

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225691	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Loomis Lakeside at Reeds Landing		STREET ADDRESS, CITY, STATE, ZIP CODE 807 Wilbraham Road Springfield, MA 01109	

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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563</p> <p>Based on observation, interview, and record review, the facility failed to ensure that one Resident (#14) out of a total sample of 12 residents, with limited range of motion (ROM) received appropriate care and services to maintain and/or improve their mobility function.</p> <p>Specifically, the facility failed to implement an Occupational Therapy (OT) recommendation for a carrot device (an assistive or orthotic device used in a hand with a contracture, or permanent tightening of muscles, tendons or ligaments that limits movement of a joint or body part) for Resident #14 to prevent further loss of range of motion and skin breakdown.</p> <p>Findings include:</p> <p>Review of the facility policy titled Assistive Devices and Equipment, dated January 2020, indicated the following:</p> <ul style="list-style-type: none"> -our facility maintains and supervises the use of assistive devices and equipment for residents. -recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan. <p>Resident #14 was admitted to the facility in May 2023, with diagnoses including Parkinsonism (a group of brain conditions that cause slowed movements, rigidity, and tremors), and Contracture of the left hand.</p> <p>Review of Resident #14's Minimum Data Set (MDS) assessment dated [DATE] indicated the following:</p> <ul style="list-style-type: none"> -the Resident has severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of a possible score of 15. -the Resident has functional limitation in range of motion (ROM) to both upper extremities. -the Resident required substantial/maximal (helper does more than half the effort) assistance to complete Activities of Daily Living (ADLs) including dressing. <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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225691	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Loomis Lakeside at Reeds Landing		STREET ADDRESS, CITY, STATE, ZIP CODE 807 Wilbraham Road Springfield, MA 01109	
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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #14's Occupational Therapy Evaluation and Plan of Treatment for the certification period of 1/9/24 through 2/6/24 indicated the following:</p> <p>-New goal: Resident will wear carrot in left hand, times 2 hours, without signs or symptoms of skin breakdown or irritation to reduce the risk of further contracture and maintain current functional use.</p> <p>>Initiate wearing schedule dated 1/9/24</p> <p>Review of Resident #14's Activities of Daily Living (ADL) Care Plan included the following intervention with a start date of 10/21/24:</p> <p>-Blue [Carrot] #10 to left hand as tolerated when out of bed. Remove for meals, transfers and tabletop tasks where he/she uses bilateral hands.</p> <p>The surveyor observed Resident #14 sitting up in his/her Broda wheelchair (a specific type of wheelchair that provides positioning support) with no carrot device in place to the Resident's left hand on the following dates and times:</p> <p>-11/13/24 at 3:05 P.M.</p> <p>-11/15/24 at 8:30 A.M.</p> <p>During an interview on 11/15/24 at 9:00 A.M., Certified Nurses Aide (CNA) #1 said she worked at the facility routinely and was familiar with Resident #14's care. CNA #1 said she remembered the Resident using a carrot device at one time but that he/she was no longer using the device.</p> <p>During an interview on 11/15/24 at 9:55 A.M., the Occupational Therapist (OT) said that she had implemented use of a carrot device when she saw Resident #14 in January 2024 and the carrot device treatment had not been discontinued by OT and should still be in use.</p> <p>During an interview on 11/15/24 at 11:16 A.M., the Corporate Nurse said that the carrot device should have been in place. The Corporate Nurse further said that she was unable to find any documentation that indicated the carrot device had been discontinued.</p> <p>The facility did not provide any additional documentation related to the Resident's use of the carrot device prior to the survey exit.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225691	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Loomis Lakeside at Reeds Landing		STREET ADDRESS, CITY, STATE, ZIP CODE 807 Wilbraham Road Springfield, MA 01109	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>42690</p> <p>Based on record review, and interview, the facility failed to maintain complete and accurate medical records for one Resident (#34) out of a total sample of 12 residents.</p> <p>Specifically, the facility failed to ensure that complete and accurate documentation of neurological assessments were completed as required after Resident #34 sustained a fall, striking his/her head.</p> <p>Findings include:</p> <p>Review of the facility policy titled Fall Management Program dated 5/27/21 indicated the following:</p> <p>e. Any fall that involves a potential/actual head injury will include neurological checks. Neurological checks will be documented on the Neurological Assessment Flowsheet.