STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 34145 Based on record review and interview, the facility failed to ensure that residents and/or their representatives were fully informed in advance and given information necessary to make health care decisions including the dose and benefits of psychotropic medications prior to their use for one Resident (#32), from a total sample of 27 residents. Findings include: Review of the facility's policy titled Policy and Procedure for Informed Consent for Psychotropic Medications, dated 3/17/16, indicated but was not limited to: -It is the policy of the facility that informed consent for the administration of psychotropic medications will be obtained prior to the administration of any psychotropic medication, including antipsychotic medications and medications used out of class for alternate clinical purpose. -Documentation will include: -Dose range for the medication -Purpose of the medication -Risks of use of the medication; if on antipsychotics, the black box warning is reviewed for use of antipsychotics in dementia related psychosis -Benefits of use of the medication Resident #23 was admitted to the facility in June 2020 with diagnoses including dementia with behavioral disturbance and bipolar disorder. The Resident's Health Care Proxy was activated on 10/28/20. Review of the Minimum Data Set (MDS) assessment, with a reference date of 6/18/24, indicated that Resident #23 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15, and was administered psychotropic medication daily. Review of the medical record indicated Physician's Orders including but not limited to: -Bupropion (antidepressant) HCl 75 milligrams (mg), give one tablet one time a day and (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
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Bupropion HCl 75 mg, give two tablets one time a day for a total daily dose of 225 mg for bipolar disorder (1/13/24) Review of April 2024 through August 2024 Medication Administration Records (MAR) indicated Bupropion was administered as ordered by the physician. Review of psychotropic consent forms indicated a consent form for Bupropion was renewed (annually) and signed by the Health Care Proxy 4/9/24. The consent form failed to identify the dose administered, failed to indicate the benefits of the medication and indicated a dose range of 0-200 mg and not up to 225 mg that the Resident is administered daily. During an interview on 8/28/24 at 11:35 A.M., Unit Manager #2 and Nurse #2 reviewed Resident #23's medical record and said the psychotropic consent for Bupropion should indicate the dose administered, benefits of the medication, and a dose range that includes the total amount of medication administered daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46562 Based on record review and interview, the facility failed to ensure the Physician/Practitioner was notified of a change in treatment for one Resident (#17), out of a total sample of 27 residents. Specifically, the facility failed to ensure the Physician/Practitioner was notified when the Wound Consultant recommended the initiation of an antibiotic. Findings include: Resident #17 was admitted to the facility in July 2024 with the following diagnoses: Stage 4 pressure ulcer on his/her right calf (a wound with full thickness tissue loss with exposed bone, tendon, or muscle). Review of the Minimum Data Set (MDS) assessment, dated 7/30/24, indicated Resident #17 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15, and had one Stage 4 pressure ulcer that was present on admission. Review of the Wound Consultant's Wound Evaluation and Management Summary, dated 8/2/24, indicated but was not limited to: -Stage 4 pressure wound of the right, upper calf, full thickness: Additional Wound Detail: Augmentin (antibiotic) 875 milligrams (mg) twice daily for seven days Review of Resident #17's August Medication Administration Record (MAR) and Treatment Administration Record (TAR) failed to indicate he/she had received Augmentin as recommended by the wound consultant. Review of Resident #17's Order Recap Report from 8/1/24 through 8/29/24 failed to indicate Augmentin 875 mg twice daily for seven days had been initiated. Review of Resident #17's progress notes from 8/1/24 through 8/29/24 failed to indicate the Physician/Practitioner was made aware of the Wound Consultant's recommendation to start Augmentin. During an interview on 8/28/24 at 3:07 P.M., Unit Manager #1 reviewed Resident #17's medical record and said there was no indication that an antibiotic had been ordered. During an interview on 8/28/24 at 3:51 P.M., the Infection Control Nurse said there was no record that Resident #17 received Augmentin during the month of August. During a telephonic interview on 8/28/24 at 1:34 P.M., the Wound Consultant said when he had a recommendation, he verbalized it to the nursing staff and included it on his Wound Evaluation and Management Summary report. The Wound Consultant said he had intended for Resident #17 to start Augmentin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 10:13 A.M., Physician #1 said the Wound Consultant's recommendation to initiate Augmentin was not brought to his attention. Physician #1 said he spoke with his Practitioner and his Practitioner had not been made aware of the Wound Consultant's recommendation either. During an interview on 8/29/24 at 10:55 A.M., Nurse #7 said she completes wound rounds with the Wound Consultant. Nurse #7 said she did not recall the recommendation to initiate Augmentin for Resident #17. Nurse #7 said she should have seen the recommendation to start an antibiotic on the Wound Evaluation and Management Summary report and should have called the Physician/Practitioner. During an interview on 8/29/24 at 10:19 A.M., the Infection Control Nurse said Physician/Practitioners should be made aware of all recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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. 46562 Based on observations and interviews, the facility failed to maintain a clean, safe, comfortable, and homelike environment for the residents at the facility, for 1 of 3 nursing units. Findings include: Review of the facility's policy titled Homelike Environment, dated as revised February 2021, indicated but was not limited to: -Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible -The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary, and orderly environment. On the following days of survey, the Surveyor observed the following in the C Unit Lounge: On 8/26/24 at: -9:27 A.M., eight resident wheeled positioning devices which included standard wheelchairs, high back wheelchairs and Broda chairs (a wheelchair that provides comfort, support, and mobility), a mattress, a rolling walker, and a set of leg rests. -11:02 A.M., six resident wheeled positioning devices which included standard wheelchairs, high back wheelchairs and Broda chairs, a mattress, a rolling walker, and a set of leg rests. -3:40 P.M., eight resident wheeled positioning devices which included standard wheelchairs, high back wheelchairs and Broda chairs, a mattress, a rolling walker, and a set of leg rests. On 8/27/24 at: -8:26 A.M., nine resident wheeled positioning devices which included standard wheelchairs, high back wheelchairs and Broda chairs, a mattress, a rolling walker, and a set of leg rests. -10:08 A.M., seven resident wheeled positioning devices which included standard wheelchairs, high back wheelchairs and Broda chairs, a mattress, a rolling walker, and a set of leg rests. An activity was on-going at this time. -12:00 P.M., six resident wheeled positioning devices which included standard wheelchairs, high back wheelchairs and Broda chairs, a mattress, a rolling