

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER Center for Extended Care at Amherst		STREET ADDRESS, CITY, STATE, ZIP CODE 150 University Drive Amherst, MA 01002	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, interview, and record review, the facility failed to provide care and services per professional standards of practice related to monitoring the use of Vitamin D (vitamin that helps regulate calcium and phosphorus in the body, crucial for bone health and immune system) medication for one Resident (#116) out of a total sample of 26 residents.</p> <p>Specifically, for Resident #116, the facility failed to obtain Physician orders to monitor serum laboratory results to determine appropriate decrease of the dosage of Vitamin D medication, when the Resident was administered high doses of Vitamin D medication weekly, putting him/her at risk for adverse effects of the medication.</p> <p>Findings include:</p> <p>Review of the National Institutes of Health (NIH) article titled: Vitamin D, Fact Sheet for Health Professionals, last updated 7/26/24, https://ods.od.nih.gov/factsheets/VitaminD-HealthProfessional/ indicated the following in part:</p> <ul style="list-style-type: none"> -Serum (blood) concentration of 25(OH)D is currently the main indicator of Vitamin D status. -Because Vitamin D is fat soluble, its absorption depends on the gut's ability to absorb dietary fat. Fat malabsorption is associated with medical conditions that include some forms of liver disease . -Excess amounts of Vitamin D are toxic. Because Vitamin D increases calcium absorption in the gastrointestinal tract, Vitamin D toxicity results in marked: <ul style="list-style-type: none"> &gt;hypercalcemia (total calcium greater than 11.1 mg/dL, beyond the normal range of 8.4 to 10.2 mg/dL), &gt;hypercalciuria, and high serum 25(OH)D levels (typically greater than 375 nmol/l [150 ng/mL]). <p>Hypercalcemia, in turn, can lead to nausea, vomiting, muscle weakness, neuropsychiatric disturbances, pain, loss of appetite, dehydration, polyuria, excessive thirst, and kidney stones.</p> <p>-In extreme cases, Vitamin D toxicity causes renal failure, calcification of soft tissues throughout the body (including in coronary vessels and heart valves), cardiac arrhythmias, and even death.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Vitamin D toxicity has been caused by consumption of dietary supplements that contained excessive Vitamin D amounts because of manufacturing errors, that were taken inappropriately or in excessive amounts, or that were incorrectly prescribed by physicians.</p> <p>Resident #116 was admitted to the facility in August 2024, with diagnoses including metabolic encephalopathy, Vitamin D Deficiency, cirrhosis of liver and Dementia.</p> <p>Review of the Minimum Data Set (MDS) Assessment, dated 5/20/25, indicated Resident #116 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of a total possible score of 15.</p> <p>Review of Resident #116's June 2025 Physician's Order Summary, indicated:</p> <p>-Ergocalciferol (Vitamin D) Oral Capsule 1.25 milligram (mg) (50000 UT), give 50000 IU by mouth one time a day, every Thursday, related to Hypocalcemia (low calcium in the blood), initiated 8/16/24.</p> <p>Further review of the Physician Order Summary failed to indicate any Physician orders to monitor for Vitamin D toxicity or ongoing orders to monitor and obtain serum laboratory values for Vitamin D levels.</p> <p>Review of the Physician's Progress Note dated 8/19/24, indicated the following relative to Resident #116:</p> <p>-Vitamin D deficiency</p> <p>-Continue Ergocalciferol 50,000 IU weekly x 8 weeks</p> <p>-Recheck Vitamin D level</p> <p>-If Vitamin D level was within Normal limit, convert Vitamin D dose to 2000 IU daily.</p> <p>Review of the Physician's Progress Note dated 9/30/24 indicated:</p> <p>-Vitamin D deficiency</p> <p>-Continue Ergocalciferol 50,000 (International Units) IU weekly x 8 weeks</p> <p>-Recheck Vitamin D level</p> <p>-If Vitamin D level was within Normal limit, convert Vitamin D dose to 2000 IU daily.</p> <p>Further review of the Physician's Progress Note dated 9/30/24, indicated that Vitamin D levels had not been ordered from admission, but had been ordered to be drawn on 10/14/24.