STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Valley Health & Rehabilitation	573 Granby Rd South Hadley, MA 01075

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 42761 Based on observation, interviews, and records and policies reviewed, the facility failed to support the right for one Resident (#17), to participate in his/her care planning process, in a total sample of 25 residents. Specifically, the facility failed to include Resident #17 in the interdisciplinary team (IDT) care plan review process when the Resident was his/her own responsible person, had a preference to be in bed, and the IDT met in a location not in the Resident's room to review Resident #17's plan of care, which impacted the Resident's ability to make choices about his/her plan of care and treatment interventions. Findings include: Review of the facility's Care Planning Policy, dated February 2023, indicated the following: - It was the policy of the facility that each resident . participate in the development of the resident's . care plans. - Residents . were invited to attend and participate in care planning conferences (admission, quarterly, annual, and significant change in status). - All care plans would be reviewed and revised by the clinical team and the resident . Resident #17 was admitted to the facility in October 2022 with diagnoses including End Stage Renal Disease (ESRD: condition where the kidney reaches advanced state of loss of function which can result in changes in urination, fatigue, swelling .), dependence on renal dialysis (blood purifying treatment given when kidney function is not optimum), obesity, and muscle weakness. Review of Resident #17's clinical record indicated the following: - A Minimum Data Set (MDS) assessment, dated 10/5/23, was completed due to the Resident having had a significant change in status. - The Resident was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total possible points. (continued on next page)

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

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- There was no evidence that the Resident's Health Care Proxy (HCP: a representative to make healthcare decisions on one's behalf if they become unable to make those decisions themselves) had been invoked. Review of a Social Services Progress Note, dated 10/20/23, indicated Resident #17 had a care plan meeting scheduled for 10/19/23 which was rescheduled to 11/6/23. Review of a Social Services Progress Note, dated 11/6/23, indicated an IDT meeting was held to discuss the Resident's current level of care, including refusals of care, . diet restrictions, dialysis, medications, and treatments. Further review of the Note indicated: - No evidence the Resident was in attendance at the meeting. - A family member of the Resident was in attendance at the meeting. - The Resident's HCP had not been invoked. On 3/20/24 at 11:01 A.M., the surveyor observed Resident #17 positioned in bed, on his/her back, with the head of the bed elevated. The surveyor observed no wheelchair in the Resident's room. During an interview at this time, Resident #17 said staff at the facility held care plan meetings, but he/she could not go because meetings were held in a certain room in the facility and he/she was unable to get out of bed on his/her own or walk and that he/she did not have a wheelchair. Resident #17 also said a care plan meeting had been held in his/her room before, but that no one had offered that to him/her for a long time. During an interview on 3/27/24 at 11:02 A.M., the Social Worker (SW) said Resident #17 never attended his/her care plan meetings because the Resident didn't get out of bed and preferred to stay in his/her room. The SW said some residents at the facility chose to have care plan meetings in their rooms, but she did not think that Resident #17 would want care plan meetings held in his/her room, so this had not been offered. The SW also said having Resident #17's IDT meeting in the Resident's room on 11/6/23 had not been offered to the Resident. The SW further said Resident #17's family member attended the meeting and was involved in IDT discussions regarding the Resident's care, but the Resident's HCP was not invoked.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 42690 Based on observations, interviews, and records reviewed, the facility failed to provide reasonable accommodation of resident needs for three Residents (#174, #30, and #67), out of 25 total residents sampled. Specifically, the facility failed to provide: 1. Resident #174 with a working call light or an alternative means to call for assistance; 2. Resident #30 with a wheelchair that accommodated the Resident's needs; and 3. Resident #67 with a seat cushion and leg rests for his/her wheelchair. Findings include: 1. Review of the facility's policy titled Answering the Call Light, dated 6/2022, indicated the following: -Some residents may not be able to use their call light. Be sure to check these residents frequently: and if applicable give the resident an alternative device . -Report all defective call lights to the nurse supervisor promptly. Resident #174 was admitted to the facility in March 2024 with the following diagnoses: anxiety disorder (a mental illness that can cause constant fear and worry), bipolar disorder (a mental illness that causes extreme mood swings, from high to low, that affect your energy, thinking, and behavior), dysphagia (difficulty in swallowing food or liquid), major depressive disorder (a persistent feeling of sadness and loss of interest), and schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, symptoms of a mood disorder, such as mania and depression), and morbid obesity. Review of the Advanced Directives care plan, initiated on 3/8/24, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total 15. Review of the Activities of Daily Living care plan, initiated on 3/20/24, indicated to encourage the Resident to use the call light to call for assistance. During an interview and observation on 3/20/24 at 1:41 P.M., Resident #174 said that he/she had not been cleaned up since yesterday and was soiled. Additionally, the Resident said he/she was unable to see his/her call light button because he/she was blind. The surveyor observed the call light button to be wrapped around the bed rail on the right side of the bed, hanging downward, just out of reach of the Resident. The surveyor requested Nurse #1 to enter the room and observe the location of the call light button. As the call light button was lifted to be given the Resident, he/she said it did not matter because the call light did not work and began to cry. Nurse #1 and the surveyor pressed the button and observed the light outside of the Resident's room to not light up. Nurse #1 indicated he would notify someone. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/21/24 at 12:27 P.M., Nurse #1 and the surveyor checked the functioning of the call light for Resident #174. Resident #174 was asked to press the call light button while Nurse #1 stepped out into the hallway to observe the light above the Resident's door. Nurse #1 said the light was not activated. He said that he notified the supervisor yesterday and the maintenance department verbally this morning. The surveyor asked the Resident if he/she was provided an alternative call bell to use while waiting for the call light to be fixed. He/she began to cry and said, No, I have nothing to call them. Nurse #1 said that the Resident did not have anything to use to call for assistance if he/she needed it but would reach out to the Unit Manager to see if they could find something to use until the call light was fixed. From 12:35 P.M. until 12:41 P.M., the surveyor observed Nurse #1 attempt to call maintenance and supervisors to remind them of the broken call light. He said that he had been trying to reach people, but no one had responded to him. He said that the standard protocol is to place equipment concerns into the maintenance log, unless it was something emergent, then he would place a phone call to maintenance. He further said that he felt the non-working call light was something that was urgent and that it should have been resolved yesterday. 44222 2. Resident #30 was admitted to the facility in July 2013 with diagnoses of morbid (severe) obesity due to excess calories, abnormal posture, hereditary lymphedema (a genetic condition affecting the lymphatic system and is characterized by chronic swelling (edema) of certain parts of the body), and muscle weakness. Review of the Physical Therapy (PT) Evaluation and Plan of Treatment, dated 8/25/23, included: -wheelchair management and training -New Goal - A letter of medical necessity will be written in order to obtain the manual wheelchair in order to decrease the risk of pressure injuries and improve comfort/Quality of Life (QOL). (Target 9/5/23) -patient goals - said I want a new wheelchair -reason for referral for assessment/ordering of a new bariatric wheelchair .due to discomfort in (his/her) current wheelchair, as well as management of severe hereditary lymphedema Review of the PT Discharge Summary, dated 9/14/23, included: -looking into getting a chair donated, therefore, this goal has been discontinued. Review of the Resident's Physician's Orders included an order for PT Evaluation for WC (wheelchair) assessment and recommendations. (initiated 2/17/24) Review of the PT Evaluation and Treatment, dated 2/17/24 indicated: -wheelchair management and training (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-goal to be able to sit upright in (his/her) wheelchair more -morbidly obese with hereditary lymphedema and weakness -Physician orders received to evaluate for recommendations for customized wheelchair . will require a custom bariatric wheelchair with an off-loading cushion to provide pressure relief when sitting and elevating foot (boxes) to allow for lymph drainage. Review of the Manual Tilt Wheelchair Functional Mobility Evaluation, dated 2/18/24, indicated that the Resident was currently in a manual wheelchair loaned to them by the facility. The form indicated that the Resident was unable to propel the chair due to the wheels being back so far. The evaluation indicated that a vendor had assessed the Resident for a custom wheelchair. The sections of the form requiring justifications for each piece of equipment for the wheelchair were left blank. The physician did approve and sign for the recommended wheelchair on 2/21/24. Review of the Resident's Minimum Data Set (MDS) assessment, dated 3/5/24, indicated the Resident was cognitively intact as evidenced by a BIMS score of 15 out of 15. On 3/20/24 at 11:20 A.M., the surveyor observed the Resident sitting forward in a wheelchair with personal belongings stored on the seat behind the Resident's back. The Resident told the surveyor that the wheelchair was uncomfortable and was not fitted for him/her, and the seat was too deep preventing him/her from sitting all the way back in the chair. During an interview on 3/27/24 at 9:36 A.M., Physical Therapist Manager #1 said that she was not aware that a script or written letter of necessity was obtained in August 2023. She said that she was not aware of any new or donated wheelchair being obtained at that time for the Resident in response to the referral and treatment in August 2023. Physical Therapist Manager #1 said she was aware that a Manual Tilt Wheelchair Functional Mobility Evaluation was completed by facility staff on 2/18/24, and then signed by the Physician on 2/21/24, but could not find any evidence that the facility staff ever finished completing the form or ever submitted the evaluation, order, and justification to the Wheelchair company in order to acquire the wheelchair. Physical Therapist #1 said that the Resident had not received the recommended wheelchair. She said that she was not aware of any reason why this evaluation and wheelchair request was not followed through with and said that it just wasn't done. 3. Resident #88 was admitted to the facility in May 2021 with diagnoses of adult failure to thrive (a syndrome of global decline that occurs in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment), unspecified dementia (a cognitive impairment that has yet to be diagnosed as a specific type), and muscle weakness. Review of the Resident's MDS assessment, dated 1/10/24, indicated that he/she was severely cognitively impaired as evidenced by a BIMS score of 2 out of 15, and it indicated a pressure relieving device for the Resident's chair was in use. On 3/20/24 at 10:18 A.M., the surveyor observed the Resident sitting in a wheelchair in the unit day room. There were no seat cushion or leg rests on the wheelchair. On the following dates the surveyor observed the Resident resting in bed. The wheelchair was adjacent to the bed with no seat cushion or leg rests visible on or near the wheelchair. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/21/24 at 11:55 A.M. -3/26/24 at 2:00 P.M. During an interview on 3/27/24 at 10:02 A.M., Physical Therapist Manager #1 said that she looked at the Resident's wheelchair and it should have had a seat cushion and leg rests but it did not. She further said that the Resident had leg rests to use, but she had found them in the Resident's closet and was unsure how long the leg rests had been in the closet.