walker, and a set of leg rests. On 8/28/24 at: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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	-8:02 A.M., nine resident wheeled positioning devices which included standard wheelchairs, high back wheelchairs and Broda chairs, a mattress, a rolling walker, and a set of leg rests. -9:45 A.M., eight resident wheeled positioning devices which included standard wheelchairs, high back wheelchairs and Broda chairs, a mattress, a rolling walker, and a set of leg rests. -12:07 P.M., seven resident wheeled positioning devices which included standard wheelchairs, high back wheelchairs and Broda chairs, a mattress, a rolling walker, and a set of leg rests. -4:48 P.M., nine resident wheeled positioning devices which included standard wheelchairs, high back wheelchairs and Broda chairs, a mattress, a rolling walker, and a set of leg rests. On 8/29/24 at: -7:54 A.M., seven resident wheeled positioning devices which included standard wheelchairs, high back wheelchairs and Broda chairs, a mattress, a rolling walker, and a set of leg rests. -10:17 A.M., eight resident wheeled positioning devices which included standard wheelchairs, high back wheelchairs and Broda chairs, a mattress, a rolling walker, and a set of leg rests. An activity was on-going at this time. -12:33 P.M., seven resident wheeled positioning devices which included standard wheelchairs, high back wheelchairs and Broda chairs, a mattress, a rolling walker, and a set of leg rests. During an interview on 8/29/24 at 9:42 A.M., Resident #71 said the Unit Lounge had been used as a storage room and with all the equipment in the room it was not welcoming or inviting. Resident #71 said the room was meant for the residents to use and not for storing the equipment. During an interview on 8/26/24 at 10:15 A.M., Resident Representative #1 said the Unit C Lounge looked more like a storage closet than an activity room/resident space. Resident Representative #1 said she has seen that the room has been heavily occupied by equipment that included wheelchairs, a mattress, a window screen and rolling walkers. During an interview on 8/29/24 at 9:38 A.M., Activities Assistant #1 said the Unit C Lounge was the room the facility used for most activities. Activities Assistant #1 said the room was also used to store equipment that is not in use. During an interview on 8/29/24 at 8:01 A.M., Certified Nursing Assistant (CNA) #4 said the C Unit Lounge is used for activities and occasionally as an additional dining room. CNA #4 said the equipment in the room was there because it was not currently in use and kept the residents' rooms less cluttered. During an interview on 8/29/24 at 10:17 A.M., Nurse #1 said when resident equipment was not in use it was stored in the Lounge to keep the resident rooms from being cluttered. During an interview on 8/29/24 at 12:50 P.M., the Maintenance Director said the facility goal was to keep resident areas clear of equipment and at one point the C Unit Lounge had been cleared of equipment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 8/29/24 at 1:01 P.M., the Administrator said the C Unit Lounge was used to store wheelchairs when a resident was not using it, instead of in their rooms. The Administrator said unassigned equipment and mattresses should not be stored in the Unit Lounge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 48695 Based on record review and interview, the facility failed to ensure staff developed a baseline or comprehensive care plan within 48 hours of the resident's admission, which included the instructions needed to provide effective and person-centered care for two Residents (#96 and #251), out of a total sample of 27 residents. Specifically, the facility failed: 1. For Resident #96, to develop and implement a baseline care plan related to falls; and 2. For Resident #251, to ensure staff provided the resident and/or their representative with a summary of the baseline care plan within 48 hours of his/her admission. Findings include: Review of the facility's policy titled Care Plans - Baseline, last revised March 2022, indicated but was not limited to: - Policy Statement: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. - The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASARR recommendation, if applicable. - The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed. - The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes, but is not limited to the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The stated goals and objectives of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary. - Provision of the summary to the resident and/or resident representative is documented in the medical record. 1. Resident #96 was admitted to the facility in June 2024 with diagnoses of legally blind and epilepsy (seizure disorder). Review of Resident #96's Minimum Data Set (MDS) assessment, dated 6/24/24, indicated he/she had a severe cognitive deficit as evidenced by staff assessment for mental status. Review of Resident #96's Fall Risk Evaluation, dated 6/18/24, indicated that he/she had a high fall risk as evidenced by a fall score of 19. Review of the medical record indicated Resident #96 sustained a fall on 7/8/24. Further review of the medical record indicated a care plan for Falls had been established on 7/8/24, 20 days (480 hours) after Resident #96's admission. During an interview with a record review on 8/28/24 at 2:32 P.M., Unit Manager (UM) #1 reviewed Resident #96's admission fall assessment and care plans. UM #1 said Resident #96 had a fall score of 19 which indicated he/she was a high fall risk and should have had a baseline care plan for falls but did not. During an interview on 8/28/24 at 2:56 P.M., the Staff Development Coordinator (SDC) said baseline care plans were put in on admission as comprehensive care plans. The SDC said a fall care plan should have been initiated within 48 hours of admission. 46562 2. Resident #251 was admitted to the facility in August 2024 with the following diagnoses: dementia and behavioral disorders. Review of the medical record indicated Resident #251 was alert and confused at baseline. Review of the Brief Interview or Mental Status (BIMS) Evaluation, dated 8/18/24, indicated he/she was severely cognitively impaired as evidenced by a BIMS score of 0 out of 15. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/26/24 at 10:15 A.M., Resident Representative #1 said she had not discussed Resident #251's goals or plan of care with the facility since he/she was admitted . Resident Representative #1 said a family member had been present daily since his/her admission, but the facility had not initiated a meeting to establish their goals and/or to find out Resident #251's baseline. Resident Representative #1 said Resident #251 had been at the facility for over a week without a meeting to establish his/her treatment plan. Review of Resident #251's Interdisciplinary Baseline Care Plan Attendance documentation failed to indicate his/her representative had been present. During an interview on 8/28/24 at 2:32 P.M., Unit Manager #1 said a baseline care plan meeting should be held within 48 hours of admission to establish a resident's goals and update his/her plan of care. Unit Manager #1 said a copy of this information should be provided to the resident and/or their representative. During an interview on 8/28/24 at 2:39 P.M., Social Worker #1 said baseline care plan meetings should be conducted within 48 hours of admission. The surveyor and Social Worker #1 reviewed the Interdisciplinary Baseline Care Plan Attendance documentation and Social Worker #1 said the meeting had been conducted telephonically in which they discussed Resident #251's history and his/her baseline. During a follow-up telephonic interview on 8/29/24 at 12:14 P.M., Resident Representative #1 said the day after Resident #251 was admitted she met with the facility to sign admission paperwork and on that day, she asked to speak with the social worker or nursing manager but that did not occur. Resident Representative #1 said the social worker had called her on the evening of 8/26/24 but had not contacted her prior to that. Resident Representative #1 said I do not know how they were able to create goals or establish care without talking to the family because her loved one could not speak for themselves. During a follow up interview on 8/29/24 at 10:43 A.M., Social Worker #1 said she wanted to clarify that Resident #251's baseline care plan had not occurred as previously reported due to an urgent issue arising at the facility. Social Worker #1 said she has since reached out to the Resident Representative and a meeting was set for 8/30/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 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. 