</p> <p>During an interview on 6/3/25 at 12:20 P.M., the Director of Nursing (DON) said there was no Physician's order for Vitamin D serum laboratory levels to be obtained for Resident #116. The DON further said Vitamin D serum laboratory levels for Resident #116 had not been ordered by the Physician, and had not been drawn.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/3/25 at 12:45 P.M., the Physician Nurse Practitioner (PNP) said Vitamin D serum laboratory levels for Resident #116 had not been ordered and there was no record that a serum Vitamin D level had been obtained. The PNP said a serum Vitamin D level was needed to monitor for the continued need of the Vitamin D 50,000 IU weekly.</p> <p>During an interview on 6/3/25 at 2:27 P.M., the Pharmacy Consultant said he did not realize Resident #116 was being administered Vitamin D 50,000 IU weekly. The Pharmacy Consultant said Vitamin D 50,000 IU was usually prescribed to be administered monthly and was not aware the Resident had been taking the Vitamin D 50,000 IU weekly for the past 10 months without serum Vitamin D laboratory levels. The Pharmacy Consultant further said Vitamin D 50,000 units being administered to Resident #116 for this length could lead to Vitamin D toxicity.</p> <p>During an interview on 6/4/25 at 9:08 A.M., the facility's Medical Director said serum Vitamin D laboratory levels for Resident #116 should have been ordered, and obtained and he was not aware that this had not been done.</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on observations, interviews, and records reviewed, the facility failed to provide care consistent with professional standards of practice to prevent deterioration of a pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) for one Resident (#41), of five applicable residents reviewed for pressure ulcer care and services, out of a total sample of 26 residents.</p> <p>Specifically, for Resident #41, the facility failed to implement the Physician's order for the use of prophylaxis booties for a Deep Tissue Injury (DTI- pressure induced damage to underlying tissues, including muscles, bones, and subcutaneous layers, while the skin surface may remain intact.) pressure ulcer resulting in the Resident ' s Pressure Ulcer deteriorating with related swelling, redness and severe pain at the Pressure Ulcer location.</p> <p>Findings include:</p> <p>Review of the facility policy titled Care Plans, Comprehensive Person-Centered, revised March 2022, included but was not limited to the following:</p> <p>-A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical .functional needs is developed and implemented for each resident.</p> <p>&gt;Each care plan is consistent with resident rights to participate .including the right to: Receive the services and/or items included in the plan of care.</p> <p>Resident #41 was admitted to the facility in February 2023 with diagnoses including Restless Leg Syndrome, Diabetes Mellitus, Difficulty Walking, Dementia and Parkinsons Disease.</p> <p>Review of Resident #41 ' s Minimum Data Set (MDS) Assessment, dated 5/6/25, included but was not limited to the following:</p> <p>-The Resident was severely cognitively impaired as evident by the Brief Interview for Mental Status (BIMS) score of six out of a total possible score of 15 with the ability to recall after cueing (something to wear).</p> <p>-The Resident required substantial/maximum assistance (helper does more than half the effort) to apply and remove footwear.</p> <p>-The Resident was at risk for Pressure Ulcers.</p> <p>-The Resident had an unhealed DTI Pressure Ulcer.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/2/25 at 11:43 A.M., the surveyor observed Resident #41 lying in bed, covered by bed linens and a pair of gray booties were observed on a chair positioned at the foot of the Resident ' s bed. During an interview at the time, Resident #41 said those are my boots over there on that chair. Resident #41 said that he/she did not have booties on his/her feet under the bed linens. Resident #41 said he/she had a wound on the left foot and the nurses were treating it. Resident #41 said he/she was unaware if the wound was getting better or not and said his/her left foot had some bad pain. Resident #41 said that he/she should have booties on when in bed, but not all staff remember to put the booties on.