STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225417	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Armenian Nursing & Rehabilitation Center	431 Pond Street Boston, MA 02130

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43846 Based on observation and interviews the facility failed to provide a dignified dining experience for several residents on one resident care unit (the first floor), out of two resident units. Findings include: Review of the facility policy titled Dignity, not dated, indicated Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. On 1/14/25 from 8:49 A.M. to 8:59 A.M., the surveyor observed a nurse standing while feeding a resident in his/her room. On 1/15/25 from 8:11 A.M. to 8:20 A.M., the surveyor observed a staff member deliver a resident his/her breakfast tray to the resident room. The staff member did not set up the tray but left it within reach of the resident and then exited the room. The surveyor observed the resident unable to initiate self-feeding. During lunch service in the first floor dining room on 1/14/25 at 12:01 P.M., a Resident was sitting at a table with three other residents who were being assisted by staff with eating. The Resident was hunched over with his/her head down facing the table with no meal in front of him/her while his/her tablemates were being assisted with eating. At 12:21 P.M., 20 minutes later, a staff member sat down with the Resident to assist with eating, the other tablemates were finished eating at this time. During breakfast service on the first floor on 1/15/25 at 8:51 A.M., a staff member delivered a breakfast tray to a resident in his/her room. At 8:57 A.M., a Certified Nursing Assistant was observed standing while feeding the resident, not at eye level of the resident, who was lying in his/her bed. During an interview on 1/16/25 at 7:54 A.M., Nurse #1 said staff should not serve a dependent resident meal to the resident until a staff member is ready to assist them with that meal. Nurse #1 said staff should be seated while assisting residents with their meal. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview on 1/16/25 at 8:37 A.M., Nurse #1 said staff should not be standing while assisting with feeding residents and all residents at a table in the dining room should be served meals at the same. During an interview on 1/16/25 at 8:10 A.M., Certified Nurse Aide (CNA) #1 said staff should not leave meal trays in front of dependent residents until a staff member is ready to assist them. CNA #1 said staff should not stand while feeding a resident and instead the staff need to sit. During an interview on 1/16/25 at 9:19 A.M., the Director of Nurses (DON) said she expects when the meal is delivered to the resident then the staff should be ready to assist that resident. The DON said she expects staff to sit while feeding a resident and that all residents should be served their meal trays at the same time if they are sitting at a table in the dining room. 45984

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45343 Based on observation, interview and record review, the facility failed to develop a care plan for one Resident (#53), out of a total sample of 19 residents. Specifically, the facility failed to develop a vision care plan. Findings Include: Review of the policy titled Care Plan-Comprehensive, undated, indicated: Policy: -An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's of medical, nursing, mental and psychological needs is developed for each resident. -Residents will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychological needs. -For newly admitted residents, the comprehensive care plan must be completed within seven days of the completion of the comprehensive assessment (MDS Admission Assessment) and no more than 21 days after admission. Resident #53 was admitted to the facility in August 2022 with diagnoses that included low vision right eye category 2, blindness left eye category 5, combined forms of age-related cataract, central retinal artery occlusion, left eye, chronic systolic (congestive) heart failure and weight loss. Review of Resident #53's most recent Minimum Data Set (MDS) dated [DATE], indicated Resident #53 has a Brief Interview for Mental Status (BIMS) exam score of 10 out of a possible 15 which indicated he/she has moderate cognitive deficits. The MDS assessment also indicated Resident #53 requires dependent assistance for self-care activities and has moderate vision impairments. On 1/14/25 at 8:10 A.M., the surveyor Resident #53 sitting in his/her chair eating breakfast. Resident #53 was asked what he/she was having for breakfast, he/she said I can't see everything on my plate. Resident #53 said he/she is unable to see out of his/her left eye and his/her vision in the right eye is blurry. Resident was asked if staff inform him/her what is on their plate, he/she said no but knows what food it is once he/she tastes it. On 1/15/25 at 12:15 P.M., the surveyor observed Resident #53 sitting in his/her chair getting