STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225766	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam North Rehab and Nursing	55 Cooper Street Agawam, MA 01001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on records reviewed and interviews, for one of four sampled residents (Resident #1), who required post-surgical care, including antibiotic therapy, wound monitoring and dressing changes, the facility failed to ensure Resident #1 was provided with nursing care and treatment that met professional standards for quality when 1) antibiotic therapy was not started upon admission despite the medication being available within the facility emergency supply, and 2) wound assessments upon admission, daily monitoring, and documentation related to treatment orders were not completed by Nursing, Findings include: Review of the Facility Policy titled, Nursing admission to the Facility, revised October 2023 indicated the following: -Observe the general condition of the resident (i.e., obvious skin issues, bruises, lacerations, bandages, any acute distress noted, general mood, etc.,) as well as his or her reaction to the admission. - All findings are to be documented in skilled charting admission note within residents' electronic medical record. - LPN/RN (must complete a full initial skin check within eight hours of admission and document in progress note. - LPN/RN must complete full skin check within 24 hours of admission and document in progress note/admission record. - LPN/RN: Completion of skilled charting admission note to be completed within 24 hours of admission by resident's primary nurse. - LPN/RN: Completion of nursing admission assessment to be completed within 24 hours of admission. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225766	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam North Rehab and Nursing	55 Cooper Street Agawam, MA 01001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of Registered Nurse and Practical Nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulations (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and function of a Registered Nurse and Practical Nurse, respectively. The regulations stipulate that both the Registered Nurse and Practical Nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the Registered Nurse and Practical Nurse incorporate into the plan of care and implement prescribed medical regimens. The Rules and Regulations 9.03 define the Standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. 1) Resident #1 was admitted to the Facility in April 2024, diagnoses included right below knee amputation, fracture of ribs right side, fracture of left tibia (the larger of two bones in the lower leg), and fracture of T11-T12 vertebra (bones that make up the spinal column). During a telephone interview on 10/17/24 at 11:30 A.M., Witness #1 said Resident #1 was admitted to the Facility after having his/her right leg amputated, that he/she required antibiotic therapy, surgical wound treatment and monitoring to both his/her right leg amputation site as well as to his/her lower left leg surgical site. Witness #1 said the Facility did not provide Resident #1 with timely antibiotic treatment, dressing changes or wound monitoring and that caused a worsening of his/her wound infection which then required him/her to be hospitalized again. Witness #1 said on 04/16/24 when Resident #1 went to a scheduled follow-up appointment with the Surgeon, the Surgeon immediately sent Resident #1 to the Hospital for evaluation of his/her infection and that Resident #1 was readmitted to the Hospital for treatment. Review of Resident #1's Hospital Discharge/Transfer Note, dated 04/10/24 indicated that Resident #1 was to receive Cephalexin (an antibiotic medication) 500 milligrams (mg) by mouth every six hours and received his/her last dose on 04/10/24 at 2:00 P.M. Review of Resident #1's Hospital Inpatient Adult Discharge Instructions, Discharge Medications, dated 04/10/24, indicated Resident #1 should receive the next dose of Cephalexin on 04/10/24 at 8:00 P.M. Review of Resident #1's April 2024 Medication Administration Record (MAR) indicated he/she had a Physician's order for: - 04/11/24, Cephalexin Oral Tablet 500 mg by mouth four times a day for infection for ten days, discontinued 04/21/24. Review of Resident #1's April 2024 Physician's Orders and MAR indicated his/her Cephalexin was not started at the Facility until 04/11/24 at 5:00 P.M., resulting in three missed doses of the antibiotic (he/she therefore missed a total of 1500 mg of an antibiotic, that was ordered to treat his/her active infection). Review of the Cubex/MedBank (electronic medication dispensing system at the facility) inventory provided to the surveyors by the Director of Nursing, indicated that there were three Cephalexin 250 mg tablets, which was regularly stocked in the Cubex. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225766	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam North Rehab and Nursing	55 Cooper Street Agawam, MA 01001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, further review of Resident #1's MAR, dated 04/10/24, indicated that even though the Cephalexin was available in the Cubex, it was not dispensed or administered to him/her. Resident #1's April 2024 MAR indicated Cephalexin was not administered on 04/10/24 at 8:00 P.M., or on 04/11/24 at 9:00 A.M. and 12:00 P.M. During a telephone interview on 10/22/24 at 1:40 P.M., the Facility's Pharmacy Customer Service Representative said Cephalexin was delivered to the facility on [DATE] at 2:33 P.M. During an interview on 10/22/24 at 1:50 P.M., Nurse #1 said when a Resident was admitted to the facility, the Nurse reviews the Hospital Discharge Summary to determine what was required to care for the new Resident. Nurse #1 said if Physician's orders were required, the Nurse would review the Discharge Summary with the Facility's Provider (Physician/Nurse Practitioner/Physician's Assistant), obtain the necessary orders and then enter the orders into the computer. Nurse #1 said the medication orders are entered, the Facility's computer system automatically communicates with the Pharmacy computer system and medications are usually delivered twice per day from the Pharmacy. Nurse #1 said if a Resident arrives after the last Pharmacy delivery of the day, Nursing will refer to the Discharge Summary to determine which medications were due next and check the Cubex system to see if any of those medications were available to dispense. During the interview, Nurse #1 and the surveyor reviewed Resident #1's Hospital Discharge Summary and noted that the Resident was to receive Cephalexin on 04/10/24 at 8:00 P.M. Nurse #1 said based on that information, the Nurse who completed Resident #1's admission should have ensured, when obtaining admission orders with the on-call Provider, that the Cephalexin had a start date of 04/10/24, not 04/11/24, and then obtained the medication from the Cubex, and administered the medication to Resident #1. Nurse #1 reviewed Resident #1's MAR with the surveyor, confirmed that Cephalexin was not scheduled to start until 04/11/24, and that the dosages due on 04/11/24 for 9:00 A.M. and 12:00 P.M. were left blank. Nurse #1 said she would have to assume Resident #1 did not receive the Cephalexin at that time. During an interview on 10/22/24 at 2:20 P.M., Nurse #2 said when a Resident was admitted to the Facility, she reviews the Hospital Discharge Summary and/or the Hospital Discharge/Transfer Note, which was more detailed than the Discharge Summary. Nurse #2 said if it was during regular hours, she would bring the Discharge Summary or Discharge/Transfer Note directly to the Facility Provider to determine what the admission orders would be and enter them into the computer accordingly. Nurse #2 said if the admission occurred after the Facility Provider left for the day, the Nurse is supposed to call the on-call Provider to review the Hospital Discharge Summary and/or the Hospital Transfer/Discharge Note over the phone with the Provider to obtain admission orders and then enter the orders into the computer. During the interview, Nurse #2 reviewed Resident #1's Hospital Discharge Summary and said based on the information provided, Cephalexin should have been ordered, removed from the Cubex, and administered to Resident #1 during the evening on 04/10/24. Nurse #2 said if there were blank spaces on the MAR, it was assumed the medication was not administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225766	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam North Rehab and Nursing	55 Cooper Street Agawam, MA 01001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Medical Record which included a Physician's Assistant Progress Note, dated 04/15/24, that indicated the following: Resident #1 was evaluated sitting up in bed. Below Knee Amputation (BKA) incision appears to have purulent (thick, milky or pus-like fluid that oozes from a wound and is a sign of infection) drainage with possible dehiscence (partial or total separation of previously approximated wound edges, due to a failure of proper wound healing). He/She (Resident #1) notes the Surgeon called the Facility to change antibiotics on Friday afternoon, however, has not received them. Spoke to Unit Manager who reached out to his office and noted they sent in a prescription for Augmentin (Amoxicillin-Potassium Clavulanate) x 14 days. This writer suggested Resident #1 should go to the Emergency Department for further management and concern for dehiscence however he/she declined and will wait for his/her appointment with the Surgeon tomorrow. Review of Resident #1's Outpatient Surgical Visit Note, dated 04/16/24, indicated the following: Right below knee wound infection. The wound is poorly healing, and I suspect it will require surgical excisional debridement (a procedure where devitalized/dead tissue in the presence of underlying infection is removed using a sharp instrument, such as a scalpel). It would be best treated with intravenous antibiotics (injected directly into the vein to treat bacterial