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 45435 Based on record review, policy review, and interview, the facility failed to execute Advance Directives (written documents that instructs health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) for one Resident (#115), out of a total sample of 25 residents. Specifically, for Resident #115, the facility failed to ensure that Advanced Directives on a completed (prior to facility admission) Massachusetts Medical Order for Life-Sustaining Treatment (MOLST) form were honored per the Resident's wishes. Findings include: Review of the facility's policy titled MOLST Form, dated 5/1/15, indicated the following: -The MOLST form is a medical order form that converts an individual's wishes regarding life-sustaining treatment into Medical Orders. -A legally recognized health care agent (HCA) or guardian may execute, revise, or revoke the MOLST form for a resident only if the resident lacks decision-making capacity. -For a resident admitted with a MOLST form already completed check to make sure all sections of the form, front and back, are filled out completely and that the form is signed by the resident or their Health Care Proxy (HCP) and a physician/NP/PA (NP-Nurse Practitioner, PA-Physician Assistant). On admission orders, write FOLLOW MOLST INSTRUCTIONS. Resident #115 was admitted to the facility in February 2024 with diagnoses including unstageable pressure ulcer (a wound with an obscured wound bed, that occurs because of prolonged pressure on a specific area of the skin). Review of the Minimum Data Set (MDS) assessment, dated 3/7/24, indicated the Resident scored 15 out of a possible 15 points on the Brief Interview for Mental Status (BIMS) assessment, indicating the Resident was cognitively intact. Review of the March 2024 Physician's Orders indicated the following: -Honor MOLST found in chart FULL CODE, date initiated 2/28/24. Further review of the Physician's orders showed no evidence that the Resident's HCP had been activated. Review of the medical record indicated a MOLST form, completed and signed by the Resident and a Physician, dated 8/24/18 (prior to facility admission), indicated a Do Not Resuscitate (DNR) and Do Not Intubate and Ventilate status. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record indicated a second MOLST form, completed and signed by the Resident's HCP and the facility Nurse Practitioner, dated 2/29/24, indicating attempt resuscitation, intubate, and ventilate. During an interview on 3/26/24 at 8:43 A.M., Nurse #4 and the surveyor reviewed both MOLST forms. Nurse #4 said that if she were to find the resident not breathing, she would use the MOLST form that said full code and start resuscitation. She said that she would use the form that was done at the facility instead of the form the Resident had signed prior to admission because he/she had an HCP. Nurse #4 and the surveyor reviewed the HCP activation form and she said that it was incomplete, and not signed by the physician. Nurse #4 said she believed that the process for invoking the HCP was to get a doctor's order, but she did not see an order, and she was not sure if the Resident should be a full code or a DNR at this time. During an interview on 3/26/24 at 9:04 A.M., the Social Worker said that the facility should honor a MOLST that was completed prior to admission unless the HCP was activated. She said when the HCP is activated, the doctor should do an evaluation, fill out the activation form and then a nurse will get the order to invoke the HCP. Once the process is completed, a new MOLST could be signed by the health care agent. She said a new MOLST was completed when Resident #115 was admitted to the facility because he/she was confused at that time. The Social Worker and the surveyor reviewed the HCP activation form and the Physician's orders, and she said a new MOLST should not have been signed unless the Resident had been invoked by the Physician but since her BIMS was 15 now, she could sign a new MOLST.

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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. 44222 Based on record review and interview, the facility failed to ensure that its staff notified the provider as ordered when test results were outside of the parameters set by the provider, for one Resident (#75), out of a total sample of 25 residents. Specifically, the facility failed to notify the provider when Resident #75's blood sugar reading was greater than 400. Findings include: Review of the facility's policy titled Policy, dated 2/2023, included: -It is the policy of the (facility), except in medical emergencies, to notify the resident, his or her attending physician, and representative of changes in the resident's condition and/or status. -Nursing services will notify the resident's attending physician when it is deemed necessary or appropriate in the best interest of the resident. Review of the facility's policy titled Nursing Care of the Resident with Diabetes Mellitus, undated, indicated that the physician will order the frequency of glucose (blood sugar) monitoring. Resident #75 was admitted to the facility in November 2021 with a diagnosis of Type 2 Diabetes (DM II - condition in which the body does not produce enough insulin and has trouble controlling blood sugar levels). Review of the Resident's March 2024 Physician's Orders included: -If blood sugar is greater than 400, recheck and notify MD (Medical Doctor) .(initiated 11/9/21) -Insulin Lispro Solution (a short-acting, man-made version of human insulin) 100 units/milliliter (unit/ml) Inject as per sliding scale: if 150-200 = 2 (units); 201-250 = 4 (units); 251-300 = 6 (units); 301-350 = 8 (units); 351-400 = 10 (units); Greater than 400 call MD/PA (Physician's Assistant)/NP(Nurse Practitioner), subcutaneously (under the skin) three times a day for diabetes. (initiated 9/17/2022) Review of the Resident's Medication Administration Record (MAR) for March 2024 indicated the following blood sugar levels recorded at 7:30 A.M.: -3/1/24 = 427 -3/4/24 = 433 -3/17/24 = 433 Review of the Resident's progress notes from 3/1/24 through 3/25/24 did not indicate any notification to the Physician related to a blood sugar result greater than 400. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/24 at 9:57 A.M., Regional Nurse #1 said she was unable to provide any evidence that the staff notified the MD as ordered when the Resident's blood sugar was greater than 400.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 42690 Based on record review and interview, the facility failed to ensure the required transfer documentation was completed and communicated the appropriate information to the receiving health care institution for one Resident (#50), out of a total sample of 25 residents, putting the Resident at risk for complications and adverse events upon transfer to the receiving facility. Findings include: Review of the facility's policy titled Transfer and Discharge Policies and Procedures, dated 2/2023, indicated the following: -All documentation concerning the transfer or discharge of a resident must be recorded in the resident's medical record. -Should it become necessary to make an emergency transfer or discharge to a hospital .the facility will implement the following procedures: . -Notify the receiving facility or unit that the transfer is being made -Prepare the transfer form to send with the resident Resident #50 was admitted to the facility in January 2024 with diagnoses that included: spinal stenosis (abnormal narrowing of the spinal canal that results in pressure on the spinal cord or nerve roots), panic disorder, type II diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), paroxysmal atrial fibrillations (an abnormal heart rhythm (arrhythmia) characterized by rapid and irregular beating of the atrial chambers of the heart), and hypertension (high blood pressure). Review of the Nurse's note, dated 3/5/24, indicated in part, that the Resident was transferred out via ambulance; the hospital notified the facility that Resident #50 was positive for a deep vein thrombosis (DVT- a type of venous thrombosis involving the formation of a blood clot in a deep vein, most commonly in the legs or pelvis) to the right femoral and popliteal vein. Review of the Nurse's note, dated 3/12/24, indicated in part, a concern for Resident #50 being short of breath, the left arm more swollen than the right, red, warm to touch and the Resident was pale in color, not within normal limits for ethnicity. The note further indicated the Nurse Practitioner ordered the Resident to be sent to the Emergency Department. Further review of the Resident's medical record indicated no documented evidence of any discharge paperwork that included the Resident's Advanced Directives (a written instruction, such as a living will or durable power of attorney for health care, recognized by the State law relating to the provisions of health care when the individual is incapacitated), any specific instructions or precautions for ongoing care, and/or provider information for the hospital transfers on 3/5/24 and 3/12/24. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/24 at 10:08 A.M., Nurse #11 said that if she needed to send a resident out to the hospital, she would send a face sheet, the MOLST (Massachusetts Order for Life Sustaining Treatment) form, a medication list, the Medication Administration Record (MAR), a change in condition form and an SBAR (Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication). She said that she is agency staff but that the process she described was typically standard for most facilities. During an interview on 3/27/24 at 8:24 A.M., the Director of Nursing (DON) said that when a resident needs to be sent out emergently, the staff assess the resident, call the doctor for further orders, call family, unless the resident is responsible for themselves, call for a transport, complete the transfer paperwork that included, a three page transfer packet or an SBAR, which would be printed and bed hold notification. During a follow up interview on 3/27/24 at 9:57 A.M., the DON said that she reviewed the Resident's medical record and spoke with the Unit Manager regarding the transfer documentation. She said she was unable to locate the intent to transfer, SBAR or the three-page transfer packet that was required to be completed upon transfer to the hospital. She further said that something should have been completed and documented in the medical record for the two transfers to the hospital that occurred on 3/5/24 and 3/12/24 but was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Pioneer Valley Health & Rehabilitation	573 Granby Rd South Hadley, MA 01075

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on record review and interview, the facility failed to ensure that the Resident and/or Resident Representative was notified in writing of a transfer or discharge and that a representative in the Office of the State Long Term Care Ombudsman was also notified for four Residents (#87, #76, #48, and #121), out of a total sample of 25 residents. Specifically, the facility failed to ensure: 1. For Resident #87, that the Resident and/or Resident Representative was notified in writing, and the reason given for a transfer or discharge; 2. For Resident #76, that the Resident and/or Resident Representative was notified in writing, and the reason given for a transfer or discharge, and that the Office of the State Long Term Care Ombudsman was notified of the transfer/discharge; 3. For Resident #48, that the Resident and/or Resident Representative was notified in writing, and the reason given for a transfer or discharge, and that the Office of the State Long Term Care Ombudsman was notified of the transfer/discharge; and 4. For Resident #121, that the Office of the State Long Term Care Ombudsman was notified of the transfer/discharge. Findings include: Review of the facility's policy titled Transfer and Discharge Policies and Procedures, dated 2/2023, included: -that an appropriate notice was provided to the resident and/or representative -the resident and/or representative will be provided with the following information: -the reason for the transfer or discharge . -the effective date of the transfer or discharge -the location to which the resident is being transferred or discharged -the name, address and telephone number of the state long-term care ombudsman -a statement that the resident has the right to appeal the action to the state . -a copy of the notice will be sent to a representative of the State Long Term Care Ombudsman (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	1. Resident #87 was admitted to the facility in March 2021 with diagnoses of cerebral infarction (CVA - a disruption in the blood flow to the brain), adult failure to thrive (a syndrome of global decline that occurs in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment), and aphasia (a language disorder caused by damage in a specific area of the brain). Review of the Health Care Proxy Activation Form, dated 6/27/23, completed by the Resident's physician indicated that the Resident did not have the capacity to make or communicate health care decisions due to a CVA, and that the duration of the incapacity was permanent. Review of the Minimum Data Set (MDS) assessment date 11/14/23 included a Brief Interview of Mental Status score of 00, indicating that the Resident was severely cognitively impaired. Review of the Resident's clinical record nursing progress notes included: -1/5/24 .Resident sent to (acute hospital) ER (emergency room) today . Review of the Resident's MDS assessment, dated 1/5/24, indicated that the Resident was discharged from the facility, return anticipated. Review of the Notice of Intent to Transfer or Discharge Resident with Less than 30 Days' Notice, dated 1/9/24, indicated that it was issued to the Resident but not to the Resident's Representative. During an interview on 3/25/24 at 11:00 A.M., Social Worker (SW) #1 said that she was unable to provide evidence that the Resident's invoked HCP was provided with the Notice of Intent to Transfer or Discharge and appeal information as required. 