ready to eat lunch. Resident #53 was asked if he/she was able to see what was on his/her plate for lunch. Resident #53 said he/she has something dark and something light on his/her plate and knows there is something to drink. Resident #53 was asked if he/she was able to identify his/her dessert, he/she said no. Resident #53 again stated that he/she will know what food it is once he/she tastes it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 1/15/25 at 3:43 P.M., failed to indicate a care plan was developed for low vision with interventions for Resident #53. During an interview on 1/16/25 at 8:25 A.M., Unit Manager #2 said the facility works with the family to identify the best strategies for the resident with visual deficits and educate the staff. Unit Manager #2 said she was not aware that Resident #53 was unable to identify the food on his/her plate. Unit Manager #2 said she would expect a visual care plan to be developed and implemented on admission. During an interview on 1/16/25 and 9:15 A.M., the Director of Nursing said she would expect a vision care plan to be developed on admission.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview, the facility failed for two Residents (#63 and #61), out of a total sample of 19 residents, to provide weekly skin assessments in accordance with the physician's order. Specifically, 1. For Resident #63, the facility failed to complete weekly skin assessments, as per the physician's order, resulting in four missed weekly skin assessments, 2. For Resident #61, the facility failed to complete weekly skin assessments, as per the physician's order. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Review of the facility policy titled Pressure Ulcer Risk Assessment and Prevention, not dated, indicated Skin assessment will be done by a licensed nurse on admission and weekly thereafter. Skin will be assessed for the presence of developing pressure ulcers or other skin conditions. 1. Resident #63 was admitted to the facility in December 2024 and has diagnoses that include but are not limited to mild cognitive impairment, neoplasm of bladder, and type 2 diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #63 scored a 9 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having moderately impaired cognition. Further, the MDS indicated Resident #63 as dependent on staff for bathing, upper and lower dressing, has no unhealed pressure ulcers, and is at-risk for developing pressure ulcers. During an observation and interview on 1/14/24 at approximately 9:30 A.M., Resident #63 was observed sitting in a wheelchair in the dining/activity room. Resident #63 said his/her feet hurt. When asked if he/she had any open areas or injuries, he/she said it feels like they (feet) are cut. Review of Resident #63's medical record indicated the following: - A nursing Admission/ReAdmission (sic) assessment dated [DATE], indicated Resident #63 was assessed to have intact skin. - A physician's order indicated weekly skin assessment by a licensed nurse, document under assessments in PCC (the electronic medical record) every evening shift, every Friday. Start date 12/20/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #63's clinical record failed to indicate any weekly skin assessments were completed. Review of the Treatment Administration Record (TAR) for December 2024 and January 2025, indicated the dates for the weekly skin assessments, signed off by licensed nursing, occurred on 12/20/24, 12/27/24, 1/3/25 and 1/10/25, resulting in four missed weekly skin assessments. During an interview on 1/15/25 at 3:49 P.M., Nurse #4 said assessing a resident's skin is done on admission and then weekly on-going. Nurse #4 said this is completed for all residents. Nurse #4 said the weekly skin assessment is documented on the weekly skin assessment in the electronic medical record. At this time, Unit Manager #2 came over and looked at Resident #63's assessments tab in the electronic medical record and said there were no weekly skin assessments there. Unit Manager #2 checked the progress notes and said there were no nursing notes regarding skin assessments. Unit Manager #2 said there was a note dated 1/10/25 regarding Resident #63's coccyx. Unit Manager #2 said the nursing staff are required to document on the weekly skin assessment the status of the resident's skin and not just sign the TAR. Review of the nursing note dated 1/10/24 at 12:44 P.M., indicated the primary nurse requested the physician and this nurse to assess Resident #63's coccyx due to redness at site. The note indicated the coccyx cleft is red and blanching, and the physician determined the area had some moisture-associated skin damage at coccyx cleft due to warm moist environment. In accordance with the physician's order, Resident #63 should have had weekly skin assessments completed for the weeks of 12/20/24, 12/27/24, 1/3/25, and 1/10/25. During an interview on 1/16/25 at 9:19 A.M., the Director of Nurses said she expects the weekly skin checks to be completed as ordered. 