</p> <p>During an interview on 6/3/25 at 8:51 A.M., the surveyor observed Resident #41 lying in bed and Resident #41 said his/her left foot was hurting. Resident #41 said he/she was not wearing booties and then pointed to the chair at the foot of his/her bed. The surveyor observed a pair of gray booties on the chair at the foot of the Resident's bed. Resident #41 then lifted the bed linens to expose his/her legs and feet, and the surveyor observed the Resident ' s legs and feet and observed no booties to be in place. The Resident ' s left ankle was observed positioned directly against the mattress. The surveyor further observed eight spots of dried light pink substance on the Resident ' s fitted sheet around the area his/her left foot was located. The Resident said he/she was unaware if the skin was open, but the ankle was hurting more than yesterday.</p> <p>On 6/3/25 at 1:53 P.M., the surveyor observed Resident #41 seated in a wheelchair at his/her bedside and wearing ankle high socks. The Resident ' s bed was unmade, and the fitted sheet on the Resident ' s bed was observed with multiple areas of dried light pink substance present on the Resident ' s fitted sheet where the Resident ' s feet were located in the previous observation at 8:51 A.M.</p> <p>During an observation and interview on 6/4/25 at 7:51 A.M., the surveyor observed Resident #41 lying in bed and a pair of gray booties were located on a chair at the foot of the Resident ' s bed. Resident #41 said that he/she had started the night with the booties on but had used the bathroom and the booties were not put back on. Resident #41 said staff should have at least put a pillow under his/her feet but not everyone does. The Resident then pulled back his/her bed linen and the surveyor observed the Residents' legs and feet. The Residents ' left ankle was observed to be flat against the mattress without booties or a pillow in place. The surveyor then observed a light pink substance on the Residents ' fitted sheet in 12 spots along the foot area. The Surveyor observed Resident #41 from the hallway continuously until 8:42 A.M without evidence of staff entering the room.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/4/25 at 8:42 A.M., the surveyor observed Resident #41 transferred out of bed and into a wheelchair by Nurse #1 and Certified Nurses Aide (CNA) #1. During an interview at the time, Nurse #1 said Resident #41 should have had booties on when he/she was in bed but did not. Nurse #1 said Resident #41 was at high risk for skin breakdown because of his/her diagnoses of Parkinsons Disease and Diabetes. Nurse #1 said the booties were ordered by the Physician to prevent Resident #41 ' s DTI from getting worse and without the booties on, the Resident ' s wound could worsen. Nurse #1 said the CNAs should know to apply the Resident ' s booties because the booties would be listed in the CNA care Kardex (resident specific information about delivery of care). The surveyor and Nurse #1 observed the CNA care Kardex for Resident #41 , which did not indicate evidence for the application of the Resident ' s booties while in bed as a care needed intervention. Nurse #1 said the booties should also be listed in the Point of Care (POC) documentation for the CNA staff. The surveyor and Nurse #1 observed the POC documentation which did not have evidence present that the Resident required booties while in bed as a care need intervention. The surveyor and Nurse #1 observed the gray booties on the chair at the foot of the Residents' bed and Nurse #1 said the gray booties belonged to Resident #41 and should have been on the Resident when he/she was lying in bed. Nurse #1 said if Resident #41 had been out of bed during the night, the staff should have re-applied the booties when the Resident returned to bed. The surveyor and Nurse #1 then observed the Residents fitted sheet which had the pink substance present on the fitted sheet and Nurse #1 said the pink substance looked like wound drainage. The surveyor and Nurse #1 observed Resident #41 ' s left ankle wound. Nurse #1 said that the Resident ' s left ankle wound had dried drainage and appeared to be opened. Nurse #1 said the Resident ' s wound had deteriorated from DTI to an open wound.