42761 2. Resident #76 was admitted to the facility in February 2022 with a diagnosis of chronic respiratory failure (when the airways that carry air to one's lungs become narrow and damaged, limiting the movement of air throughout one's body). Review of Resident #76's clinical record indicated the following: - A Physician's Order, dated 11/9/23, to invoke the Resident's Health Care Proxy (HCP: a representative to make healthcare decisions on one's behalf if they become unable to make those decisions themselves). - A Nurse Note, dated 12/24/23, that indicated the Resident was transferred to the hospital for a medical evaluation. - An Entry Tracking MDS assessment, dated 12/26/23, that the Resident returned to the facility on [DATE]. - A Nurse Note, dated 1/18/24, that the Resident was again transferred to the hospital. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	- An Entry Tracking MDS Assessment, dated 1/20/24, that the Resident returned to the facility on [DATE]. Further review of Resident #76's clinical record included no evidence the Resident's Representative was notified of the Resident's transfer to the hospital and the reasons for the move in writing, or that a copy of the notice was sent to a representative of the Office of the State Long-Term Care Ombudsman. During an interview on 3/27/24 at 10:46 A.M., the Social Worker (SW) said Resident #76's HCP was invoked, so each time the Resident was transferred to the hospital, written notice of transfer was supposed to be provided to the Resident's HCP. The SW also said a copy of the notice was to be sent to the Office of the State Long-Term Care Ombudsman. The SW said there was no evidence written notices for Resident #76's hospital transfers were provided to the Resident's HCP or to the Office of the State Long-Term Care Ombudsman for the Resident's hospital transfers on 12/24/23 or 1/18/24. 50138 3. Resident #48 was admitted to the facility in August 2018 with diagnoses including: persistent vegetative state (completely unresponsive to psychological and physical stimuli and displays no sign of higher brain function), congestive heart failure (the inability of the heart to maintain an adequate supply of blood to organs and tissues), functional quadriplegia (complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord), and cerebral infarction. Review of Resident #48's medical record indicated the Resident had a legal Guardian, effective 12/27/18. Review of Resident #48's medical record indicated Resident #48 had been transferred to the hospital on 12/2/23, 2/28/24, and 3/9/24, due to a change in condition. Further review of Resident #48's medical record did not contain evidence that the Guardian and The Office of the State Long-Term Care Ombudsman had been notified of the transfers. During an interview on 3/27/24 at 11:04 A.M. the Director of Nursing (DON) said there was no evidence of written transfer notification for hospital transfers from 12/2/23, 2/28/24, and 3/9/24 to Resident's #48 Guardian, nor to a representative of The Office of the State Long Term Care Ombudsman for Resident #48. The DON said this is important because the resident representative needs to know where the resident is. 42690 4. Resident #121 was admitted to the facility in December 2023 with hypertension (high blood pressure). (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the Nurse's note, dated 12/24/23, indicated the Resident was having difficulty breathing, oxygen level at 91% on two liters of supplemental oxygen (a therapy that provides oxygen to individuals who cannot get enough oxygen through breathing on their own), was experiencing chest pain, had severe pain in his/her throat and requested to be sent to the Emergency Department for an evaluation. Further review of the medical record indicated no documented evidence that The Office of the State Long-Term Care Ombudsman had been notified of the 12/24/23 transfer to the hospital. During an interview on 3/27/24 at 1:55 P.M., the SW said that she had no documented evidence that The Office of the State Long-Term Care Ombudsman had been notified of Resident #121's transfer to the hospital on 12/24/23.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on interview and record review, the facility failed to provide a Notice of Bed-Hold Policy at the time of transfer to a hospital or shortly thereafter for three Residents (#87, #76, and #48), who were expected to return to the facility, and/or their Representatives, out of a total sample of 25 residents. Findings include: Review of the facility's policy titled Transfer and Discharge Policies and Procedures, dated 2/2023, included: -Should a resident be transferred or discharged from our facility with the intent of returning, the resident's bed will be held upon request of the resident and/or the resident's representative. -It is the policy of (the facility) to give the resident and/or responsible person a written notice that specifies our bed-hold policy at the time of transfer or discharge. 1. Resident #87 was admitted to the facility in March 2021 with diagnoses of cerebral infarction (CVA - a disruption in the blood flow to the brain), adult failure to thrive (a syndrome of global decline that occurs in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment), and aphasia (a language disorder caused by damage in a specific area of the brain). Review of the Health Care Proxy Activation Form, dated 6/27/23, completed by the Resident's physician indicated that the Resident did not have the capacity to make or communicate health care decisions due to a CVA, and that the duration of the incapacity was permanent. Review of the Minimum Data Set (MDS) assessment, dated 11/14/23, included a Brief Interview of Mental Status score of 00, indicating that the Resident was severely cognitively impaired. Review of the Resident's clinical record nursing progress notes included: -1/5/24 .Resident sent to (acute hospital) ER (emergency room) today . Review of the Resident's MDS assessment, dated 1/5/24, indicated that the Resident was discharged from the facility, return anticipated. Review of the Notice of Intent to Transfer or Discharge Resident with Less than 30 Days' Notice, dated 1/9/24, indicated that it was issued to the Resident but not to the Resident's Representative. During an interview on 3/25/24 at 11:00 A.M., Social Worker (SW) #1 said that she was unable to provide evidence that the Resident's invoked HCP was provided with the Notice of Bed Hold Policy upon the Resident's transfer to the hospital, as required. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	42761 2. Resident #76 was admitted to the facility in February 2022 with a diagnosis of Chronic Respiratory Failure (when the airways that carry air to one's lungs become narrow and damaged, limiting the movement of air throughout one's body). Review of Resident #76's clinical record indicated the following: - A Physician's Order, dated 11/9/23, to invoke the Resident's Health Care Proxy (HCP: a representative to make healthcare decisions on one's behalf if they become unable to make those decisions themselves). - A Nurse's Note, dated 12/24/23, that indicated the Resident was transferred to the hospital. - An Entry Tracking MDS assessment, dated 12/26/23, that the Resident returned to the facility on [DATE]. - A Nurse's Note, dated 1/18/24, that the Resident was again transferred to the hospital. - An Entry Tracking MDS assessment, dated 1/20/24, that the Resident returned to the facility on [DATE]. Further review of Resident #76's clinical record included no evidence the Resident's Representative was provided with a written bed-hold notice, specifying the duration of the bed-hold, upon the Resident's transfer to the hospital. During an interview on 3/27/24 at 10:46 A.M., the Social Worker (SW) said Resident #76's HCP was invoked, so each time the Resident was transferred to the hospital, written notice of the facility's bed-hold policy was supposed to be provided to the Resident's HCP. The SW said there was no evidence written notices regarding the facility's bed-hold policy were provided to Resident #76's HCP when the Resident was transferred to the hospital on 12/24/23 and 1/18/24. 50138 3. Resident #48 was admitted to the facility in August 2018 with diagnoses including: persistent vegetative state (completely unresponsive to psychological and physical stimuli and displays no sign of higher brain function), congestive heart failure (the inability of the heart to maintain an adequate supply of blood to organs and tissues), functional quadriplegia (complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord), and cerebral infarction. Review of Resident #48's medical record indicated the Resident was transferred to the hospital on 12/2/23, 2/28/24 and 3/9/24, due to a change in condition. Review of Resident #48's medical record indicated His/her Guardianship appointment occurred on 12/27/2018. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #48's medical record did not contain evidence that the Guardian was given written notice that specified the facility bed hold policy at the time of transfer on 12/2/23, 2/28/24, and 3/9/24. During an interview on 3/27/24 at 11:04 A.M., the Director of Nursing (DON) said there was no evidence of written notification to Resident #48's Guardian for the facility bed hold policy, relating to hospital transfers on 12/2/23, 2/28/24 and 3/9/24. The DON said the bed hold policy is important because the resident representative needs to know our bed hold policy.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on record review and interviews, the facility failed to ensure timely completion of a Minimum Data Set (MDS) Comprehensive Assessment for one Resident (#174), out of a total of 25 residents sampled. Specifically, for Resident #174, the facility failed to complete the Admission Comprehensive Assessment no later than day 14 after the Resident was admitted to the facility to assist in planning and providing appropriate care to attain or maintain the highest practicable level of well-being. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual indicated for Admission Comprehensive Assessments: -The ARD (Assessment Reference Date) (item A2300) must be sent no later than day 14, counting the date of admission as day 1. -Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. -The MDS completion date (item Z0500B) must be no later than day 14. Review of the facility's policy titled Resident Assessment (MDS) and Care Planning Policies and Procedures, dated 2/23, indicated the following: -A comprehensive assessment (MDS) is completed within fourteen (14) days of the resident's admission to the facility. Resident #174 was admitted to the facility in March 2024 with the following diagnoses: anxiety disorder (a mental illness that can cause constant fear and worry), bipolar disorder (a mental illness that causes extreme mood swings, from high to low, that affect your energy, thinking, and behavior), dysphagia (difficulty in swallowing food or liquid), major depressive disorder (a persistent feeling of sadness and loss of interest), and schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, symptoms of a mood disorder, such as mania and depression), progressive neurological condition, and morbid obesity. Review of Resident #174's medical record indicated an MDS assessment, dated 3/18/24, was overdue. Further review of the MDS, indicated the following sections had not yet been completed by the required interdisciplinary team members: B (Hearing, Speech and Vision), GG (Functional Ability and Goals), H (Bowel and Bladder), I (Active Diagnoses), J (Health Conditions), L (Oral/Dental Status), M (Skin Conditions), N (Medications), O (Special Treatments and Procedures), and P (Restraints). (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/24 at 10:07 A.M., the MDS Nurse and the surveyor reviewed the MDS assessment dated [DATE]. She said that it had not been completed and should have been as the facility had 14 to days to complete the admission comprehensive assessment. She further said that it should have been completed by 3/20/24 but was not.