50740 Based on observations, interviews, and records reviewed for two Residents (#35 and #52), out of 27 sampled residents, the facility failed to develop and/or implement comprehensive care plans to reflect the individual needs of the resident. Specifically, the facility failed: 1. For Resident #35, to develop and implement a comprehensive person-centered care plan to address the Resident's diagnoses of dementia with behavioral disturbance and psychotic disorder with delusions; and 2. For Resident #52, to develop and implement a comprehensive person-centered care plan to address trauma informed care related to post-traumatic stress disorder (PTSD) diagnosis. Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, revised March 2022, indicated but was not limited to the following: -Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his/her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR (Pre-Admission Screening and Resident Review) recommendations; and (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. reflects currently recognized standards of practice for problem areas and conditions. 1. Resident #35 was admitted to the facility in June 2024 with diagnoses including dementia with behavioral disturbance and psychotic disorder with delusions. Review of the Minimum Data Set (MDS) assessment, dated 7/2/24, indicated Resident #35 was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 4 out of 15. Further review of the MDS indicated that the Resident exhibited verbal behaviors, wandering, and other behaviors (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) and that the cognitive loss/dementia and behavioral symptoms care areas were triggered for the Resident and addressed in the Resident's Care Plan. Review of Resident #35's Physician's Orders included but was not limited to the following: - HCP (Health Care Proxy) ACTIVATED 6/27/24 (6/27/24) -ANTIPSYCHOTIC MEDICATION: Monitor for dry mouth, constipation, blurred vision, disorientation/confusion difficulty urinating, hypotention [sic], dark urine, yellow skin, N/V, lethargy, drooling, EPS symptoms (tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue) (6/27/24) Review of Resident #35's Kardex failed to indicate target behaviors that the Resident should be monitored for related to his/her diagnoses of dementia with behavioral disturbance and psychotic disorder with delusions. Review of Resident #35's Care Plan included but was not limited to the following: -Focus: [Resident #35] uses psychotropic medications (specify medications) [sic] r/t Behavior management -Goal: The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date -Interventions: a. Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness q-shift (every shift). b. AIMS (Abnormal Involuntary Movement Scale) assessment every 6 months and PRN (as needed). c. Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the Resident's Care Plan failed to indicate that a care plan was developed related to the Resident's impaired cognition related to his/her dementia diagnosis. Additionally, Resident #35's Care Plans failed to indicate that a care plan was developed related to the Resident's behavioral disturbance related to his/her diagnoses of dementia and psychotic disorder with delusions. Review of Resident #35's Progress Notes included but was not limited to the following: -7/23/24 at 10:29 P.M.: Resident noted to be agitated in the evening, yelling and shouting. -7/20/24 at 2:15 P.M.: Resident stated no its not after being told these are your medications and no I told you no after trying to administer medications again. Resident Refused after medication education stating, I don't care, I said no. -7/8/24 at 6:53 A.M.: Resident alert and responsive, confusion, awake most of night. Resident very disturbing behaviors to other resident shouting able to be redirected. Kept looking to go home and for his/her truck. -7/7/24 at 10:54 P.M.: Resident noted to be alert but confused, yelling out and disturbing other residents. Also resisting care, wanting to leave. During an interview on 8/29/24 at 12:19 P.M., the MDS Nurse said that she would expect that care areas triggered on the MDS would be addressed in the Resident's care plan. 49428 2. Review of the facility's policy titled Trauma Informed Care Policy, undated, indicated but was not limited to the following: -if a resident has a history of trauma that is documented or if they have triggered from the assessment, the Social Worker (SW) and interdisciplinary team (IDT) need to immediately formulate a plan of care to assist the resident in coping within the facility with whatever issue has been identified. -the plan of care needs to be specific and include anything that has been shared that can trigger a memory of the incident. Resident #52 was admitted to the facility in July 2023 with diagnoses including unspecified dementia with agitation, anxiety disorder, major depressive disorder (MDD), and chronic PTSD (mental health condition that is triggered by a terrifying event, either by experiencing it or witnessing it. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event). Review of Resident #52's MDS assessment, dated 5/16/24, indicated Resident #52 had a BIMS score of 0 out of 15, which is indicative of severe cognitive impairment. Further review of the MDS indicated Resident #52 had active diagnoses that included dementia, anxiety, depression, and PTSD; and the Resident displayed physical, verbal, and other behavioral symptoms directed toward others. Review of Resident #52's Physician's Orders indicated but was not limited to the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Seroquel, 25 milligrams (mg) by mouth one time a day related to chronic PTSD, MDD, severe with psychotic symptoms, start 3/6/24; -Seroquel, 50 mg by mouth one time a day related to chronic PTSD, MDD, severe with psychotic symptoms, start 3/6/24. During an interview on 8/28/24 at 2:56 P.M., Social Worker (SW) #1 reviewed Resident #52's care plan. SW #1 said a trauma informed care care plan, which would include documentation of PTSD triggers, was not completed for the Resident. SW #1 said she could not find documentation of specific trauma or triggers related to the Resident's PTSD in the Resident's medical record. During an interview on 8/29/24 at 9:53 A.M., Unit Manager (UM) #1 said any resident with a diagnosis of PTSD must have a trauma informed care care plan that would include information such as PTSD triggers. UM #1 said Resident #52 should have a trauma informed care plan but did not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 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** 50740 Based on observation, interviews, and record review, the facility failed to ensure residents were provided care in accordance with professional standards of practice for two Residents (#35 and #63), out of a total sample of 27 residents. Specifically, the facility failed: 1. For Resident #35, a. to ensure that the Resident's fingerstick blood sugar was obtained per physician's order, b. to ensure that a physician's order was in place for the care and maintenance of the Resident's catheter drainage bag, and c. to ensure that a voiding trial (a procedure in which the ability of the bladder to empty after removal of a urinary catheter is measured) on 8/23/24 was implemented per physician's order; and 2. For Resident #63, to ensure physician's orders were complete for the management of a continuous glucose monitoring sensor and included orders to remove and change the device every 14 days. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated but was not limited to: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber 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. 1. Review of the facility's policy titled Diabetes - Clinical Protocol, revised November 2020, indicated but was not limited to the following: -As indicated, the Physician will order appropriate lab tests (for example, periodic finger sticks or A1C) and adjust treatments based on these results and other parameters such as glycosuria, weight gain or loss, hypoglycemic episodes, etc. Review of the facility's policy titled Insulin Administration, revised September 2014, indicated but was not limited to the following: -Characteristics and Types of Insulin Type: Long-acting Onset: 1-2 hours (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Peak: up to 8 hours Duration: up to 24 hours Review of the facility's policy titled Catheter Care, Urinary, revised August 2022, indicated but was not limited to the following: -Changing Catheters 1. Do not change indwelling catheters or drainage bags at routine, fixed intervals. 2. Change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Resident #35 was admitted to the facility in June 2024 with diagnoses including infection and inflammatory reaction due to indwelling urethral catheter, diabetes mellitus, urinary tract infection, obstructive and reflex uropathy, and benign prostatic hyperplasia. Review of the Minimum Data Set (MDS) assessment, dated 7/2/24, indicated Resident #35 was severely cognitively impaired, as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 4 out of 15. Further review of the MDS indicated the Resident had an indwelling urinary catheter and diagnosis of diabetes. a. Review of Resident #35's Physician's Orders included but was not limited to the following: - Fingerstick; contact MD below 70 above 350 one time a day (scheduled at 7:00 A.M.) (7/10/24) - Lantus (long-acting insulin) 100 units/milliliter; Inject 10 units subcutaneously one time a day (scheduled at 8:00 P.M.) (6/27/24) Review of Resident #35's Medication Administration Records (MAR) for July 2024 and August 2024 indicated that the fingersticks were obtained daily as ordered at 7:00 A.M. 7/10/24 through 8/28/24, but no values for the fingersticks obtained were documented on the MAR. Review of Resident #35's Weights and Vitals Summary showed that the Resident's blood sugar was documented as 160 milligrams (mg)/deciliter (dL) on 8/15/24 at 5:44 A.M. and 130 mg/dL on 8/11/24 at 7:06 A.M. From 7/10/24 through 8/26/24, 41 blood sugar values were entered in the Resident's record between 7:04 P.M. and 12:57 A.M., outside of the scheduled 7:00 A.M. time per the physician's order for fingersticks. b. Review of Resident #35's Physician's Orders included, but was not limited to, the following: - Foley Catheter Care every shift (7/30/24) - Foley catheter size 16 Fr (French) (7/30/24) - Irrigate Foley with 60 ml NS as needed (8/18/24) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No physician's order for replacement/changing of the Resident's catheter drainage bag was identified. Review of Resident #35's August 2024 MAR indicated that the Resident completed a course of Linezolid (an antibiotic) for treatment of a Vancomycin-resistant Enterococci (a bacteria resistant to Vancomycin, an antibiotic commonly used to treat enterococci infections) urinary tract infection on 8/8/24. Review of Resident #35's Treatment Administration Records (TAR) failed to indicate that his/her catheter drainage bag had been changed. c. Review of Resident #35's Physician's Orders included, but was not limited to, the following: - Foley Catheter Care every shift (7/30/24) - Foley catheter size 16 Fr (French) (7/30/24) - Void trial-reinsert foley if unable to void 8hrs, abdominal pain or distention one time only for retention for 1 Day (8/6/24) - Void trial-reinsert >400cc, abdominal distention, inability to void >8 hours (8/23/24) Review of Resident #35's TAR for July 2024 and August 2024 indicated that a voiding trial was completed 8/23/24; however, the TAR indicated that Foley catheter care was completed every shift on 8/23/24. Review of Resident #35's Progress Notes indicated, but was not limited to, the following: -On 8/20/24, Nurse #2 indicated that the Physician Assistant (PA) ordered a voiding trial for Friday (8/23/24) at 6:30 A.M. -On 8/21/24, Nurse #2 indicated that a voiding trial was scheduled for Friday (8/23/24) at 6:30 A.M. -On 8/26/24, Nurse #2 indicated that the Resident's catheter was removed at 7:00 A.M. for an attempted voiding trial but was reinserted as the Resident had not voided at 3:00 P.M. -On 8/27/24, Physician Assistant #1 indicated that the Resident had failed the voiding trial and that his/her blood sugar monitoring was without indications of hypoglycemia. No physician's order for a voiding trial on 8/26/24 was identified in the Resident's record. No progress note was entered on 8/23/24 indicating a voiding trial was attempted on that date or that communication with the physician had occurred to obtain an order to change the date of the voiding trial. No progress note was entered on 8/23/24 that indicated a voiding trial was attempted on that date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No progress note was entered that indicated communication with the physician had occurred to inform him/her that the voiding trial was not completed on 8/23/24 and/or to obtain an order to change the date of the voiding trial. During an interview on 8/28/24 at 2:59 P.M., Nurse #2 said that the Resident had undergone catheter removal for a voiding trial in the morning on 8/26/24, but was unable to void and the catheter was reinserted that afternoon. 34145 2. Review of the facility's policy titled Blood Glucose Monitoring-Continuous Policy, dated January 2023, indicated but was not limited to: -Staff should change out the site monitor/transmitter per manufacturer recommendations. Review of [NAME] Freestyle Libre Continuous Glucose Monitoring (CGM- https://www.freestyle.[NAME]/us-en/home.html) guidelines, included but was not limited to: -the Libre CGM is a small sensor-based system that provides real-time glucose readings day and night, without fingersticks; -The sensor is applied to the back of the upper arm with a simple, disposable device called an applicator. When the sensor is applied, a small (5 millimeter) filament (needle) is inserted just under the skin and held in place with a small adhesive pad; -There is a needle (sharp) in the applicator to insert the filament in the back of your upper arm so the sensor can monitor your glucose; -The sensor lasts up to 14 days and it is recommended to rotate application site of the sensor between arms. Review of Quick Start Guide for FreeStyle Libre 2 Reader (cgmmonitors.com/how-to-apply-freestyle-libre-sensor/) indicated, but was not limited to: -Select site on the back of upper arm. Do not use other sites as these may result in inaccurate glucose readings. -Wash site using a plain soap, dry, and then clean with alcohol wipe. Allow site to air dry before proceeding. -Place Sensor Applicator over site and push down firmly to apply Sensor. CAUTION: Do not push down on Sensor Applicator until placed over prepared site to prevent unintended results or injury. -Rotate application sites: To avoid skin irritation or tissue buildup, it's essential to rotate the sensor's application site regularly. Do not apply the sensor to the same spot consecutively. This helps maintain accurate readings and reduces the risk of skin-related issues. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #63 was admitted to the facility in February 2024 and had diagnoses including diabetes mellitus, type 1. Review of the MDS assessment, dated 5/27/24, indicated Resident #63 had moderate cognitive impairment as evidenced by a BIMS score of 8 out of 15 and received insulin injections daily. Review of August 2024 Physician's Orders indicated, but was not limited to: -FreeStyle Libre 2 Reader Device (Continuous Glucose System Receiver), 1 unit three times a day for diabetes mellitus (DM) monitoring using sliding scale as ordered (5/23/24) The physician's orders failed to include an order to change the device every 14 days. Review of August 2024 MAR/TAR and the entire medical record failed to indicate staff changed the sensor every 14 days as recommended by the manufacturer. During an interview on 8/30/24 at 8:38 A.M., Unit Manager #2 reviewed Resident #63's medical record. She said Resident #63 did not have a physician's order to change the device every 14 days but there should be. Telephone calls with voice messages left for Physican #2 on 8/30/24 and 9/13/24 were not returned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on observation, record review, and interview, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one Resident (#57), out of a total sample of 27 residents. Specifically, the facility failed to fully develop and implement interdisciplinary care plans related to his/her dominant language of Albanian and failed to ensure staff provided person-centered care and services to determine and support the Resident's communication needs. Findings include: Resident #57 was admitted to the facility in May 2019 and had diagnoses including Alzheimer's disease, major depressive disorder, and adjustment disorder. Review of the Minimum Data Set assessment, dated 7/9/24, indicated Resident #57's preferred language was Greek and requires an interpreter to communicate with his/her physician and health care staff. Review of the care plan for communication problems, initiated 5/12/19, indicated Resident #57 has a language barrier and prefers to speak in Albanian, but can understand some Greek and English words. The care plan indicated a language translator will be used for communication. Review of the care plan for Resident #57's dependence on staff for meeting emotional, intellectual, physical, and social needs, initiated 6/10/19, indicated all staff to converse with the Resident while providing care: I speak Albanian and Greek with limited English. On 8/26/24 at 9:25 A.M., the surveyor observed Resident #57 ambulating independently in his/her room. The surveyor greeted the Resident with good morning. The Resident's roommate told the surveyor that Resident #57 does not understand or speak English. During an interview on 8/26/24 at 9:26 A.M., Resident #57's Health Care Proxy (HCP) said Resident #57 speaks Albanian and Greek only and there is only one staff person that speaks Greek, but he/she hasn't seen her in a long time. The HCP said staff call him a lot to translate and he doesn't mind, but it would be very helpful if they had some basic words and pictures posted on the bulletin board in the Resident's room for staff to use so they could communicate with him/her. The HCP said there is not a communication book or translation service available for staff to use to communicate with Resident #57. The surveyor and HCP looked around the Resident's room and were unable to find a communication book or information about the availability of a language translation service. As the surveyor was leaving Resident #57's room on 8/26/24 at 9:32 A.M., Nurse #1 greeted Resident #57 in Spanish, [NAME] estas?. Resident #57 did not respond. On 8/26/24 at 9:30 A.M., the surveyor inspected the nursing station and vicinity, including all shelving and accessible storage areas and found no language communication book or information about the availability of a language translation service. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 2:00 P.M., the surveyor observed Resident #57 standing in his/her doorway. The surveyor greeted the Resident with good morning. The Resident began to speak in his/her language. At this time, Certified Nursing Assistants (CNA) #1 and #5 were standing outside of the Resident's room. During an interview, the CNAs said they have Resident #57 on their assignment regularly and neither of them speak Albanian or Greek and cannot communicate with the Resident or understand what he/she is trying to say. CNA #1 said she asks the family to translate when they are in to visit, but they don't come in every day. The CNAs said there was no communication book with pictures or simple phrases available to assist in communicating with Resident #57 and they were not aware of the availability of a language translation service. During an interview on 8/27/24 at 2:10 P.M., Nurse #1 said she cannot speak Albanian or Greek and uses hand gestures to try and communicate with Resident #57. She said one of the physicians that comes to the facility can speak Greek and one staff person from consultant service provider that occasionally comes to the facility also speaks Greek. On 8/27/24 at 2:15 P.M., the surveyor again inspected the nursing station and vicinity, including all shelving and accessible storage areas and found no language communication book or information about the availability of a language translation service. During an interview on 8/27/24 at 2:35 P.M., Volunteer #1 said he/she usually comes to the facility on ce a week. He/she said the staff can't speak Greek and it is sad that they can't communicate and engage the residents for which English is not their primary language. The Volunteer said there used to be someone here that could speak Greek, but he/she hasn't seen her in a while. The Volunteer said he/she is not aware of a language translation service available to residents, staff and volunteers. During an interview on 8/28/24 at 11:35 A.M., the surveyor asked Unit Manager #2 and Nurse #2 what resources are available for staff to communicate with non-English speaking residents. They said they try to interpret Resident #57's gestures to figure out what he/she needs, but don't know of any resources when they are not in the building. Nurse #2 said she is not aware of the availability of a language translation line. Unit Manager #2 said the social worker had just brought up a telephone number for a translation line and put it somewhere at the nursing station. Nurse #2 searched the nursing station and vicinity and moved a large computer monitor away from the wall to access a piece of paper tacked to a cork board with the words Translator Services and a telephone number printed on it. Unit Manager #2 and Nurse #2 said they didn't know the telephone number was there, did not know the translation service was available, and had never called the number. Unit Manager #2 removed a red binder, labeled Unit B Greek Translation, from a shelving unit holding medical records. The surveyor shared observations on 8/26/24 and 8/27/24 of no communication book at the nursing station and vicinity