43846 2. Resident #61 was admitted to the facility in March 2024 with diagnoses that included Parkinson's disease, end stage renal disease, and type 2 diabetes. Review of Resident #61's most recent Minimum Data Set (MDS) assessment, dated 12/14/24, indicated he/she scored a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating moderate cognitive impairments. The MDS further indicated the Resident is at-risk for developing pressure ulcers. Review of Resident #61's physician order, dated 3/28/24, indicated Weekly skin assessment by a licensed nurse, document under assessments in the electronic medical record. Review of Resident #61's diabetes care plan, dated 3/28/24, indicated Weekly skin assessment by a licensed nurse. Review of Resident #61's assessment section in the electronic medical record indicated the last completed skin assessment occurred on 11/21/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #61's nursing progress notes from 11/24/24 through 1/15/25 failed to indicate that the Resident refused any skin checks. During an interview and observation of Resident #61's medical record on 1/16/25 at 8:06 A.M., Nurse #2 said Resident #61 does have an order for weekly skin checks and they should be done under the assessment tab in the electronic medical record. Nurse #2 said the last skin check recorded in the medical record was on 11/21/24. Nurse #2 said if a resident refuses a skin check, then it should be written in a nurse's progress note. During an interview on 1/16/25 at 9:19 A.M., the Director of Nurses said she expects the weekly skin checks to be completed as ordered.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observations, record review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs), for two Residents (#45 and #64) out of a total sample of 19 residents. Specifically, the facility failed to provide assistance and/or supervision with meals as per the plan of care for Resident #45 and for Resident #64. Findings include: Review of the facility policy titled Activity of Daily Living, not dated, indicated ADL assistance will be provided according to the needs of the residents. ADL include bathing, grooming, dressing, mobility, incontinence care, positioning, transfer, eating and others. 1a. Resident #45 was admitted to the facility in September 2024 with diagnoses that included dementia, dysphagia, cognitive communication deficit and depression. Review of Resident #45's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairments. The MDS further indicated he/she is dependent on staff for eating. On 1/14/25 from 8:48 A.M. to 8:59 A.M., the surveyor observed Resident #45 in bed with his/her breakfast tray setup with out any staff present. Resident #45 was observed not initiating self- feeding. On 1/14/25 from 12:09 P.M. to 12:23 P.M., the surveyor observed Resident #45 in the dining room with his/her lunch tray setup without any staff present assisting him/her. Resident #45 was observed not initiating self-feeding and falling asleep at times. On 1/15/24 from 8:38 A.M. to 9:00 A.M., the surveyor observed Resident #45 in bed with his/her breakfast tray setup without any staff present. Resident #45 was observed not initiating self- feeding. Review of Resident #45's Activity of Daily Living (ADLs) care plan, dated 9/9/24, indicated ADL DEPENDENT: The Resident is dependent on staff with all ADLs due to: Dementia. During an interview on 1/16/25 at 7:54 A.M., Nurse #1 said Resident #45 needs assist from a staff member to eat. During an interview on 1/16/25 at 7:55 A.M., the MDS Nurse said if the Resident MDS is coded as the Resident being dependent with eating then that resident needs a staff member to feed them. During an interview on 1/16/25 at 8:10 A.M., Certified Nurse Aide (CNA) #1 said she is Resident #45's regular CNA during the day and said the Resident is a dependent resident and needs assist to eat his/her meal. CNA #1 said if the meal was in front of the Resident a staff member should be with him/her to assist the Resident with their meal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/25 at 9:19 A.M., the Director of Nurses (DON) said if a resident is coded as dependent for eating then a staff member should be assisting the resident with their meal. 45984 1b. Resident #64 was admitted to the facility in January 2022 with diagnoses including chronic diastolic heart failure, dysphagia (difficulty swallowing) and Parkinson's disease. Review of Resident #64's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 15 out of 15 indicating intact cognition. Further review of the MDS indicated that Resident #64 requires supervision or touching assistance from staff while eating meals. The surveyor made the following observations: - On 1/14/25 at 8:15 A.M., Resident #64 was sitting up in his/her bed eating his/her breakfast in his/her room at the end of the hallway. There were no staff members in his/her room offering assistance or providing supervision and the Resident could not be seen by staff