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on interviews and record reviews, the facility failed to accurately complete Minimum Data Set (MDS) assessments for two Residents (#76 and #21), out of 25 total sampled residents. Specifically, the facility failed to accurately code: 1. One MDS assessment for Resident #76 relative to medication injections; and 2. Two MDS assessments for Resident #21 relative to a urostomy (opening made in one's abdomen to redirect urine flow out of the body). Findings include: 1. Resident #76 was admitted to the facility in February 2022 with a diagnosis of diabetes mellitus (DM: disorder in which the body has high sugar levels for prolonged periods of time). Review of Resident #76's MDS assessment, dated 2/29/24, indicated no medication injections (administered into one's body by use of a needle) were received by the Resident within the seven-day observation period (2/23/24 through 2/29/24). Review of Resident #76's February 2024 Medication Administration Record (MAR) indicated the Resident received 18 units of Insulin Glargine Solution (long-acting injectable medication used to treat Diabetes) 100 units/ml (milliliters) daily between 2/23/24 and 2/29/24. Further review of Resident #76's February 2024 MAR indicated the Resident received Humalog Solution (short-acting injectable medication used to treat Diabetes) 100 unit/ml per the Physician ordered sliding scale (how much medication to take based on blood sugar level) 17 times between 2/23/24 and 2/29/24. During an interview on 3/27/24 at 12:18 P.M., the MDS Coordinator said she reviewed Resident #76's clinical record, and the Resident did receive Insulin injections daily between 2/23/24 and 2/29/24. The MDS Coordinator said the MDS, dated [DATE], was not coded accurately and should have been coded to reflect medication injections had been received by Resident #76 seven out of seven days during the MDS's observation period. 45435 2. Resident #21 was admitted to the facility in November 2023 with diagnoses including neuromuscular dysfunction of the bladder (a condition in people who lack bladder control due to a brain, spinal cord, or nerve problem) and artificial openings of urinary tract status. Review of the Physician's Orders, dated 3/23/24, indicated the following: -Urostomy (a surgical procedure that creates an artificial opening for the urinary system) care every shift, date initiated, 11/22/23. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	-Inspect the condition of the skin around the urostomy stoma (a surgically created artificial opening) for any irritation or breakdown every shift, if present, notify the supervisor and Physician immediately, date initiated 11/22/23. Review of the MDS assessments, dated 12/5/23 and 2/28/24, under Section H- Bladder and Bowel, did not indicate the Resident had an urostomy. During an interview on 3/22/24 at 2:34 P.M., the MDS Nurse said the presence of an ostomy should have been coded on the MDS assessments, dated 12/5/23 and 2/28/24, and that the MDS was inaccurate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on interviews and record reviews, the facility failed to develop comprehensive care plans according to Minimum Data Set (MDS) Assessment Care Area Assessments (CAAs) for three Residents (#53, #63, and #50), out of 25 total sampled residents. Specifically, the facility failed to: 1. Develop a care plan for Resident #53 relative to rejection of care when behaviors for refusal of care were triggered on the Resident's MDS Assessment's CAA for Behavior, facility staff indicated a care plan for rejection of care was to be developed, and the Resident continued to reject care. 2. Develop a care plan for Resident #63 relative to vision when vision impairments were triggered on the Resident's MDS Assessment's CAA for Vision and facility staff indicated a care plan was to be developed. 3. Develop a care plan for Resident #50 relative to pain when pain was triggered on the Resident's MDS Assessment's CAA for Pain and facility staff indicated a care plan was to be developed. Findings include: Review of the facility's Care Planning Policy, dated February 2023, indicated the following: -A comprehensive care plan is developed within seven days of completion of the resident assessment, or within 21 days of the resident's admission, whichever comes first. Further review of the policy indicated the comprehensive care plan has been designed to: -Incorporate identified problem areas and their risk factors. -Build on the resident's strengths. -Reflect treatment goals and objectives in measurable outcomes. -Prevent declines in the resident's functional status . -Enhance the optimal functioning of the resident . 1. Resident #53 was admitted to the facility in [DATE] with a diagnosis of chronic pain. Review of Resident #53's Physician's Order, dated [DATE], indicated: Change foam dressing to neck incision every shower day . Review of Resident #53's [DATE] Treatment Administration Record (TAR) indicated the Resident refused to have the dressing to his/her neck changed on 10//,d+[DATE], as ordered. Review of Resident #53's MDS assessment, dated [DATE], indicated the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The Resident demonstrated behavior for rejection of care between one and three days during the MDS Assessment's observation period ([DATE] through [DATE]). - Behavioral symptoms for rejection of care triggered on the Assessment's CAA for Behavior. - Facility staff indicated a care plan for rejection of care was to be developed. - The Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total possible points. Review of Resident #53's Physician Order, dated [DATE], indicated: Posterior neck . cleanse with wound cleanser, pat dry, apply Xeroform (non-adherent sterile wound dressing), cover with dry protective dressing (foam) . change every other day. Review of Resident #53's TARs for [DATE] through [DATE] indicated the following relative to rejection of wound care: - The Resident refused ordered wound care 6 out of 13 days wound care was ordered to be administered in [DATE]. - The Resident refused ordered wound care 5 out of 15 days wound care was ordered to be administered in [DATE]. - The Resident refused ordered wound care 6 out of 14 days wound care was ordered to be administered in February 2024. - The Resident refused ordered wound care 6 out of 10 days wound care was ordered to be administered through [DATE]. Review of Resident #53's active Comprehensive Care Plan included no evidence a care plan had been developed relative to rejection of care. During an interview on [DATE] at 12:27 P.M., Resident #53 said he/she refused to have the dressing on his/her neck changed every other day as ordered. Resident #53 further said he/she usually agreed to have the dressing changed once to twice per week. During an interview on [DATE] at 12:49 P.M., Nurse #4 said Resident #53 refused ordered dressing changes and that the Resident usually agreed to have the dressing on his/her neck changed once or twice per week, when the Resident had showers. During an interview on [DATE] at 5:15 P.M., the MDS Coordinator said Resident #53's CAA for behavioral symptoms relative to rejection of care triggered on the Resident's MDS assessment, dated [DATE], and that the facility staff indicated a decision to develop a care plan for rejection of care. The MDS Coordinator then said a care plan relative to rejection of care should have been developed but it was not. 42690 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #63 was admitted to the facility in [DATE] with a diagnosis of glaucoma (a group of eye conditions that damage the optic nerve). During an interview on [DATE] at 10:59 A.M., Resident #63 said that he/she was going to the eye doctor every eight weeks to receive an injection in the left eye to stop it from bleeding and felt that it was working. The Resident said he/she did not know what would happen if he/she stopped getting the injection but has had no issues with the bleeding at this time. The Resident continued to say that he/she would really like to see the eye doctor as he/she has been seeing him for years due to his/her eye concerns. Review of the MDS assessment, dated [DATE], the CAA for vision triggered a care plan to be developed due to the Resident having cataracts (a condition affecting the eye that causes clouding of the lens), glaucoma and/or macular degeneration (a vision impairment resulting from deterioration of the central part of the retina, a thin layer at the back of the eye on the inner side). Review of the medical record indicated no documented evidence that a care plan regarding vision or glaucoma had been developed. During an interview on [DATE] at 10:14 A.M., the MDS Nurse and surveyor reviewed the MDS assessment dated [DATE]. She said that visual function was triggered indicating a comprehensive care plan should be developed. Further review of the medical record did not indicate that a comprehensive care plan had been developed. The MDS Nurse said that a comprehensive care plan should have been developed based on the CAA due to the Resident having a diagnosis of glaucoma. 3. Resident #50 was admitted to the facility in [DATE] with diagnoses that include: spinal stenosis (abnormal narrowing of the spinal canal that results in pressure on the spinal cord or nerve roots) and fibromyalgia (a disorder that affects muscle and soft tissue characterized by chronic muscle pain, tenderness, fatigue and sleep disturbances). Review of the MDS assessment, dated [DATE], indicated the CAA for pain was triggered and a care plan was to be developed. During an observation and interview on [DATE] at 10:59 A.M., Unit Manager (UM) #1 and the surveyor entered Resident #50's room. The Resident told UM#1 that his/her tailbone hurt so much and was in a lot of pain. The Resident asked the surveyor not to leave him/her alone stating that he/she was in so much pain that he/she did not care if he/she died . During an interview on [DATE] at 12:17 P.M., UM #1 said that the Resident had pain since the first day he/she was admitted to the facility. Together the UM and the surveyor reviewed the comprehensive care plan and noted that a care plan for pain had not been created until [DATE]. UM #1 said that something should have been developed prior to this as the Resident has had pain since being admitted to the facility that was being managed, but it was ongoing. During an interview on [DATE] at 2:50 P.M., the MDS Nurse said that a pain care plan had been triggered upon admission as indicated through the CAA. She further said that it had not been developed until [DATE] and should have been developed upon admission or soon after.