including all shelving and accessible storage areas. Unit Manager #2 could not explain why no staff, Health Care Proxys or volunteers interviewed were aware of the existence of a Greek language communication book and language translation service. Unit Manager #2, Nurse #2 and the surveyor reviewed the communication binder. A page in the binder listed four names of Greek translators available. Nurse #2 said she didn't know how old the book was, because three out of the four names listed no longer worked at the facility. She said the fourth name was a contracted consultant service provider and is not available to interpret unless she is in the building seeing her patients. Unit Manager #2 said Resident #57's physician speaks Greek and is always available to translate for staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 8:58 A.M., Physician #1 said he is Resident #57's attending physician and he speaks Greek with both residents and their families. He said if there is a medical problem, staff call him. He gave an example that if the Resident isn't feeling well, they call him to translate to find out what is going on. He said he only performs translation for medical issues and does not translate for anything non-medical.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 46562 Based on observation and interview, the facility failed to provide an ongoing program of individual and group activities designed to meet the interests of and support the physical, mental and psychosocial well-being for one Resident (#251), out of 27 sampled residents. Specifically, for Resident #251, the facility failed to consistently provide activities based on the comprehensive assessment and care plan. Findings include: Resident #251 was admitted to the facility in August 2024 with the following diagnoses: dementia and behavioral disorders. Review of the medical record indicated Resident #251 was alert and confused at baseline. Review of the Brief Interview for Mental Status (BIMS) Evaluation, dated 8/18/24, indicated the Resident scored 0 out of 15 indicating he/she was severely cognitively impaired. Review of Resident #251's care plans included but were not limited to: -Focus: Resident admitted for long term care. Resident in need of 24 hour care and supervision, dated 8/16/24. Interventions: Encourage/involve in daily activities, dated 8/16/24 -Focus: Resident #251 is dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits due to dementia, depression, anxiety, anemia, physical limitations due to gait and balance problems, dated 8/22/24. Interventions: I need 1:1 bedside/in-room visits and activities if unable to attend out of room events, dated 8/22/24. Invite Resident #251 to scheduled activities. I enjoy Musical Events, dated 8/22/24 Review of Resident #251's August 2024 Activity Participation Record indicated but was not limited to: -8/16/24: TV/Radio, 1:1 visit, Family Visit -8/17/24: TV/Radio -8/18/24: TV/Radio, Outside Family Visit -8/19/24: TV/Radio, Family Visit, Entertainment -8/20/24: TV/Radio, Family Visit -8/21/24: TV/Radio -8/22/24: TV/Radio -8/23/24: TV/Radio (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/24/24: TV/Radio, Family Visit, Holy Communion, 1:1 Visit -8/25/24: TV/Radio, Family Visit -8/26/24: TV/Radio, Family Visit -8/27/24: TV/Radio, 1:1 visit -8/28/24: TV/Radio, 1:1 visit -8/29/24: TV/Radio, 1:1 visit On the following dates and times of survey, the surveyor observed Resident #251: On 8/27/24: -8:27 A.M., lying in bed, no TV/music, with no staff engagement -10:08 A.M., sitting in his/her chair, door to room partially closed, no TV/music, with no staff engagement. Multiple residents observed in the C Unit Lounge participating in an exercise group -10:29 A.M., sitting in his/her chair, door to room partially closed, no TV/music, with no staff engagement. Multiple residents observed in the C Unit Lounge participating in an exercise group -12:12 P.M., sitting in his/her chair, door to room partially closed, no TV/music, with no staff engagement On 8/28/24: -7:58 A.M., lying in bed, no TV/music, with no staff engagement -9:44 A.M., sitting in his/her chair, no TV/music, with no staff engagement -11:52 A.M., lying in bed, no TV/music, with no staff engagement -2:46 P.M., sitting in his/her chair looking at a paper on his/her overbed table, no TV/music, with no staff engagement. Multiple residents observed in the C Unit Lounge participating in a music activity. -4:48 P.M., sitting in his/her chair, no TV/music, with no staff engagement On 8/29/24: -7:55 A.M., lying in bed, no TV/music, with no staff engagement -9:47 A.M., sitting in his/her chair with a baby doll in hands, no TV/music, with no staff engagement (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10:11 A.M., sitting in his/her chair, no TV/music, with no staff engagement. Multiple residents observed in the C Unit Lounge participating in an exercise group -12:33 P.M., sitting in his/her chair, no TV/music, with no staff engagement During an interview on 8/26/24 at 10:15 A.M., Resident Representative #1 said Resident #251 was used to being involved in structured activity. Resident Representative #1 said Resident #251 was not being engaged by the staff and had not been to any activities. During an interview on 8/28/24 at 2:17 P.M., Certified Nursing Assistants (CNA) #2 and #3 said Resident #251 stayed in his/her room most of the time with his/her baby doll and family photos. CNA #2 said his/her family visited often and that Resident #251 had gone to one or two group activities. During an interview on 8/28/24 at 12:02 P.M., Nurse #4 said Resident #251 was new to her, but from what she has seen, Resident #251 sits in his/her room with the baby doll and seemed content with that. Nurse #4 said she was not aware if Resident #251 had attended activities. During an interview on 8/29/24 at 10:53 A.M., Social Worker #2 said she was reviewing Resident #251's medical record and that goal of care was to get him/her involved in a routine and activities. During an interview on 8/29/24 at 1:48 P.M., the Activities Director said she would go in and provide 1:1 visits with Resident #251. The Activities Director said Resident #251's family visited often and he/she spent time with them outside. The Activities Director provided the surveyor with a copy of Resident #251's August 2024 Activity Participation Record and said any activities he/she had participated in would be recorded. The Activities Director said the (Activity Participation Record) sheets were updated daily and were accurate at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34145 Based on observation, record review, and interview, the facility failed to ensure residents were free from accident hazards for two Residents (#32 and #62), out of a total sample of 27 residents. Specifically, the facility failed to complete his/her quarterly smoking evaluations. Findings include: Review of the facility's policy titled Smoking Policy and Procedure, dated as revised 11/1/2018, indicated but was not limited to: -All residents expressing the desire to smoke tobacco products or use E-cigarettes will be assessed upon admission to the center, when there is a change in status and quarterly. On 8/26/24 at 1:30 P.M. and 8/29/24 at 9:07 A.M., the surveyor observed Residents #32 and #62 smoking in the facility's designated smoking area with staff supervision. a. Resident #32 was admitted to the facility in June 2020 and had diagnoses including bipolar disorder and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 3/19/24, indicated Resident #32 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15 and utilized tobacco products. Review of the medical record indicated the last smoking and safety assessment was conducted on 12/18/23. Further review of the entire medical record failed to indicate any smoking and safety assessments were conducted after 12/18/23. b. Resident #62 was admitted to the facility in March 2021 and had diagnoses including bipolar disorder and anxiety. Review of the MDS assessment, dated 1/2/24, indicated Resident #32 had moderate cognitive impairment as evidenced by a BIMS score of 8 out of 15 and utilized tobacco products. Review of the medical record indicated the smoking and safety assessment were conducted on: -1/20/23 -6/16/23 -4/1/24 -7/1/24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record indicated no quarterly smoking and safety assessments were conducted in 4/2023, 9/2023, 12/2023 and 3/2024. During an interview on 8/27/24 at 1:49 P.M., Unit Manager #2 said smoking and safety assessments are to be completed quarterly. She said some assessments were missed and not done quarterly for Residents #32 and #62.