for the care of the resident. B. Resident Representative information including contact information. C. Advanced Directive Information. D. All special instructions or precautions for ongoing care, as appropriate. E. Comprehensive care plan goals. F. All other necessary information, including a copy of the resident's discharge summary, consistent with state and federal regulations as applicable, to ensure a safe and effective transition of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225392	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sixteen Acres Healthcare Center	215 Bicentennial Highway Springfield, MA 01118

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #13 was admitted to the facility in December 2021, with diagnoses including Schizoaffective Disorder (mental health condition marked by a mix of schizophrenia symptoms like hallucinations [seeing things or hearing voices] and delusions [believing things that are not real or not true], and mood disorder symptoms such as depression, mania and hypomania), Conversion Disorder (also known as functional neurological symptom disorder {FND} is a condition where mental health issues disrupt how your brain works) with seizures or convulsions, Major Depressive Disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy), Post-Traumatic Stress Disorder (PTSD: a mental and behavioral disorder that develops from having experienced a traumatic event, causing flashbacks, nightmares and severe anxiety), Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations) and Borderline Personality Disorder (mental illness that can cause a person to have long-term difficulty managing their emotions). Review of the Resident Census indicted the Resident was sent to the hospital on 7/12/24 and 7/30/24. Review of the Resident's medical record indicated no documented evidence of any discharge paperwork that included the Resident's Advanced Directives (legal documents that provide instructions for medical care and only go into effect if you are unable to communicate your own wishes), any specific instructions or precautions for ongoing care, and/or Provider (Physician/ Medical Doctor) information for the hospital transfers on 7/12/24 and 7/30/24. During an interview on 8/22/24 at 11:56 A.M., the Director of Nursing (DON) said when Resident #13 was sent to the hospital on 7/12/24 and 7/30/24, at minimum the E-interact transfer form (a form used by the facility when a resident is transferred out of the facility) and/or a Nurse's note should have been completed. The DON said that the facility has a transfer packet that is usually sent out with the Resident that would include Physician's orders, the Advanced Directives, pertinent labs, and the most recent progress note from the Provider. The DON said at the time of this interview there was no documented evidence that the receiving facility/hospital received the appropriate documentation when the Resident was transferred to the hospital on 7/12/24 and 7/30/24 and there should have been as required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225392	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sixteen Acres Healthcare Center	215 Bicentennial Highway Springfield, MA 01118

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on record review and interview, the facility failed to ensure that a Minimum Data Set (MDS) Assessment was accurately coded for one Resident (#39) out of a total sample of 22 residents. Specifically, for Resident #39, the facility staff failed to accurately code that the Resident had falls on the most recent Quarterly MDS Assessment. Findings include: Resident #39 was admitted to the facility in August 2020, with diagnoses including Central Cord Syndrome (a cervical spinal cord injury that can cause loss of power and sensation in the arm and hands) and Unspecified Dementia (a mental disorder that occurs when someone has Dementia but does not have a specific diagnosis). Review of the Quarterly MDS assessment dated [DATE], indicated the Resident had no falls during the look back period (the time frame during which a resident's condition is captured by the MDS Assessment). Review of the Resident's Nursing Progress Notes indicated the Resident had documented falls on 3/30/24, 4/5/24 and 4/23/24, during the look back period for the most recent Quarterly MDS Assessment. During an interview on 8/22/24 at 10:47 A.M., the MDS Nurse said Resident #39 did have falls during the look back period and the 4/23/24 MDS assessment was coded inaccurately and needed to be modified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225392	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sixteen Acres Healthcare Center	215 Bicentennial Highway Springfield, MA 01118