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on interview and record review, the facility failed to revise the comprehensive care plan, in accordance with the facility's policy, for one Resident (#48), out of 25 total residents sampled. Specifically, the facility failed to revise Resident #48's comprehensive care plan following completion of a comprehensive assessment, which increased the Resident's risk for improper delivery of care related to changing goals, preferences, and needs of the resident and in response to current interventions. Findings include: Review of the facility's policy titled Resident Assessment (MDS) and Care Planning Policies and Procedures, dated 2/2023, indicated that it was the policy of the facility that the care plan/interdisciplinary team develops a comprehensive care plan for each resident within 7 days of the completion of assessment and reviews are made at least every 92 days. Resident #48 was admitted to the facility in August 2018 with diagnoses including: persistent vegetative state (completely unresponsive to psychological and physical stimuli and displays no sign of higher brain function), congestive heart failure (the inability of the heart to maintain an adequate supply of blood to organs and tissues), functional quadriplegia (complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord), and cerebral infarction (when the blood flow to the brain is disrupted due to issues with the arteries that supply it). Review of Resident #48's medical record indicated an Annual Comprehensive (MDS) assessment dated [DATE]. Review of Resident #48's clinical record indicated the Resident's active care plan was last updated on 6/9/23. During an interview on 3/27/24 at 11:04 A.M., the Director of Nursing (DON) said the most recent comprehensive care plan in Resident #48's medical record was last revised on 6/9/23. During an interview on 03/27/24 at 10:35 A.M., the Social Worker said there was no evidence in the medical record of completed comprehensive care plan updates for Resident #48 since June of 2023. She said that there was no evidence of an Interdisciplinary care plan meeting occurring nor proof of invitation for Resident #48's Guardian to attend a meeting. She said it is important to revise care plans because it's the plan of care and they change, for the correct delivery of care and services to the resident. During an interview on 3/27/24 at 11:28 A.M., the MDS Nurse said the current comprehensive care plan for Resident #48 was last updated 6/9/23. She said the interdisciplinary care plan review/revision correlating with the Comprehensive Assessment, dated 2/15/24, was due on 2/29/24 but was not complete. She said that care plan revisions were important for the delivery of resident care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 44222 Based on observation, interviews, and records reviewed, the facility failed to provide activities of daily living (ADLs) to maintain grooming and personal hygiene for one Resident (#88) who was unable to carry out ADLs independently, out of a total of 25 residents sampled. Specifically, the facility failed to provide Resident #88 with grooming needs relative to facial hair and nail care. Findings include: Resident #88 was admitted to the facility in May 2021 with diagnoses of adult failure to thrive (a syndrome of global decline that occurs in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment) and unspecified dementia (a cognitive impairment that has yet to be diagnosed as a specific type). Review of the facility's policy titled Activities of Daily Living (ADLs) Support, effective 1/2023, indicated: -Task related to personal care such as personal hygiene, toileting, feeding, ambulating, bed mobility, transfer, walking, in room and in the corridor, locomotion on and off the unit, and dressing. -Resident will perform selfcare with ADLs at the level on the CNA care plan or care card or assigned tasks . -Assist the resident to be clean, neat and well-groomed including nail care and (s)having. Finger and toenails will be cut/trimmed per policy. Review of the facility policy titled Care of Fingernails/Toenails, effective 1/2023 included: -The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. -Nail care includes cleaning and regular trimming. Review of the Resident's ADL care plan, last revised on 11/24/23, indicated that the Resident had a self-care performance deficit and was dependent on staff for personal hygiene tasks. Review of the Resident's Minimum Data Set (MDS) assessment, dated 1/23/24, indicated that the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15, and further indicated that the Resident had not exhibited any episodes of rejection of care. Review of the Resident's CNA Kardex (a brief overview of a Resident's care needs) Report, undated printed on 3/25/24, indicated that the Resident required extensive assistance for personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor observed that the Resident had fingernails that were excessively long with brown debris visible under the nails, and excessively long facial hair on the chin and upper lip during the following observations: -On 3/20/24 at 10:06 A.M. -On 3/21/24 at 11:46 A.M. -On 3/25/24 at 12:30 P.M. Review of the Resident's CNA care documentation for March 2024 indicated that the Resident received personal hygiene care assistance every day and was dependent on staff for personal care on 3/20/24, 3/24/24, and 3/25/24 (the time period during which the surveyor observed the Resident with excessively long fingernails with debris and facial hair). Review of the Resident's clinical record did not indicate any refusal of care by Resident #88. During an interview on 3/25/24 at 12:30 P.M., Nurse #2 and the surveyor observed Resident 88's facial hair and fingernails. Nurse #2 said that the facial hair should have been addressed/shaved during morning care and that the Resident's fingernails should have been cleaned during morning care, but they were not. During an interview on 3/25/24 at 4:00 P.M., the Director of Nursing (DON) said that shaving and fingernail care were part of morning and evening care and that the Resident's facial hair should have been shaved and their fingernails should have been cleaned by the CNA.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42761 Based on observations, interviews, and records and policies reviewed, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and choices for one Resident (#17), out of 25 total sampled residents. Specifically, the facility failed to: a. Provide seating, adequate for the Resident's condition, when the Resident was non-ambulatory (unable to walk) and required assistance from staff to get out of bed, increasing the Resident's for further physical debility and social isolation. b. Maintain an accurate record of the Resident's fluid intake and urinary output when the Resident's Physician ordered fluid intake and output monitoring and the Resident had a history of fluid overload (too much fluid in one's body that can cause swelling, high blood pressure, and impact organ function). c. Provide timely incontinent (loss of bladder control) care when the Resident had been incontinent of urine, was dependent on staff for incontinent care, and requested incontinent care be provided which increased the Resident's risk for a deterioration in skin condition. Findings include: Resident #17 was admitted to the facility in October 2022 with diagnoses including End Stage Renal Disease (ESRD: condition where the kidney reaches advanced state of loss of function which can result in changes in urination, fatigue, swelling .), dependence on renal dialysis (blood purifying treatment given when kidney function is not optimum), obesity, and muscle weakness. a. Review of the facility's policy titled Seating System and Positioning Devices, dated December 2023, indicated: - The guideline was to establish appropriate seating systems for residents . to maintain comfort and good . body alignment. - Seating systems . assist with . maintaining independence so residents remain engaged in functional activities of choice. Review of Resident #17's Activities of Daily Living (ADL) Care Plan, initiated 10/10/22 and revised 1/18/24, indicated: - The Resident required assistance of two staff for all positioning. - The Resident did not walk. - The Resident required assistance when out of bed with the use of a wheelchair. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #17's Activities Care Plan, initiated 1/20/23 and revised 1/18/24, indicated: - Needs a variety of activity types and locations to maintain interests. Review of Resident #17's Physical Therapy Evaluation, dated 6/15/23, indicated: - The Resident was dependent on staff for transfers to and from a chair/wheelchair. - The Resident did not walk. - The Resident's Mobility Function Score was 0 (using a 0 to 12 scale where 12 is the highest function). Review of Resident #17's Physical Therapy Discharge Summary, dated 6/20/23, indicated: - The Resident's Mobility Function Score was 0. - The Resident was discharged to the hospital. Review of Resident #17's Activity Care Plan, initiated 7/20/23 and revised 1/18/24, indicated: - Explain the importance of social interaction . Review of Resident #17's Minimum Data Set (MDS) assessment, dated 1/4/24, indicated: - The Resident had impaired range of motion in both lower extremities. - Transfers to and from the bed and chair/wheelchair had not been attempted. - The Resident did not use a wheelchair. On 3/20/24 at 11:01 A.M., the surveyor observed Resident #17 positioned in bed, on his/her back, with the head of the bed elevated. The Resident's legs were covered with bed linens and the surveyor observed the Resident's upper body dressed in a hospital gown. During an interview at this time, Resident #17 said he/she was unable to walk, was unable to get up without the use of a mechanical lift operated by two staff members, and did not have a chair to sit in, so he/she just stayed in bed. At this time, the surveyor observed the Resident's room and bathroom. There was a standard straight back chair next to the Resident's bed, but the surveyor observed no wheelchair. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 3/26/24 at 10:12 A.M., Resident #17 said he/she used to have a wheelchair, but that he/she had not seen it for months and did not know where it was at that time. Resident #17 said she did not ask staff to help him/her out of bed because he/she refused often a while back and no one offered for him/her to get out of bed anymore. Resident #17 said the straight back chair in the room next to the bed had been there since the Resident had been in that room, but that he/she had never tried sitting in it because he/she needed a different width chair. Resident #17 further said he/she would like to get out of bed. During an interview on 3/26/24 at 10:53 A.M., Certified Nurse Aide (CNA) #3 said Resident #17 used to have a wheelchair in his/her room, about four to five months prior, but that the Resident had a history of refusing to get out of bed when this was offered by staff. CNA #3 further said Resident #17 no longer had a wheelchair available to get into if he/she did want to get up. During an interview on 3/26/24 at 12:00 P.M., Therapist #2 said Resident #17's most recent therapy episode occurred in June 2023. Therapist #2 said Resident #17 was dependent upon staff with the use of a mechanical lift for transfers, the Resident could not walk, and that the Resident was discharged from therapy services with a wheelchair to sit in if he/she got out of bed. At this time, the Regional Rehab Director said all residents who required a wheelchair should have one. During an interview on 3/26/24 at 1:13 P.M., the Director of Nursing (DON) said she thought Resident #17 had a wheelchair available to sit in if the Resident chose to get out of bed. The DON further said the facility provided all residents with a wheelchair if they needed one. On 3/27/24 at 8:00 A.M., the surveyor observed Resident #17 lying in his/her bed with the head of the bed elevated. The surveyor also observed a wheelchair with a seat cushion and bilateral leg rests in Resident #17's room, beside the Resident's bed. During an interview at this time, Resident #17 said a staff member brought the wheelchair into the room that morning and left it beside the Resident's bed. During an interview on 3/27/24 at 12:35 P.M., the Regional Rehab Director said Resident #17 was evaluated by one of the Therapists on 3/26/24 and it was identified that the Resident did not have a wheelchair available to him/her to get out of bed, so one was provided for the Resident in the morning on 3/27/24. The Regional Rehab Director then said that every resident who needs a wheelchair should have one as an option to get out of bed. b. Review of the facility's policy, titled Intake and Output (I and O) Measuring, dated January 2023, indicated: - The purpose was to accurately determine the amount of liquid a resident consumed and put out in a 24-hour period. - At the end of the shift, total the amounts of all liquids the resident consumed in cubic centimeters (milliliters: mls). - If a resident is continent, record output in mls . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- If a resident is incontinent, record the number of episodes of incontinence. - The amount of fluid consumed, and number of urinary incontinence episodes were to be documented in the resident's medical record. Review of Resident #17's Nutrition Care Plan, initiated 1/9/23 and revised 2/4/24, indicated: - The Resident was at risk for fluid imbalance relative to ESRD and Dialysis. - A 1500 ml fluid restriction was in place. - Fluid intake monitoring was required for each meal. Review of Resident #17's Nutrition Assessment, dated 2/4/24, indicated the following: - The Resident had fluid gains between dialysis treatments, occasionally as much as nine kilograms (equivalent to 19.8 pounds). - A 1500 milliliter (ml) fluid restriction was recommended. Review of Resident #17's March 2024 Physician's Orders indicated the following: - 1500 ml daily fluid restriction, initiated 2/5/24. - Intake and output monitoring every shift with total intake and output on 11-7 shift . every night shift, 1.5 Liter (1500 ml) fluid restriction, initiated 2/5/24. Review of Resident #17's March 2024 Treatment Administration Record (TAR) indicated the following relative to fluid intake: - Total fluid intake was recorded in mls on 21 out of 25 days reviewed (three days were indicated as unknown and one day was indicated as + for total fluid intake). - One day (7:00 A.M. through 3:00 P.M.) shift and four evening (3:00 P.M. through 11:00 P.M.) shifts were not completed. Further review of Resident #17's March 2024 TAR indicated the following relative to urine output: - Measurable total urine output was recorded in mls on 16 out of 25 days reviewed. - Total urine output was indicated as not applicable on two days, unknown on one day, x on one day, and x 1 on five days out of 25 days reviewed. During an interview on 3/26/24 at 10:12 A.M., Resident #17 said that he/she was incontinent of urine and used incontinent briefs. Resident #17 said he/she used to have a urinary catheter, but did not have one anymore, and he/she did not use a bed pan, so he/she was unsure how staff monitored his/her urinary output. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/26/24 at 1:33 P.M., Nurse #6 said staff were required to monitor fluid intake (I) and urine output (O) for residents on I and O monitoring and that the monitoring for I and O was recorded on residents' TARs. Nurse #6 said Resident #17 was on a fluid intake restriction and that the Resident had a physician's Order for I and O monitoring. Nurse #6 said the Resident's fluid intake was supposed to be recorded on the MAR in mls, but that the urine output had to be recorded as number of incontinent episodes as the Resident did not have any devices in use to measure urine output in mls and was incontinent of urine. At this time, the surveyor reviewed Resident #17's March 2024 TAR with Nurse #6. While reviewing the Resident's TAR, Nurse #6 said staff had not been accurately recording Resident #17's I and O. Nurse #6 further said all the boxes on the TAR should have been completed to indicate how many mls of fluid the Resident took in each shift and daily, and how many urinary incontinent episodes the Resident had each shift and daily. Nurse #6 then said recording the Resident's I and O on the TAR was the only place where fluid intake and urine output were documented. During an interview on 3/27/24 at 12:30 P.M., the Registered Dietitian (RD) said Resident #17's fluid restriction was implemented due to having weight gain between dialysis treatments. The RD said staff should record the Resident's I and O accurately for monitoring purposes. c. Review of the facility's policy, titled Answering the Call Light, dated June 2022 indicated it was the policy of the facility that quick response was given to a resident's call light to respond to the resident's request and needs in a timely fashion. Review of Resident #17's Incontinence Care Plan, initiated 4/21/23 and revised 1/18/24, indicated: - The Resident was at risk for skin breakdown due to incontinence and impaired mobility. - The Resident was incontinent of bowel and bladder. - The Resident used disposable incontinence briefs. - Staff were to clean the Resident's peri area with each incontinent episode. Review of Resident #17's MDS assessment, dated 1/4/24, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total possible points. Further review of the MDS assessment indicated: - The Resident required substantial/maximal assistance to roll in bed. - The Resident required substantial/maximal assistance for toilet hygiene. - The Resident was always incontinent of urine. On 3/20/24 at 11:01 A.M., the surveyor observed Resident #17 positioned in bed, on his/her back, with the head of the bed elevated. The Resident's legs were covered with bed linens and the surveyor observed the Resident's upper body dressed in a hospital gown. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview at this time, Resident #17 said he/she was incontinent of urine and that he/she wore incontinence briefs. Resident #17 said he/she used the call bell to request assistance from staff for incontinent care when needed, but that staff did not assist him/her with incontinent care in a timely manner. When asked how the Resident determined timely assistance, the Resident #17 said wait times for staff to provide assistance ranged anywhere from 30 minutes to a few hours after he/she rang the call bell. Resident #17 then said staff had provided incontinent care to him/her around 5:00 A.M. that day and that he/she used the call light around 8:30 A.M. to request incontinent care be provided again. Resident #17 said staff responded to the call light but told the Resident they were still assisting other residents with breakfast, so he/she would need to wait. Resident #17 further said no staff had returned to provide him/her with the incontinent care he/she requested around 8:30 A.M., and that he/she was still waiting. On 3/26/24, between 9:30 A.M. and 10:10 A.M., the surveyor observed the following outside of Resident #17's room: - The Resident's call light was observed to be on at 9:30 A.M. - Nurse #10 entered the Resident's room at 9:31 A.M., turned off the call light, and exited the room. - At 9:32 A.M., Nurse #10 told CNA #3 Resident #17 requested incontinent care and CNA #3 said okay. - At this time, CNA #3 entered another resident's room and closed the door. - Nurse #6 entered Resident #17's room at 9:33 A.M. and said, Did I leave my thermometer in here?, then exited the Resident's room and closed the door. - At 9:52 A.M. the surveyor observed an activities staff member place a rolled piece of paper behind Resident #17's door handle. At this time, the Activities staff member said she was delivering the Daily Chronicle to residents on the Unit and that if a resident's door was closed, she would leave it behind the door handle and nursing staff would bring it into the room when they went in. - At 9:54 A.M., the surveyor observed CNA #3 exit the Resident's room she was observed to enter at 9:32 A.M. - The surveyor observed CNA #3 enter Resident #17's room at 10:02 A.M. with one other CNA. and close the door. - Both CNAs exited Resident #17's room at 10:10 A.M. Throughout this observation, the surveyor observed two nurses at the nurses' station. (continued on next page)

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Pioneer Valley Health & Rehabilitation	573 Granby Rd South Hadley, MA 01075

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/26/24 at 10:12 A.M., Resident #17 said he/she had put the call light on that morning to request incontinent care because he/she had urinated in his/her incontinence brief. Resident #17 further said it took staff about a half-hour before they came into his/her room to provide the incontinent care he/she requested. During an interview on 3/26/24 at 10:53 A.M., Certified Nurse Aide (CNA) #3 said the unit was staffed with four CNAs and three Nurses on the day shift. CNA #3 said from the start of the shift through lunchtime it was difficult to answer call lights and provide incontinent care to residents because the CNAs were busy providing morning personal care to residents. CNA #3 said that residents would sometimes have to wait a half-hour or more after calling for assistance if the CNAs were busy assisting other residents with morning personal care. CNA #3 also said residents would have to wait until after mealtimes if they required incontinent care during mealtimes. CNA #3 said Nurse #10 told her that Resident #17 requested incontinent care that morning, but she needed to assist another resident with morning personal care first, so she was unable to provide incontinent care to Resident #17 until about a half-hour later. CNA #3 then said Resident #17 required assistance of two staff for incontinent care, so CNA #3 had to wait until another CNA was available to help her provide incontinent care to Resident #17. During an interview on 3/26/24 at 5:30 P.M., the Director of Nursing (DON) said the census capacity on the East One Unit was 39 residents and there were currently several empty beds. The DON said the Unit was adequately staffed, with four CNAs and three Nurses, on the day shift. The DON also said any Nurse or CNA could assist residents with incontinent care and it was not required that a resident's assigned CNA be the only CNA responsible to provide care to the resident. The DON further said staff on the Unit just needed to communicate with each other to request help if a