</p> <p>Review of Resident #41 ' s medical record included but was not limited to:</p> <ul style="list-style-type: none"> -A Nursing Progress Note, dated 5/1/25 at 23:20 (11:20 P.M.) indicating Resident #41 had a new DTI pressure area to the left outer ankle. -A Physician's order for Skin Prep to the Resident ' s left outer ankle; DTI every shift for left ankle DTI, effective 5/2/25. -A Rehabilitation Screen request, dated 5/2/25 for new DTI to left ankle with a recommendation response to discontinue previous brace and continue booties to bilateral feet. -A Physicians order to apply booties to bilateral feet when in bed, every shift (11:00 P.M.-7:00A.M., 7:00 A.M.-3:00 P.M., 3:00 P.M.-11:00 P.M.) for prophylaxis; Pressure Wound, effective 5/3/25. <p>Review of Resident #41's Treatment Administration Record (TAR) for May 2025 and June 2025 indicated:</p> <ul style="list-style-type: none"> -Ankle brace to the left foot was discontinued, effective 5/2/25. -Booties were applied to bilateral feet as ordered, effective 5/3/25-6/4/25. -Skin Prep was applied to the left outer ankle DTI as ordered, effective 5/1/25- 6/4/25. <p>Review of Resident #41 ' s weekly wound documentation for May 2025 included the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-On 5/3/25 and 5/10/25 the Resident ' s left ankle DTI was intact, measured 7 mm (millimeters) in length by 8 mm in width by 0 mm depth.</p> <p>-On 5/17/25 the Resident ' s left ankle DTI was intact, without evidence of measurements present.</p> <p>-On 5/24/25 the Resident ' s DTI was scabbed, improving, and measured 0.5 centimeters (cm).</p> <p>-On 5/31/25 the Resident ' s DTI was scabbed and measured less than 0.5 inch.</p> <p>Further review of Resident #41's medical record failed to indicate any evidence that the scabbed area identified on 5/24/25 and 5/31/25 to the Resident ' s left ankle had reported to the MD and/or the facility ' s wound care nurse and/or assessed as a newly identified skin issue.</p> <p>Review of Resident #41 ' s June 2025 Physician's orders included but was not limited to:</p> <p>-Activated Health Care Proxy (HCP-A person that can make decisions for another when they are unable to do so themselves), effective 4/19/24.</p> <p>-Apply Skin Prep (a liquid applied to the skin that forms a protective film barrier to protect against friction/shearing) to bilateral heels and left outer ankle pink areas to prevent breakdown, every day shift (7:00 A.M.-3:00 P.M.) and evening shift (3:00 P.M.-11:00 P.M) for to [sic] prevent skin breakdown, effective 3/27/24 .</p> <p>-Diabetic Foot Care at bedtime (3:00 P.M.-11:00 P.M.): note any abnormal findings in nurses note, effective 12/4/24.</p> <p>-Document Behavior Symptoms every shift; 4 = Rejection of care (code all that are observed; write a note for any observed behavior, effective 2/27/23.</p> <p>Review of Resident #41's Person-Centered care plan for Activity of Daily Living (ADL) Performance, revised 2/7/25, indicated:</p> <p>-The Resident had self care deficits.</p> <p>-The Resident required substantial/maximum assistance of one person for dressing.</p> <p>-The Resident required substantial/maximum assistance of one person for bed mobility.</p> <p>Review of Resident #41's Person-Centered care plan for Risk of/and Actual Skin Impairment, revised 5/2/25, indicated:</p> <p>-Resident will maintain or develop clean and intact skin through next review date, 8/6/25.</p> <p>-Administer treatment as ordered.</p> <p>-Report abnormalities, failure to heal .to Medical Doctor (MD).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #41 ' s Behavior Monitoring documentation for May 2025 and June 2025 included but was not limited to:</p> <p>-No evidence of documented refusal of care.