</p> <p>Review of a blank facility Neurological Assessment Flowsheet indicated Neurological (Neuro) and vital signs (VS) to be completed as follows:</p> <ul style="list-style-type: none"> -Every 15 minutes times four -Every 30 minutes times four -Every hour for the next four hours -Every four hours for the next 20 hours <p>Resident #34 was admitted to the facility in May 2024 with diagnoses including lack of coordination, Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment), repeated falls, and difficulty walking.</p> <p>Review of Resident #34's Nursing Progress Note dated 9/11/24, indicated the following:</p> <p>-At 7:30 PM this writer just turn [sic] away from Resident and heard a loud noise coming from his/her direction, saw Resident falling onto the floor, hit his/her head on the foot of the computer stand, roll to his/her right side . did sustain . a bump on top toward the back of his/her left head slightly pink, cold pad applied.</p> <p>Review of Resident #34's Nursing Progress Note dated 9/12/24 indicated the following:</p> <p>- .up in wheelchair, denies pain, neuro intact.</p> <p>Further review of Resident #34's medical record indicated no documented evidence that a Neurological Assessment Flowsheet had been completed that included neuro checks being done as follows:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225691	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Loomis Lakeside at Reeds Landing		STREET ADDRESS, CITY, STATE, ZIP CODE 807 Wilbraham Road Springfield, MA 01109	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Every 15 minutes times four</p> <p>-Every 30 minutes times four</p> <p>-Every hour for the next four hours</p> <p>-Every four hours for the next 20 hours</p> <p>During an interview on 11/18/24 at 9:08 A.M., the Assistant Director of Nursing (ADON) said when a Resident hits their head either witnessed or unwitnessed, the staff follow a protocol that included neuro checks being completed as outlined on the facility Neurological Assessment Flowsheet for 24 hours. The ADON said staff document the neuro checks and VS's on the Neurological Assessment Flowsheet that is scanned into the electronic medical record (EMR).</p> <p>During a follow-up interview on 11/18/24 at 9:50 A.M., the ADON said that she was unable to locate documentation that Resident #34's neuro checks and VS's had been completed on the Neurological Assessment Flowsheet as required, after Resident #34 sustained a fall, striking his/her head on 9/11/24. The ADON said that there were notes in the nursing progress notes on 9/11/24 and 9/12/24 that indicated Neuro intact, VS's, but the neuro checks and VS's had not been completed on the Neurological Assessment Flowsheet. The ADON said that the Resident did not have any changes neurologically, and the neuro checks were just not documented per the facility protocol.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225691	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Loomis Lakeside at Reeds Landing		STREET ADDRESS, CITY, STATE, ZIP CODE 807 Wilbraham Road Springfield, MA 01109	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563</p> <p>Based on observation, interview and record review, the facility failed to adhere to infection control practice standards to prevent the development and transmission of communicable diseases and infections in the facility, and for one Resident (#7) out of a total sample of 12 residents.</p> <p>Specifically, the facility failed to:</p> <ol style="list-style-type: none"> 1) Develop and implement a Water Management Program to reduce the risk of Legionella growth and spread in the facility. 2) Ensure that infection control practices were adhered to during the removal of Personal Protective Equipment (PPE: equipment, such as a gown, gloves, mask, etc., that is worn to protect from the spread of infection) during observation of a medication administration process with Nurse #1. 3) For Resident #7, ensure that staff adhered to Enhanced Barrier Precautions (EBP- protective barrier gowns and gloves used as an infection control intervention designed to reduce transmission of multi-drug-resistant organisms [MDRO] during high contact resident care) during the care of an indwelling urinary catheter (a device inserted into the bladder to drain urine outside of the body). <p>Findings include:</p> <ol style="list-style-type: none"> 1) Review of the Centers for Medicare and Medicaid Services (CMS) Memo titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD), reference QSO-17-30, revised 7/6/18, indicated the following: <ul style="list-style-type: none"> -Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water. -This policy memorandum applies to . Long-Term Care -Facilities must have water management plans and documentation that, at a minimum ensure each facility: <ul style="list-style-type: none"> >develops and implements a water management program that considers the ASHRAE industry standard and the CDC toolkit. <p>During an interview on 11/15/24 at 2:29 P.M., the Maintenance Director provided the surveyor with the CDC toolkit Version 1.1 assessment, dated June 5, 2017. The Maintenance Director said the facility did not have a Water Management Plan since there were no stagnant water sources in the facility. The Maintenance Director said the facility water source was supplied by the city of [NAME].