resident needed care and their assigned CNA was caring for another resident. The DON further said Resident #17 should not have had to wait for a half-hour after his/her call light was answered to be provided with incontinent care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42761 Based on observations, interviews, record reviews, and policy review, the facility failed to provide respiratory care, consistent with professional standards of practice, for one Resident (#48) who required the use of Oxygen, out of 25 total sampled residents. Specifically, the facility failed to maintain Resident #48's oxygen delivery equipment in a sanitary manner when: a. The concentrator's filter cover was covered with dust, while the Resident used Oxygen via a nasal cannula (plastic device inserted into one's nose to assist in delivering Oxygen) attached to the concentrator, increasing risk for sub-optimal air flow and compromised health. b. The top and front of the concentrator had areas of dust and dried, spattered debris while the Resident used Oxygen via nasal cannula which was attached to the concentrator, increasing risk for compromised health. Review of the facility's policy titled Suggested O2 (Oxygen) Equipment Cleaning Schedules, dated June 2022, indicated: - All equipment would be cleaned and stored according to infection control . guidelines. - Oxygen delivery devices were to be cleaned every seven days and as needed for soiling. Resident #76 was admitted to the facility in February 2022 with diagnoses including: pneumonia and chronic respiratory failure (occurs when airways that carry oxygen to one's lungs become narrow and damaged) with hypoxia (low levels of oxygen in one's body tissues). Review of Resident #76's March 2024 Physician's Orders indicated the following: - Oxygen at 1-3 Liters via nasal cannula to maintain sats (measure of how much oxygen is in one's blood) between 88-93% ., dated 4/24/23. - . Clean filter weekly ., dated 3/19/24. On 3/20/24 at 9:38 A.M., the surveyor observed Resident #76 sitting upright in bed. There was an oxygen concentrator next to the bed that was in the on position, set at 3 Liters and running. The oxygen tubing was connected to the oxygen concentrator with a nasal cannula in the Resident's nose. At this time, the surveyor observed areas of dust and dried debris on the top and front of the oxygen concentrator, and there was dust covering the concentrator's filter cover on the back of the concentrator. On 3/21/24 at 1:00 P.M., the surveyor observed Resident #76 in his/her bed with Oxygen in use via nasal cannula. The surveyor's observation of the oxygen concentrator was unchanged from the observation made by the surveyor on 3/20/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/22/24 at 11:30 A.M., the surveyor observed Resident #76 in his/her bed with Oxygen in use via nasal cannula. The surveyor's observation of the oxygen concentrator was unchanged from the observations made by the surveyor on 3/20/24 and 3/21/24. During an interview on 3/22/24 at 11:38 A.M., Nurse #4 said she knew that oxygen tubing was changed weekly on the night (11:00 P.M. through 7:00 A.M.) shift, but that she was unsure how frequently oxygen concentrators and filters were required to be cleaned or changed. At this time, the surveyor observed Resident #48 and his/her oxygen concentrator with Nurse #4. Nurse #4 said the Resident's oxygen concentrator should not have areas of dried, spattered debris and dust on it. Nurse #4 also said the oxygen concentrator's filter cover should not have been covered with dust and should have been cleaned. During an interview on 3/22/24 at 12:30 P.M., the Staff Development Coordinator (SDC) said maintaining residents' oxygen equipment had been identified as a facility concern recently and that cleaning the oxygen delivery equipment had been tasked to the night shift. The SDC said it was clear Resident #48's oxygen concentrator had not been cleaned per the facility's policy, but it should have been.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42761 Based on observations, interviews, and test tray results, the facility failed to serve palatable food, at an appetizing temperature, to all residents. Specifically, the facility failed to: 1. Serve palatable food, relative to texture, to residents on the East One Unit for one breakfast meal. 2. Serve food to residents on the [NAME] Two Unit that was palatable, relative to taste and texture, and hot when the food was meant to be served hot. Findings include: On 3/21/24 from 2:00 P.M. through 3:00 P.M., the surveyor conducted a Resident Council meeting. Residents in attendance stated that the food that was supposed to be served hot but it was served cold. The residents said the taste and texture of the food was undesirable. The residents also said cold food was brought up during monthly Resident Council meetings and during the Food Committee meetings. On 3/22/24, between 8:01 A.M. and 8:19 A.M., the surveyor observed the following on the East One Unit: - The second meal cart arrived on the Unit at 8:01 A.M. - The last resident meal tray was served at 8:19 A.M. and the surveyor received the test tray at this time. - The test tray included puree eggs, puree French toast, French toast with banana topping, pancake, scrambled eggs, and oatmeal. - The surveyor tasted each food item with Food Service Director (FSD) #2 present and noted: the pancake was 97 degrees F, barely warm and had a rubbery texture, and the white toast was soggy. On 3/22/24, between 8:15 A.M. and 8:30 A.M., the surveyor observed the following on the [NAME] Two Unit: - The second meal cart arrived on the Unit at 8:15 A.M. - The last resident meal tray was served at 8:29 A.M. - The test tray was provided for the surveyor by FSD #2 at 8:30 A.M. At this time, FSD #2 used a thermometer to check food temperatures. The surveyor tasted the food and noted the following: - Oatmeal 118.2 degrees F, warm and watery. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Toast 102.8 degrees F, cool and soggy. - French toast 114.1 degrees F, warm. - Scrambled eggs 102.2, cool. - Puree French toast 115.5 degrees F, barely warm and tasted sour. - Puree eggs 106 degrees F, cool. - Pancake 98.5 degrees F, hard to cut, chewy, and cold. The two test trays validated the residents' complaints of cold and unpalatable food. During an interview on 3/22/24 at 8:45 A.M., FSD #1 said the food items served to residents for the breakfast meal that morning were meant to be palatable and served at a hot temperature. FSD #1 said the pancakes should not have been chewy or hard to cut. FSD #1 also said he was unsure why the puree French toast was sour, but that he did not make it that morning, so he did not know what the Cook used to thin it out into puree when she made it. FSD #1 said it was important for all residents to be provided with food that was palatable and at an appetizing temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42761 Based on observations, interviews, and policies reviewed, the facility failed to adhere to professional standards and the facility's policies for: 1. Food storage, preparation and service, and cleanliness of food preparation equipment in the facility's main kitchen, placing residents at risk for foodborne illness; and 2. Food storage, food equipment cleanliness, and reheating of resident food items in one Unit (West 2) Kitchenette out of three-unit kitchenettes observed. Specifically, the facility failed to: - Serve thoroughly cooked eggs at one breakfast meal when the eggs were not pasteurized. - Maintain cold food storage according to professional standards in the walk-in refrigerator. - Maintain food preparation equipment in a sanitary manner. - Maintain unit nourishment kitchens in a sanitary manner. - Provide equipment and proper instructions for staff to reheat resident food items according to food safety requirements. Findings include: 1. Review of the facility's policy titled Dietary-Proper Food Preparation, dated December 2022, indicated all foods would be prepared following established procedures for sanitation, handling, and protection from cross-contamination. Review of the facility's policy titled Dietary-Food Purchasing, dated December 2022, indicated only Grade A pasteurized shell eggs and egg products were allowed. Review of the facility's policy, titled Sanitizing Equipment and Dietary Space, dated December 2022, indicated all equipment and dietary areas would be maintained in a sanitary manner to prevent contamination and infections. Review of the facility's policy titled Dietary-Food Storage, dated December 2022, indicated it is the policy of the facility that prepared foods shall be kept labeled with contents and dated, raw meats should be placed on sheet pans, and that refrigerator units will be kept clean at all times and placed on a routine and as needed cleaning schedule. On 3/20/24 at 7:19 A.M., the surveyor observed the following during the initial kitchen walk-through: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- A puddle of wet pink liquid on the floor of the refrigerator, dripping from a box of raw chicken stored on the bottom rack of the refrigerator. Some of the pink liquid at the edge of the puddle on the floor was dry. The pink liquid was also dripping from the box of chicken onto an adjoining tray of meat. - One torn yellow piece of paper laying on the floor of the refrigerator in the pink liquid that indicated: made 3/14 egg salad. - One plate containing a wet, white, lumpy substance that was covered in plastic wrap and labeled with black marker, but unable to be read. - Two boxes of 15 dozen each, Grade A Cage Free eggs. One box was open and half empty. There was no indication on either box that the eggs were pasteurized. Cooking instructions located on the box indicated to cook thoroughly. - One juice cart located in the food preparation area with dry, crusty, brown and white debris on the bottom shelf of the cart and atop the juice pump. - Pots and pans stored on a shelving unit with dry, white spattered debris on the shelves. - The blender base was stored on a counter in the food preparation area with dry, spattered white and brown debris on the top and front of the unit. - One soup tureen, bolted to the floor in the food preparation area, covered with a black plastic bag, coated in dust and dried white spattered substance. - One black metal fan coated with dust on the blades and the outer cage on top of the counter next to the three-compartment sink in the dish room, on and blowing toward the dish machine. There was a three-tiered plastic cart that contained three plates, a mini spatula, one soup bowl, and a beverage pitcher next to the dish machine. The cart was soiled with dried and spattered white debris. During an interview on 3/20/24 at 8:12 A.M., Food Service Director (FSD) #1 said he had been working at the facility for approximately six weeks and that he was just starting to be able to put in for food orders himself. He said that the facility was supposed to order pasteurized shelled eggs if they were to be served runny. FSD #1 said kitchen staff served runny, fried, and