</p> <p>During an interview and observation on 6/4/25 at 9:08 A.M., Unit Manager (UM) #1 said she was the Wound Care Nurse in the facility and was following Resident #41 for the DTI pressure area of the left ankle. UM #1 said the DTI had been identified on 5/1/25 during evening care and had been thought to be caused by the Resident's previous foot brace, therefore the foot brace had been discontinued, and booties were ordered for protection along with a topical treatment of Skin Prep to the area. UM #1 said she first assessed the Resident ' s wound on 5/2/25 following morning report and the left ankle area was intact, maroon in color and non-blanching (an area of redness that does not fade when pressed on, typically due to bleeding under the skin). UM #1 said the Resident ' s left ankle DTI could get worse without the use of booties in place because the booties provided protection against pressure from the bed surface. UM #1 said the Resident ' s booties should be listed on the CNA Kardex and POC, but they were not. UM #1 said it was important to include the booties on the CNA Kardex and POC so that the CNA staff would know what was required for the care of Resident #41. UM #1 said Resident #41 spends most of the day in bed and the booties were important for protection of the DTI. UM #1 said Resident #41 had a history of refusing care but if the booties were refused the staff should use pillows to offload and float the DTI area to prevent skin breakdown. During that same time the surveyor and UM #1 observed Resident #41 ' s left ankle wound, and UM #1 said the Resident ' s wound had deteriorated, was open, was painful to the Resident when touched, and presented with new swelling. UM #1 further said the Resident ' s wound bed was now open and had drainage. UM #1 said that she should have been contacted sooner by the nurses about the change in the Resident ' s DTI area.</p> <p>During an interview on 6/4/25 at 9:40 A.M., the Director of Nursing (DON) said Resident #41 did not have evidence of documented refusal of care for the months of May 2025 and June 2025. The DON said the Resident's booties should have been in place as ordered by the Physician.</p> <p>During an interview on 6/4/25 at 11:13 A.M., CNA #1 said she was the CNA providing care to Resident #41 today. CNA #1 said the nurses give report for anything a resident needed for care and that CNA staff could also read the residents ' care Kardex too. CNA #1 said she was aware that Resident #41 was supposed to have booties on when in the bed but had not checked the Resident until 8:42 A.M. for breakfast delivery. CNA #1 said there have been times in the past when CNA #1 came on duty and the Resident ' s booties were not in place from the night before, so she would have to put the booties on. CNA #1 said when she came to the Resident ' s room today to transfer the Resident for breakfast, the booties were not on the Resident but should have been on, to protect the left ankle wound.</p> <p>During an interview on 6/4/25 at 11:35 A.M., UM #1 said she had cleansed and measured the Resident ' s left ankle wound area to be 1 cm long by (x) 0.8 cm wide x 0.1 cm deep, and that the wound had scant serosanguinous (light pink) drainage, redness to the area, swelling and painful to touch. UM #1 said that Resident #41 reported nine out of 10 pain, and the Provider would be seeing the resident later today for examination.</p> <p>During an interview on 6/4/25 at 1:40 P.M., the DON said Resident #41 ' s intervention for booties were not listed on the CNA Kardex but should have been so that CNA staff would know how care was to be delivered for the Resident.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that resident meal trays were served timely for three Units (West 1, [NAME] 2 and Dharma), out of three units observed.</p> <p>Specifically, the facility failed to ensure that resident meals were delivered timely and coordinated with medication administration times for residents that required meals in order for medications to be appropriately administered.</p> <p>Findings include:</p> <p>Review of the Food Truck Delivery Schedule, undated, indicated the following meal delivery times:</p> <p>>Breakfast:</p> <p>West 2-A: 7:55 A.M.</p> <p>West 2-B: 8:05 A.M.</p> <p>West 1-A: 8:15 A.M.</p> <p>West 1-CDR: 8:25 A.M.</p> <p>West 1-B: 8:30 A.M.</p> <p>Skole (Dharma Unit): 8:35 A.M.</p> <p>Gluckin (Dharma Unit): 8:40 A.M.</p> <p>[NAME] 1 (Dharma Unit): 8:45 A.M.</p> <p>>Lunch:</p> <p>West 2-A: 11:55 A.M.</p> <p>West 2-B: 12:00 P.M.</p> <p>West 1-A: 12:05 P.M.</p> <p>West 1-CDR: 12:20 P.M.</p> <p>West 1-B: 12:30 P.M.</p> <p>Skole (Dharma Unit): 12:35 P.M.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Gluckin (Dharma Unit): 12:45 P.M.