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	08/28/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to ensure nursing staff provided assistance with Activities of Daily Living (ADLs) for one Resident (#89), out of a total sample of 26 residents. Specifically, for Resident #89 the facility failed to provide assistance with the removal of facial hair. Findings include:Review of the facility's policy titled Activities of Daily Living (ADL) Supporting, dated 3/18, indicated the following: Policy-Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).-Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Policy Interpretation and Implementation:-Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care). Resident #89 was admitted to the facility in March 2022, with diagnoses including chronic kidney disease Stage 4, atrial fibrillation, Type 2 Diabetes Mellitus, and dementia. Review of Resident #89's most recent Minimum Data Set (MDS) assessment, dated 7/23/25, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, indicating he/she had intact cognition. Further review of the MDS indicated Resident #89 required supervision or touching assistance to partial or moderate assistance for self-care activities. During an interview on 8/26/25 at 8:02 A.M., Resident #89 said he/she normally does not have facial hair and would like it removed but needs a razor and assistance. On 8/26/25 at 8:02 A.M., and 12:14 P.M., 8/27/25 at 8:14 A.M., 9:59 A.M., 12:50 P.M., and 3:03 P.M., and 8/28/25 at 8:13 A.M., the surveyor observed Resident #89 with long chin hair, approximately an inch long. Review of Resident #89's ADL care plan last revised, 8/26/25, indicated the following:Grooming: Continue supervision to assist of 1. Review of Resident #89's personal hygiene care card (documentation indicating level of care provided for combing hair, shaving, applying make-up, and washing/drying face and hands), indicated Resident #89 requires continued supervision to assist of 1 to complete personal hygiene. During an interview on 8/28/25 at 8:28 A.M., Unit Manager #1 said the Certified Nursing Assistants (CNAs) normally shave residents during morning care with their permission. Unit Manager #1 said Resident #89 is mostly independent, requires supervision and is not known to refuse care. Any refusals should be documented in the medical record. During an interview on 8/28/25 at 9:02 A.M., the Director of Nursing said he would expect facial hair to be removed with the resident's permission during routine care, and any refusals should be documented in the medical record. During an interview on 8/28/25 at 9:51 A.M., CNA #2 said we remove facial hair with the resident's permission during morning care. CNA #2 said Resident #89 does not normally refuse care, but he/she likes to do it themselves. CNA #2 said if a resident refuses care she will let the nurse know. CNA #2 said she will ask Resident #89 now if he/she would like their facial hair removed. Review of Resident #89's nursing progress notes failed to indicate he/she refused ADL care.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to follow up on a significant weight change in a timely manner and failed to implement a nutrition intervention as recommended by the Registered Dietitian (RD) for one Resident (#11), out of a total of 26 residents. Specifically, the facility failed to assess a significant weight loss for over 11 weeks and implement interventions for a nutrition supplement as recommended by the RD for Resident #11.Findings include:Review of the facility's policy titled ?Weight Assessment and Interventions', dated March 2022, indicated but was not limited to:-Resident weights are monitored for undesirable or unintended weight loss or gain.-Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing.Resident #11 was admitted to the facility in July 2019 with diagnoses including dysphagia, oropharyngeal phase (difficulty swallowing), adult failure to thrive, and dementia.Review of Resident #11's Minimum Data Set (MDS) assessment, dated 6/26/25, indicated Resident #11 could not participate in the Brief Interview for Mental Status (BIMS) due to impaired cognition. The MDS further indicated Resident #11 was setup assistance for meals, had triggered for a non-prescribed weight loss and was on a mechanically altered diet.Review of the weight report for Resident #11 indicated the following weights:12/1/24-129.0 pounds (lbs.)1/3/25- 106.0 lbs.Review of the weights indicated Resident #11 lost 23 lbs. in one month, which is a significant weight loss of 21.7%.Review of Resident #11's nutrition care plan indicated the following:Focus: Resident is at potential nutritional risk due to inadequate by mouth intakes, need for altered diet, diagnosis of dementia, dysphagia, hypertension, hyperlipidemia, failure to thrive.Review of Resident #11's Physician's Order, dated 6/26/24, indicated the following:-Glucerna (an oral nutrition supplement) two times a day Glucerna 240 milliliters (mls) by mouth, document percentage in the medication administration record (MAR).Review of the nutritional assessment completed by the RD, dated 3/25/25, indicated Resident #11 would maintain stable weight within +/- five pounds of 128 lbs. The RD did not assess Resident #11's significant weight loss until over 11 weeks after the significant weight loss was documented.Further review of the nutritional assessment indicated the following plan/recommendation from the RD:-Recommend increasing Glucerna from twice a day to three times a day.Review of the medical record failed to indicate the Glucerna was increased to three times a day.During an interview on 8/28/25 at 8:41 A.M., Unit Manager #2 said the Resident is on Glucerna twice a day. She said if a resident is weighed and there is a significant weight loss the dietitian will be notified. She further said she was not sure if the dietitian was aware of Resident #11's weight change between December and January. Unit Manager #2 said the dietitian can write orders in the medical record, but the nurses have to approve it after speaking with the physician. She said she was not aware Resident #11's Glucerna had been recommended to be increased to three times a day.During an interview on 8/28/25 at 8:44 A.M., Nurse #1 said Resident #11 accepts Glucerna and he/she receives it twice a day.During an interview on 8/28/25 at 8:54 A.M., the RD said she keeps track of Resident's weights using the electronic medical record and if a resident has a significant weight change the system will alert her. The RD said if a Resident flags for a significant weight change, she will request the resident to be reweighed to confirm it and once confirmed she will assess the resident as soon as possible. The RD and the surveyor reviewed Resident #11's weight history and the RD assessment from 3/25/25. The RD said Resident #11 should have been assessed much sooner and she was not sure why the recommendation for Glucerna three times daily was never implemented. The RD then said Resident #11 is at risk of losing more weight without the recommended interventions being implemented.During an interview on 8/28/25 at 9:44 A.M., Certified Nursing Assistant (CNA) #2 said Resident #11 likes to eat breakfast but not the other offered meals. She said that the Resident will at times refuse to get weighed but once reapproached he/she will allow to be weighed.