from the hallway. - On 1/15/25 from 8:11 A.M. until 8:26 A.M., Resident #64 was sitting up in his/her bed eating his/her breakfast in his/her room at the end of the hallway. There were no staff members in his/her room offering assistance or providing supervision and the Resident could not be seen by staff from the hallway. - On 1/15/25 at 12:05 P.M., Resident #64 was eating lunch in his/her room at the end of the hallway. The resident was standing, hunched over his/her bedside table where the lunch tray was. Resident #64 was eating very rapidly and not alternating bites and sips of liquid. There were no staff members in his/her room offering assistance or providing supervision and the Resident could not be seen by staff from the hallway. - On 1/16/25 at 8:12 A.M., Resident #64 was eating breakfast in his/her room at the end of the hallway. The resident was standing, hunched over his/her bedside table where the lunch tray was. Resident #64 was eating very rapidly and not alternating bites and sips of liquid. The Resident's door was shut to his/her room. there were no staff members in his/her room offering assistance or providing supervision and the Resident could not be seen by staff from the hallway. At 8:33 A.M., 21 minutes since Resident #64 received his/her breakfast tray, a staff member checked in on the resident. Review of Resident #64's ADL Guide indicated that the resident requires supervision or touching assist while eating. Review of Resident #64's ADL Assistance care plan indicated the following interventions dated 2/8/24: Supervise and/or assist resident during meals to dysphagia and prefers to take his/her meals in his/her room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #64's nutrition care plan dated and revised 10/11/24 indicated that the resident is at risk of compromised nutritional status related to selective appetite with a history of dysphagia with silent aspiration of fluids. The care plan had the following intervention: Monitor for signs/symptoms of aspiration (wheezing, trouble breathing, a hoarse voice after eating, drinking and/or vomiting, or experiencing heartburn) at meal and snack time. Review of Resident #64's document titled Speech Therapy - Speech Language Pathologist Discharge Summary, dated from 2/8/24 - 5/7/24 for dysphagia therapy, indicated the following: - D/C (Discharge) instructions: Upright for intake, small bites/sips, slow rate, alternate solids/liquids, clear bolus before next bite. The document indicated that staff were educated on the discharge instructions for Resident #64. Review of Resident #64's Dietary Quarterly Assessment completed by the Registered Dietitian, dated 1/8/25, indicated the following: - Risk Factors: Silent aspiration of fluids During an interview on 1/16/25 at 8:37 A.M., Nurse #1 said staff will look at the care plans to know what type of ADL care residents need. Nurse #1 said Resident #64 is on aspiration precautions and he/she should be supervised as much as possible while eating. Nurse #1 said he/she can choke in an instant and staff need to do a better job with his/her supervision while he/she is eating. During an interview on 1/16/25 at 9:21 A.M., the Director of Nursing (DON) said the Certified Nursing Assistants use care cards to know what ADL care each residents need. The DON said the facility uses rotating supervision where staff go around and check in on each resident while they are eating in their rooms. The DON said a resident can choke in an instance and Resident #64 should be supervised more closely during meals.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 15016 Based on policy review and interview, the facility failed to educate and offer the COVID-19 vaccine to one of one (Nurse #3) sampled staff member. Findings include: Review of the facility policy COVID-19 Infection Control Protocol dated as revised 11/6/23, indicated: All employees are encouraged to be vaccinated with the current vaccine requirements to be considered vaccinated according to DPH guidelines. We will honor employees' wishes and can decline vaccine booster for religious, medical and personal reasons in accordance to the most current DPH guidelines. During an interview with the Director of Nursing (DON) on 1/16/25 at 9:32 A.M., the surveyor requested evidence that the facility had educated Nurse #3 on the benefits and risks and potential side effects associated with the COVID-19 vaccine. The surveyor also requested evidence the facility had offered Nurse #3 the COVID-19 vaccine or information on obtaining the vaccine. The DON said the facility had not educated Nurse #3 about the COVID-19 vaccine or offered the COVID-19 vaccine, or provided information either verbally or in writing on how to obtain the vaccine. The DON said Nurse #3 was not offered a consent or declination form for the vaccine. The DON said that when staff ask her about acquiring the vaccine, she directs them to their local pharmacy. The DON said Nurse #3 had not asked her about how to obtain the COVID-19 vaccine.