</p> <p>[NAME] 1(Dharma Unit): 12:50 P.M.</p> <p>>Dinner:</p> <p>West 2-A: 4:50 P.M.</p> <p>West 2-B: 5:00 P.M.</p> <p>West 1-A: 5:10 P.M.</p> <p>West 1-CDR: 5:20 P.M.</p> <p>West 1-B: 5:30 P.M.</p> <p>Skole (Dharma Unit): 5:40 P.M.</p> <p>Gluckin (Dharma Unit): 5:50 P.M.</p> <p>[NAME] 1 (Dharma Unit): 6:00 P.M.</p> <p>On 6/3/25 from 1:30 P.M. to 2:30 P.M., a Resident Council Meeting was held with the surveyor, and the following concerns were relayed:</p> <p>-Resident #8 said when alternate food items were requested, it took 30 minutes for the food to be received.</p> <p>-Resident #86, who resided on [NAME] 1 Unit, said the meals were not delivered timely. Six other residents who were in the meeting agreed. Resident #86 further said that he/she was Diabetic and received Insulin medication prior to meals, and the timing of his/her meals mattered for the medication administration. Resident #86 said his/her breakfast meal tray delivery could range from 8:00 A.M. until 9:30 A.M., lunch meal tray delivery could range from 12:00 P.M. to 1:30 P.M. and dinner tray meal delivery could range from 4:30 P.M. to 6:30 P.M.</p> <p>During an interview on 6/4/25 at 10:05 A.M., Family Member #1, whose family resided on the Dharma Unit, said the times that the resident meals were delivered varied greatly. Family Member #1 said the dinner meal for his/her family could be served at 5:15 P.M. up until 6:30 P.M., which made a difference with when medications were administered and the effect of the medications. Family Member #1 said his/her family received a medication to assist with sleep and if that medication was administered prior to receiving the dinner meal and the meal was late, his/her loved one would be sleepy and would have difficulty consuming the meal. Family Member #1 said when he/she requested an alternate meal/items, there were times when the kitchen would be contacted and no one would respond to attend to the request. Family Member #1 said this occurred mostly on the weekends when staff in the kitchen were not available for meal/food requests, so he/she had been bringing in food from home on the weekends to give to his/her family. Family Member #1 said he/she requested an early dinner meal for 5:00 P.M. on 5/29/25 so he/she could attend a family support meeting at the facility for 6:00 P.M. and the dinner meal did not arrive until 6:15 P.M., so he/she missed the meeting.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER Center for Extended Care at Amherst		STREET ADDRESS, CITY, STATE, ZIP CODE 150 University Drive Amherst, MA 01002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Food Truck Delivery Daily Tracking Logs from 5/2/25 through 5/31/25 indicated that on 25 out of 29 days, resident meals were delivered 20 minutes or more from the scheduled meal delivery time indicated.</p> <p>On the following dates/times, the following was observed by the surveyors:</p> <p>-6/3/25 at 8:17 A.M., the [NAME] 2-B Food Truck arrived on the [NAME] 2 Unit (scheduled to arrive at 8:05 A.M.)</p> <p>-6/4/25 at 12:36 P.M., the [NAME] 2-B Food Truck arrived to the [NAME] 2 Unit (scheduled to arrive at 12:00 P.M.)</p> <p>-6/4/25 at 12:38 P.M., the [NAME] 1-A Food Truck arrived to the [NAME] 1 Unit (scheduled to arrive at 12:05 P.M.)</p> <p>-6/4/25 at 12:45 P.M., the [NAME] 1-B Food Truck arrived to the [NAME] 1 Unit (scheduled to arrive at 12:30 P.M.)</p> <p>-6/4/25 at 12:56 P.M., the [NAME] 1-CDR Food Truck arrived to the [NAME] 1 Unit (scheduled to arrive at 12:20 P.M.)</p> <p>-6/4/25 at 1:03 P.M., the Skole Food Truck arrived to the Dharma Unit (scheduled to arrive at 12:35 P.M.)</p> <p>-6/4/25 at 1:12 P.M., the Gluckin Food Truck arrived to the Dharma Unit (scheduled to arrive at 12:45 P.M.)</p> <p>-6/4/25 at 1:20 P.M., the [NAME] Food Truck arrived to the Dharma Unit (scheduled to arrive at 12:50 P.M.)</p> <p>During an interview on 6/4/25 at 2:32 P.M., the surveyor reviewed the concerns about meal delivery times and observations from survey with the Food Service Director (FSD). The FSD said she was made aware by nursing on occasion when resident meals were late, but was not aware that this was a consistent concern. The FSD said when she reviewed the Food Truck Delivery Logs, she saw that there were issues with when resident meals were delivered to the units compared to when they were scheduled to be delivered. The FSD said unless there was a concern expressed, she did not routinely review the Food Truck Delivery Logs, but should have been. The FSD said she understood the concern relative to the resident meal delivery times and that this process needed to be changed.</p> <p>During an interview on 6/04/25 at 3:22 P.M., the Administrator said he was aware and understood that there was an issue with when resident meals were delivered.</p>		