sunny side up eggs to residents that requested them for breakfast. At this time, FSD #1 removed the open box of Grade A Cage Free eggs from the refrigerator, reviewed the labels on the box, and said the eggs were not pasteurized, so they should only be served after being cooked thoroughly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At this time, the surveyor observed the refrigerator, food preparation area, and dish room with FSD #1. FSD #1 said the dripping box of raw chicken should have been stored on a pan to prevent leaking and surface contamination. FSD #1 said the plated wet, white, lumpy substance was unidentifiable and he did not know if it belonged to a staff member or was facility food. FSD #1 said that the shelved pots and pans in the food preparation area were clean and should not have been stored on shelves that were not clean. FSD #1 said the juice cart, blender base, and soup tureen cover were not clean, but should have been. FSD #1 said that the fan in the dish room should be clean but it was not. FSD #1 further said that he could not produce any evidence that kitchen equipment had been cleaned or sanitized since he started working at the facility. During an interview on 3/20/24 at 8:25 A.M., Cook #1 said she thought the facility only ordered shelled eggs that were pasteurized. Cook #1 said that she had cooked runny eggs for three residents for breakfast that day because they requested them. She said that she usually cooks runny eggs to about 135 degrees F because if they were cooked to a higher temperature, they would not be runny. When asked what temperature the shelled eggs were cooked to that morning for the three residents who requested them Cook #1 said she did not check the final cooked temperature. She further said the eggs were served without having their temperatures checked. Cook #1 then said that cooking unpasteurized eggs thoroughly was important to prevent residents from getting sick. 2. Review of the facility's policy titled Food Brought in for the Residents from the Outside, dated February 2022, indicated: - Any unlabeled food containers/items would be removed from the refrigerator and will be disposed of accordingly. - Any perishable foods that require refrigeration would be placed in the unit's nourishment/kitchen refrigerator and needed to be consumed within 72 hours of the date brought in. - Unit refrigerators would be checked daily by . staff. - Any foods stored in the refrigerator would be discarded after the 72-hour time frame. - Any foods not stored or labeled properly would be discarded. Review of the facility's policy titled Food and Liquid Re-heating, undated, indicated: - The facility would provide foods and liquids to residents in the allowable temperature range by State and Federal regulations, both at initial delivery as well as when re-heated. - Necessary equipment and supplies included a food thermometer and approved sanitizing solution for the thermometer (alcohol swabs or equivalent). - Re-heat leftover or cooled food/liquid items to 165 degrees F for 15 seconds . On 3/22/24 at 8:23 A.M., the surveyor observed the following in the [NAME] Two Unit Kitchenette: - The inside of the microwave and the refrigerator were soiled with dried debris and crusted matter. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Two keep frozen breakfast bowls were dated 3/14 and stored on the bottom shelf of the refrigerator, not in the freezer. - One open apple sauce container, dated 3/20 located on the top shelf in the refrigerator. - One sign, posted to the wall of the Kitchenette, that indicated: when heating food please ensure the temperature is not above Food: 120 degrees, Liquid 110 degrees. - There was no thermometer present in the kitchenette at the time of observation. During an interview on 3/22/24 at 10:05 A.M., FSD #2 said that any food items in the refrigerator that were outdated should have been discarded and the room should be stocked and cleaned twice a day. FSD #2 said the breakfast bowls that were stored in the refrigerator should have been kept frozen, but they were not, so they should have been discarded. FSD #2 said she thought food requiring reheating in the microwave would need to be reheated to 125 degrees F, but needed to confirm that once she had time to check. She said she had removed the posted sign for reheating from another kitchenette area in the building and did not realize the same sign was posted in the [NAME] Two Unit Kitchenette. FSD #2 also said microwaved food needed to sit for a minute after heating because pockets of high temperatures could be present in the heated food and cause burns to a resident. During an interview on 3/22/24 at 10:20 A.M., CNA #3 said she reheated resident foods and water for tea or coffee using the microwave in the Kitchenette. CNA #3 said she would reheat food items for a minute or so just to make sure they were lukewarm and not too hot. CNA #3 said that she had never seen or used a thermometer to check the temperature for reheated food items and that she was unaware of any specified reheating protocol. During an interview on 3/22/24 at 10:20 A.M., CNA #4 said she had never seen a thermometer in the kitchenette to be used for reheating resident food items and she did not know if there was a specific protocol for reheating resident food items.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45435 Based on observations, interviews, policies, and records reviewed, the facility failed to ensure staff adhered to infection control standards for residents on Transmission-based Precautions (TBP), to mitigate the spread of infection, for one Resident (#77), out of three applicable sampled residents, out of a total sample of 25 residents. Specifically, the facility failed to ensure staff wore the required personal protective equipment (PPE) when providing care to a Resident on Droplet precautions (a precaution used to prevent the spread of pathogens that are passed through respiratory secretions such as when coughing or sneezing) for Influenza infection. Findings include: Review of the facility's policy titled Influenza Prevention and Control, dated February 2022, indicated the following: -Use droplet precautions when caring for patients with suspected or confirmed seasonal influenza. -Signage from CDC (Centers for Disease Control and Prevention) on transmission-based precautions . are utilized by the facility to communicate the particular type of precautions needed. Review of the CDC Droplet Precautions sign posted at the entry to Resident #77's room indicated the following: Everyone must: -Clean their hands, including before entering and when leaving the room. -Make sure their eyes, nose and mouth are fully covered before room entry. -Remove face protection before room exit. Resident #77 was admitted to the facility in September 2023 with a diagnosis of dementia (a progressive persistent loss of intellectual functioning with impairment of memory and thinking). Review of the March 2024 Physician's Orders indicated the following: -Maintain droplet precautions secondary to influenza, initiated 3/25/24. -Tamiflu oral capsule 30 milligrams by mouth two times a day for influenza for five days, date initiated 3/23/24. On 3/27/24 at 9:35 A.M., the surveyor observed Nurse #3 enter Resident #77's room without wearing eye protection and exit the room without changing her mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/24 at 9:42 A.M., Nurse #3 said that Resident #77 was on precautions for the flu. She further said that she should have put on an eye shield before she entered the room and that she should have changed her mask when she exited the room to prevent the spread of the flu. During an interview on 3/27/24 at 11:50 A.M., the Regional Nurse said that staff should wear a mask and eye protection before entering the room of a resident on Droplet precautions and should remove them before exit from the room.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 44222 Based on observation, policy review, and interview, the facility failed to ensure that its staff maintained wheelchair equipment in safe operating condition for one Resident (#67), out of a total of 25 sampled residents. Specifically, for Resident #67, the facility failed to identify that the left side panel was missing from the wheelchair creating a large gap on the left side of the wheelchair where the Resident's left arm could slip through and be caught in the wheel spoke. Findings include: Resident #67 was admitted to the facility in December 2018 with diagnoses including unspecified dementia (when symptoms and findings of cognitive dysfunction do not meet the criteria for a specific type of dementia), weakness, and other lack of coordination. Review of the facility policy titled Seating System and Positioning Devices, effective 12/2023, indicated that . Seating systems may be routinely checked during rounds, mealtimes, quarterly/annual screening process . Review of the facility's policy titled Equipment Calibration/Maintenance - Guideline, effective 12/2023, included: -All equipment (wheelchairs, walkers, canes, gym equipment, etc.) requires periodic maintenance and inspection to operate properly. When a piece of equipment has been identified to be unsafe, broken, or in need of repair it shall be removed from circulation and replaced with a loaner until repairs and/or replacements have been made. -Wheelchairs - Brakes, armrest, leg-rest, seats, etc. shall be inspected periodically, all staff are responsible for ensuring that the wheelchair/seating system being issued and/or utilized remains in good condition. Review of the Resident's Minimum Data Set (MDS) assessment, dated 1/10/24, indicated that he/she was severely cognitively impaired as evidenced by a Brief Interview for Mental Status of 2 out of 15. Review of the Resident's current care plan, last revised 10/31/23, indicated that he/she used a wheelchair for mobility and required staff assistance. On 3/20/24 at 10:18 A.M., the surveyor observed the Resident sitting up in his/her wheelchair in the unit dayroom. The left side panel was missing from the wheelchair, creating a large gap on the left side at the level of the Resident's left forearm, leading directly to the open spokes of the wheel. On the following dates, the surveyor observed the Resident resting in bed; the wheelchair with the left side panel missing was adjacent to the bed: -3/21/24 at 11:55 A.M. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225757	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Valley Health & Rehabilitation	573 Granby Rd South Hadley, MA 01075

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/26/24 at 2:00 P.M. During an interview on 3/27/24 at 10:02 A.M., the Rehabilitation Services Manager #1 said that she had looked at the wheelchair and confirmed that the left side panel was missing. She said that it was not safe to use the wheelchair with the panel missing as the Resident's left arm would be able to freely hang out through the opening and be caught in the spokes of the wheel. She said that the staff should have removed the wheelchair for repairs, but they had not done so.