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 42741 Based on interview, record and policy review, the facility failed to ensure the risks and benefits of bed rails was reviewed with the Resident and/or Resident Representative and informed written consent was obtained prior to the use of bed rails for one Resident (#15) out of a total sample of 22 residents. Specifically, for Resident #15, the facility failed to ensure the risks and benefits of bed rails was reviewed with Resident #15's Guardian (a court appointed person who makes important personal and healthcare decisions for an adult who lacks the capacity to make their own decisions) and written consent was obtained from the Guardian prior to the installation and use of bed rails. Findings include: Review of the facility policy titled Use of Side Rails, undated, indicated the following: -Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks. Resident #15 was admitted to the facility in February 2024, with a diagnosis of Paranoid Schizophrenia (type of Schizophrenia characterized by paranoia [distrust, suspicious, and fearful without any good reason], delusions and hallucinations). Review of the Resident's Permanent Decree of Guardianship, signed by the Justice of Probate and Family Court Department on 3/8/00, indicated Resident #15 was appointed a Permanent Guardian on 3/8/00. Review of the side rail care plan indicated the use of side rails for Resident #15 was initiated on 2/23/24 and resolved on 7/5/24. Review of the Physician's orders dated 4/10/24, indicated Resident #15 had quarter (1/4) side rails (rail/bar approximately one-quarter of the length of the bed, that attaches to the side of the bed and can be used to help patients get in and out of bed) to both sides of his/her bed. Review of the Nursing Progress Note dated 7/5/24, indicated Resident #15 had his/her side rails removed from his/her bed. Review of the Informed Consent for the Use of Side Rails Form, indicated Resident #15 had consented to his/her use of side rails. Further review of the medical record did not indicate that Resident #15's Guardian had been provided with the risk and benefits of side rail use or that the Guardian had provided consent for the facility to use side rails on Resident #15's bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225392	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sixteen Acres Healthcare Center	215 Bicentennial Highway Springfield, MA 01118

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/24 at 12:05 P.M., the Director of Nursing (DON) said she was unable to locate any documentation that staff at the facility had attempted to reach out to Resident #15's Guardian to acquire consent for the use of side rails. The DON said that staff should have reached out to the Guardian to obtain consent and documented in the Resident's medical record that attempts were made to obtain a signed consent for the use of side rails, but this was not done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225392	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sixteen Acres Healthcare Center	215 Bicentennial Highway Springfield, MA 01118

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 - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42741 Based on record review and interview, the facility failed to maintain complete and accurate medical records for one Resident (#15) out of a total sample of 22 residents. Specifically, for Resident #15, the facility failed to contact the Resident's Guardian (a court appointed person who makes important personal and healthcare decisions for an adult who lacks the capacity to make their own decisions) and ensure that the Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST-form that indicates what types of medical treatment a resident wishes to have concerning life-sustaining treatment) form was signed by the Guardian and not by the Resident. Findings include: Review of the facility's policy titled Massachusetts Advanced Directives, last revised 8/3/22, indicated the following: -Guardian: A person who is appointed by the court to make decisions for an incapacitated person. A Guardian's authority varies based on the type of guardianship and grants specifically permitted by a Judge. -The Nursing Home Administrator is responsible for appointing staff who will initiate conversation to identify residents' responsible parties. Elected staff will confirm that information is appropriately documented in the medical record. Resident #15 was admitted to the facility in February 2024 with a diagnosis of Paranoid Schizophrenia (type of Schizophrenia characterized by paranoia [distrust, suspicious, and fearful without any good reason], delusions and hallucinations). Review of the Resident's Permanent Decree of Guardianship, signed by the Justice of Probate and Family Court Department on 3/8/00, indicated Resident #15 was appointed a Permanent Guardian on 3/8/00. Further review of the Resident's Guardianship paperwork indicated no documentation where the court indicated the Resident retained the ability to sign a MOLST Form. Review of Resident #15's MOLST Form on file indicated that the MOLST was completed and signed by the Resident on 2/24/24 after his/her admission to the facility and signed by the Physician/Nurse Practitioner/Physician Assistant on 2/26/24. Further review of the Resident's medical record indicated no documentation that the facility staff had contacted Resident #15's Guardian regarding completing a MOLST Form. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225392	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sixteen Acres Healthcare Center	215 Bicentennial Highway Springfield, MA 01118

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 - Few	During an interview on 8/22/24 at 9:46 A.M., the Director of Nursing (DON) said Resident #15 should not have completed his/her own MOLST Form and the facility staff should have consulted with the Resident's Guardian on what capacity the Guardian had to make advanced directive decisions, and this was not done.