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NAME OF PROVIDER OR SUPPLIER Center for Extended Care at Amherst		STREET ADDRESS, CITY, STATE, ZIP CODE 150 University Drive Amherst, MA 01002	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, interview and record review, the facility failed to maintain a clean and sanitary kitchen.</p> <p>Specifically, the facility failed to ensure:</p> <ul style="list-style-type: none"> -storage for resident food/fluids remained clean and free of foul odors -shelves that maintained clean pots/pans/dishware used for resident meals were clean and free from debris -fans in the facility kitchen were free of dust/debris <p>Findings include:</p> <p>Review of the facility policy titled Sanitation, undated, indicated the following:</p> <p>&gt;Equipment and Utensils:</p> <ul style="list-style-type: none"> -utensils and food-contact surfaces of equipment shall be cleaned and sanitized -tableware shall be washed, rinsed, and sanitized after each use -non-food-contact surfaces of equipment shall be cleaned as often as necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris <p>On 6/2/25 from 7:25 through 7:41 A.M., during an initial kitchen tour, the surveyor observed the following:</p> <ul style="list-style-type: none"> -shelf/tray that house containers of spices were dirty and had debris present -large utility fan in the storage area was thickly covered with dirt/dust. -milk cooler had a strong rancid odor and had puddles of water and milk on the bottom of the cooler. -presence of fruit flies/gnats <p>On 6/4/25 from 11:36 A.M. through 1:15 P.M., the surveyor observed the following in the main facility kitchen:</p> <ul style="list-style-type: none"> -multi-shelve units that housed clean pots/pans located to the left of the walk-in refrigerator had observable dirt, grease present -clear bins with clean utensils had presence of food particles <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Center for Extended Care at Amherst		STREET ADDRESS, CITY, STATE, ZIP CODE 150 University Drive Amherst, MA 01002	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-lower shelves near the preparation areas which had clean pots/pans present, were visibly dirty and had food particles/debris present</p> <p>-large utility fan located in a preparation and clean dishes area was observed on and was dirty and dust laden.</p> <p>-presence of fruit flies/gnats</p> <p>During an observation and interview on 6/4/25 at 11:56 A.M., the Food Service Director (FSD) said the shelving/bins that had clean pots/pans/utensils were dirty and should be cleaned weekly and as needed. The FSD said this was not currently a task delegated on the kitchen's cleaning schedule and would need to be added. The FSD said the utility fans located in the kitchen were dusty, were maintained by the Maintenance Department and were cleaned when the Dietary staff notified them that they needed to be cleaned. The FSD further said that the sanitization concerns identified in the kitchen were an infection control concern. The FSD said the Maintenance Department were aware of the fruit flies/gnats located in the kitchen.</p> <p>During an interview on 6/4/25 at 4:10 P.M., the Director of Maintenance said there had been an issue with fruit flies/gnats in the facility kitchen for approximately a month and was improving with treatment. The Director of Maintenance further said the utility fans were put in the kitchen to draw out the fruit flies/gnats from the facility kitchen. The Director of Maintenance said there was no routine cleaning of the utility fans and that they would typically not be in the kitchen until the weather was warmer, and that they should not have been in the kitchen if they were dirty.</p>		