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 50740 Based on interview and record review, the facility failed to ensure staff implemented dialysis care and services consistent with professional standards of practice for one Resident (#10), out of 27 sampled residents. Specifically, the facility failed to provide ongoing communication between the nursing facility and dialysis facility. Findings include: Review of the Long Term Care Facility Outpatient Dialysis Services Agreement, dated 6/15/07, indicated but was not limited to the following: 3. Resident Information. The Facility shall ensure that all appropriate medical and administrative information accompany all residents at the time of transfer or referral to the Center. This information, shall include, but is not limited to, where appropriate, the following: a. Resident's name, address, date of birth, and Social Security Number; b. Name, address and telephone number of the resident's next of kin; c. Resident's third party payor data; d. Appropriate medical records, including history of the resident's illness, including laboratory and x-ray findings; e. Treatment presently being provided to the resident, including medications; f. Name, address and telephone number of the nephrologist with admitting privileges at the Center referring the resident to the Center; and g. Any advance directive executed by the resident. Resident #10 was admitted to the facility in October 2021 with diagnoses including end stage renal disease and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment, dated 6/25/24, indicated Resident #10 was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15. Further review of the MDS indicated the Resident received dialysis treatments. Review of the Physician's Orders indicated Resident #10 had dialysis three times weekly. Review of the Dialysis Communication Book indicated that no dialysis communication forms were completed by the facility from 10/28/23 through 8/27/24. Further review of the dialysis communication book indicated that communication forms were completed by the dialysis center for communication to the facility 10/28/23 through 8/27/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #10's Progress Notes failed to indicate the facility called the dialysis center and provided verbal communication from 10/28/23 through 8/27/24. During an interview on 8/27/24 at 12:40 P.M., Unit Manager (UM) #2 said that the nurse should complete the facility's Dialysis Communication Form in the Resident's dialysis communication book before the Resident leaves for dialysis. UM #2 reviewed the dialysis communication book with the surveyor and said that she did not see any completed Dialysis Communication Forms in the book. During an interview on 8/27/24 at 12:45 P.M., Nurse #2 said that the nurse on duty when the Resident leaves for dialysis is responsible for completing the Dialysis Communication Form and that she reviews the Resident's dialysis book when he/she returns from dialysis. During a telephonic interview on 8/27/24 at 3:49 P.M., the Dialysis Nurse said that the facility does not usually complete a communication form to share information with the dialysis center on a regular basis but will report if something out of the ordinary occurs with the Resident. During an interview on 8/29/24 at 10:25 A.M., Nurse #2 said that the facility utilizes the paper communication forms in the Resident's dialysis communication book to communicate with the dialysis center.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 48695 Based on record review, policy review, and interview, the facility failed to monitor adverse consequences (side effects) of anticoagulant medications (used to prevent the blood from clotting; a blood thinner) for one Resident (#41), out of a total sample of 27 residents. Findings include: Review of the facility's policy titled Anticoagulation-Clinical Protocol, last revised November 2018, indicated but was not limited to: - Monitor and Follow-Up 5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. Resident #41 was admitted to the facility in January 2024 with diagnoses of atrial fibrillation and hypertension. Review of Resident #41's Minimum Data Set (MDS) assessment, dated 7/25/24, indicated Resident #41 had a moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. Further review of the MDS indicated that Resident #41 received anticoagulant medication. Review of Resident #41's current Physician's Orders indicated but was not limited to: - Rivaroxaban (Xarelto, anticoagulant medication) 20 milligrams (mg), give 1 tablet by mouth one time a day for AFIB (atrial fibrillation), dated 3/7/24 Review of Resident #41's August 2024 Medication Administration Record (MAR) indicated he/she received Rivaroxaban as ordered. Further review of Resident #41's medical record failed to indicate Resident #41 was monitored for adverse consequences of anticoagulant medication. During an interview on 8/29/24 at 9:04 A.M., Nurse #8 said residents who received anticoagulant medications should be monitored for adverse consequences. Nurse #8 reviewed Resident #41's physician's orders and said the Resident had an order for anticoagulant medication and had received it as ordered. Nurse #8 said Resident #41 should have had an order to monitor for adverse consequences of anticoagulant medication but did not. During an interview on 8/29/24 at 9:10 A.M., Nurse #5 said any resident who takes an anticoagulant medication should have an order to monitor for adverse consequences. During an interview on 8/29/24 at 12:09 P.M., the Staff Development Coordinator (SDC) said residents who take anticoagulant medications should be monitored for adverse consequences every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 1:33 P.M., Unit Manager (UM) #1 said all residents who receive an anticoagulant medication should have an order to monitor for adverse consequences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48695 Based on record review and interview, the facility failed to ensure one Resident's (#56) drug regimen was free from unnecessary psychotropic medications, out of a total sample of 27 residents. Specifically, the facility failed to ensure an as needed antipsychotic medication was limited to 14 days, or extended beyond 14 days with a documented clinical rationale and duration. Findings include: Review of the facility's policy titled Antipsychotic Medication Use, last revised July 2022, indicated but was not limited to: - Policy Statement: - Residents will not receive medications that are not clinically indicated to treat a specific condition. - Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. - Policy Interpretation and Implementation: 1. Resident will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 16. PRN (as needed) orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication and documented the rationale for continued use. The duration of the PRN order will be indicated in the order. Resident #56 was admitted to the facility in July 2024 with a diagnosis of Alzheimer's disease. Review of Resident #56's August 2024 Physician's Orders indicated but were not limited to: - Quetiapine (antipsychotic medication) 25 milligrams (mg), Give 1 tablet by mouth every six hours as needed for Breakthrough Aggression and Agitation with an end date listed as indefinite. (dated 8/9/24) - Quetiapine 25 mg, give half a tab (12.5 mg) two times daily for Breakthrough Aggression and Agitation related to Alzheimer's disease (dated 8/9/24) Review of Resident #56's medical record failed to indicate that Quetiapine 25 mg as needed was re-evaluated after 14 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/24 at 3:21 P.M., Unit Manager (UM) #1 said any resident who had an order for an as needed anti-psychotic medication should have the order for no longer than 14 days. UM #1 reviewed Resident #56's medical record and said the Resident had an order for an as needed anti-psychotic medication, Quetiapine, that did not have a stop date and was put into the physician's orders as indefinitely. UM #1 said the order for Quetiapine should have been 14 days, and then the physician should have re-evaluated the medication. During an interview on 8/29/24 at 10:15 A.M., the Staff Development Coordinator said as needed anti-psychotic medications should be prescribed for no longer than 14 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28450 Based on observation and interview, the facility failed to store, prepare and serve food in accordance with professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Ensure food was properly labeled in two out of two refrigerators in the kitchen; and 2. Properly label, date, and store food products in two of two nourishment kitchenettes. Findings include: Review of the facility's policy titled Food Storage: Cold Foods, revised ,d+[DATE], indicated but was not limited to: - All foods will be stored wrapped or in covered containers, labeled and dated and arranged in a manner to prevent cross contamination. - All refrigerated, ready-to-eat Time/Temperature Control Safety (TCS) prepared foods that are to be held for more than 24 hours at a temperature of 41 degrees Fahrenheit or less, will be labeled and dated with a prepared date (Day 1) and use by date (Day 7). Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated, but was not limited to: ,d+[DATE].18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A food specified in ,d+[DATE].17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3- 501.17(A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in ,d+[DATE].17(A). 1. On [DATE] at 7:35 A.M., the surveyor along with the Food Service Manager (FSM) observed the following in Refrigerator #1 and #2 in the main kitchen: - Refrigerator #1: one large, opened package of American cheese opened [DATE] no use by date, one large bowl of egg salad dated [DATE] no use by date. - Refrigerator #2: one container of feta cheese dated [DATE] no use by date. One bag of parmesan cheese delivered [DATE] opened and undated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:10 A.M., the FSM said the kitchen staff should have labeled the refrigerated food items with an opened and a use by date. She said the items in use stored in the main kitchen refrigerators were not properly labeled. 2. Review of the facility's policy titled Food Brought by Family/Visitors, reviewed [DATE], indicated but was not limited to: - The nursing staff is responsible for discarding perishable foods on or before the use by date. - The nursing and/or food service staff must discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). On [DATE] at 9:50 A.M., the surveyor along with the FSM observed the following in the second-floor nourishment kitchenette: - One bottle of apple juice dated [DATE] and no use by date. - One small container of applesauce dated [DATE] and no use by date. - One bottle of peach flavored iced tea with no resident name or date. - One take-out food container dated [DATE]-[DATE] with no resident name. - One plastic shopping bag that contained meat, cucumbers, and a bowl of stew with no resident name or date. - One dish containing stuffing, green beans and turkey meat dated [DATE], indicated room [ROOM NUMBER] without a name. - One 16-ounce cup containing watermelon, honeydew, and pineapple that appeared to be deteriorating. - Garlic parmesan refrigerated dinner, which appeared partially eaten, with no resident name or date. - One small jar of tartar sauce, which the FSD said is not supplied by the facility, with no resident name or date. - Three packages of frozen dinners in the refrigerator with no resident name or date. - One container of prepared food consisting of baked chicken with no resident name or date. - One carton box of shrimp scampi, a la vodka with Italian sausage. - One box of meatloaf with mashed potatoes not labeled. - One box of macaroni and cheese dinner not labeled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225418	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hellenic Nursing & Rehabilitation Center	601 Sherman Street Canton, MA 02021

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One lunch box on the counter. During an interview on [DATE] at 9:51 A.M., the FSM said foods brought from home are to be verified by nurses and to be labeled and stored in the refrigerator. She also said beverages and dairy products must have an opening and discard date. On [DATE] at 9:55 A.M., the surveyor along with the FSM, observed the following in the third-floor nourishment kitchenette: - One bottle of hot sauce, the FSM said was not supplied by the facility, with no resident name or date. - One can of chicken noodle soup with no resident name. - One box of spaghetti, stored in the cabinet next to the refrigerator with no resident name or date. - One brown bag of fast-food containing chicken nuggets, one cheeseburger, one fish sandwich, two containers of French fries, dated [DATE] with no resident name indicated. - Six slices of oatmeal bread, which the FSM said was not supplied by the facility, with no resident name or date. - Three zipper bags containing soup in the refrigerator with no resident name or date. - Two blueberry muffins with no resident name or date. - One snack pack of garlic hummus and chips with no resident name or date. - One can of coconut water, unopened, with no resident name or date. On [DATE] at 9:55 A.M., the surveyor observed in the third-floor nourishment kitchenette refrigerator splashes and spills of liquid substances on refrigerator shelves and the sides of the interior. The surveyor observed containers of food set on top of the spilled substances. During an interview on [DATE] at 10:10 A.M., the FSM said the items observed in the refrigerator should be labeled with the resident's name and a use by date. The FSM said any items in kitchenettes that have no resident name or date should be thrown away. The FSM said the kitchenette refrigerator was dirty and should have been clean by the dietary aides who were supposed to clean the kitchenette and the refrigerator prior to restocking snacks and beverages. Review of the Dietary Morning Checklist - Kitchenettes undated indicated: Check the refrigerator temperature, and freezer; check and discard expired items, Check labels and dates - if no label and date for Resident Food notify Nurse or Certified Nursing Assistant; Check Inventory - milk, juice, supplement shake, bread, snack and condiments, post menu of the day. During an interview on [DATE] at 7:40 A.M., the Administrator said dietary is responsible to clean the refrigerator in the kitchenettes.