</p> <p>Review of the facility's CDC toolkit assessment Version 1.1, dated June 5, 2017, titled: Identifying Buildings at Increased Risk, indicated the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225691	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Loomis Lakeside at Reeds Landing		STREET ADDRESS, CITY, STATE, ZIP CODE 807 Wilbraham Road Springfield, MA 01109	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-If you answer yes to any of the questions 1 through 4, you should have a water management program for that building's hot and cold water distribution system.</p> <p>-The facility answered yes to questions number 1 through 3 on the assessment.</p> <p>The facility did not provide any additional documentation related to a facility water treatment plan to the survey team prior to or at the survey exit.</p> <p>2) Review of the facility policy titled Handwashing/Hand Hygiene, dated 3/5/20, indicated the following:</p> <p>-The facility considers hand hygiene the primary means to prevent the spread of infections.</p> <p>-Use of alcohol-based hand rub containing at least > 60% ethanol or >70% isopropyl alcohol; or, alternatively, soap and water for the following situations:</p> <p>>After removing gloves.</p> <p>On 11/14/24 at 7:50 A.M., during a medication administration process completed by Nurse #1, the surveyor observed the following:</p> <p>-Nurse #1 donned (put on) gloves at the medication cart to open a medication capsule added into yogurt for administration.</p> <p>-Nurse #1 doffed (take off) gloves and continued the medication preparation without performing hand hygiene.</p> <p>-Nurse #1 went into a resident's room to administer medications and donned gloves without performing hand hygiene.</p> <p>-Nurse #1 administered eye drops to the resident and doffed gloves without performing hand hygiene.</p> <p>-Nurse #1 donned new gloves, completed a fingerstick (when a finger is pricked with a lancet [small single use needle] to obtain blood for testing) blood glucose test, administer a medication injection and then doffed gloves and performed hand hygiene.</p> <p>During an interview on 11/14/24 at 8:05 A.M., Nurse #1 said she should have performed hand hygiene each time she removed her gloves.</p> <p>During an interview on 11/15/24 at 3:27 P.M., the surveyor reviewed the medication administration observation of Nurse #1 removing gloves without performing hand hygiene with the Infection Control Preventionist (ICP). The ICP said the first thing staff should do when removing gloves is perform hand hygiene. The ICP further said that not performing hand hygiene after removing gloves is an infection control concern.</p> <p>42690</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225691	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Loomis Lakeside at Reeds Landing		STREET ADDRESS, CITY, STATE, ZIP CODE 807 Wilbraham Road Springfield, MA 01109	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3) Resident #7 was admitted to the facility in January 2024 with diagnoses including Chronic Kidney Disease (CKD- when the kidneys are damaged and cannot filter blood the way that it should) and absence of right leg below the knee.</p> <p>Review of the facility policy titled Enhanced Barrier Precautions, dated 4/1/24 indicated the following:</p> <ol style="list-style-type: none"> Enhanced barrier precautions (EBP) are used as an infection prevention and control intervention to reduce the spread of multi drug resistant organisms (MDROs) to residents. EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include . device care or use (central line, urinary catheter, feeding tube, tracheostomy ventilator, etc.) <p>Review of Resident #7's October 2024 Physician order's indicated the following urinary catheter orders:</p> <ul style="list-style-type: none"> -Foley (type of urinary catheter) catheter output document every shift, start date 11/3/24 -Foley catheter French (French scale or system used to size catheters) 18 with 10 cubic centimeter (cc) balloon(retention balloon - a tiny balloon at the end of the indwelling urinary catheter that is inflated with water to prevent the indwelling urinary catheter from sliding out of the body) to gravity drain every shift, clarity and odor and color, start date 11/1/24 -Change as needed for leakage, start date 11/1/24 -Catheter care every shift, start date 11/1/24 -Catheter irrigation as needed with 60 cc normal saline (ns), start date 11/1/24 <p>On 11/14/24 at 9:54 A.M., the surveyor observed the following:</p> <ul style="list-style-type: none"> -EBP signage posted outside of Resident #7's room indicating to wear PPE when performing high contact care. -Three drawer bin containing PPE items. -Nurse #1 was observed at Resident #7's bedside, holding the tubing of Resident #7's urinary catheter in her ungloved hands. -While the surveyor spoke to the Resident, Nurse #1 lowered the urinary catheter tubing, excused herself, performed hand hygiene and exited the room. <p>During an interview on 11/14/24 at 11:05 A.M., the Unit Manager (UM) said that she would expect gloves to be worn by staff when touching the tubing of the urinary catheter.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225691	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Loomis Lakeside at Reeds Landing		STREET ADDRESS, CITY, STATE, ZIP CODE 807 Wilbraham Road Springfield, MA 01109	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/18/24 at 11:30 A.M., the ICP said at every encounter with a urinary catheter or any part of the urinary catheter, including the tubing, gloves should be worn to prevent the spread of germs.		