infections) and hospitalization . During an interview on 10/22/24 at 12:45 P.M., The Director of Nursing (DON) and surveyor reviewed Resident #1's Medication Administration Record (MAR) and Treatment Administration Record (TAR). The DON said it was her expectation that if a Nurse administered a medication or performed a treatment, the Nurse was to sign it off as completed on the MAR or TAR. The DON also said it was her expectation that if a medication was not given or a wound treatment was not provided, the Nurse was to document the reason on either the MAR, TAR or in a Nursing Progress Note. The DON said where there were blank spaces on the MAR and TAR, she would have to assume medications were not given and/or the treatments were not completed, as ordered. 2. Review of the Facility Policy titled, Skin Prevention, Assessment, and Treatment, revised October 2023 indicated the following: - Purpose: To provide a systematic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown. - Any skin impairments, including pressure ulcers, non-pressure ulcer wounds, surgical wounds, skin tears, abrasions, etc., should be assessed and documented weekly by the Wound Nurse or designee, in the Medical Record. Review of Resident #1's Hospital Discharge/Transfer Note dated 04/10/24 indicated the following: - Left foot in CAM boot (a boot used to stabilize the foot and ankle after an injury or surgery). - The skin edges of the Below the Knee (BKA) amputation site are beginning to separate with some signs of white ischemic (tissue death) changes, re-evaluated by the surgeon today, ready for discharge to Rehab on Cephalexin (an antibiotic medication) for ten days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225766	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam North Rehab and Nursing	55 Cooper Street Agawam, MA 01001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Right BKA incision line management: Betadine (an antiseptic) paint to incision line, cover with dry dressing and secure. Change twice daily and as needed. Apply ACE wrap and stump sock (sock used to protect the amputation site). Patient is to wear right BKA Ampushield (a removable, adjustable, rigid plastic limb protector that helps patients heal after an amputation) as much as possible. - Left lower extremity management: Staples/sutures have been removed from left lower extremity, steri-strips (provides wound support and increases tensile strength of the wound) applied and will fall off on their own, continue to wrap ACE bandage around lower left leg until incisions fully heal to prevent friction against boot. Resident #1's April 2024 Treatment Administration Record (TAR) indicated he/she had Physician's orders for the following treatments: - 04/11/24, Manage incision of right BKA, apply Betadine paint to incision line, cover with dry dressing and secure, apply ACE wrap and stump sock, twice per day, discontinued 04/15/24. - 04/15/24, Manage incision of right BKA, apply Betadine paint to incision line, cover with dry dressing and secure, apply ACE wrap and stump sock, three times per day. Review of Resident #1's Medical Record, which included Nursing Progress Notes and his/her Treatment Administration Record (TAR), indicated there was no documentation to support that Nursing staff performed a full skin assessment upon admission, regularly monitored and assessed his/her left leg surgical incision, or infected right leg amputation site until 04/15/24, the day before Resident #1 was re-hospitalized . Further review of Resident #1's Medical Record indicated there was no documentation to support that Nursing was applying the CAM boot to his/her left leg and the Ampushield to his/her right leg as indicated in the Hospital Discharge/Transfer Note. Review of Resident #1's April 2024 Treatment Administration Record indicated the wound treatment was not documented as being completed on the following dates and times: - 04/11/24 9:00 A.M. - 04/12/24 9:00 P.M. - 04/14/24 9:00 A.M. - 04/16/24 8:00 A.M. During an interview on 10/22/24 at 1:50 P.M., Nurse #1 and the surveyor reviewed Resident #1's April 2024 TAR. Nurse #1 confirmed Resident #1's wound treatment orders were not signed off as being completed by Nursing on 04/11/24, 04/12/24, 04/14/24 and 04/16/24. Nurse #1 said she would have to assume that Resident #1 did not receive any wound care treatment on those dates and times, because they were left blank. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225766	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam North Rehab and Nursing	55 Cooper Street Agawam, MA 01001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/24 at 2:20 P.M., Nurse #2 and the surveyor reviewed Resident #1's April 2024 TAR. Nurse #2 confirmed Resident #1's wound treatment orders were not signed off as being completed by Nursing on 04/11/24, 04/12/24, 04/14/24, and 04/16/24 and said if there were blank spaces on the TAR it was assumed the wound treatments were not completed. During an interview on 10/22/24 at 11:45 A.M., the Assistant Director of Nursing (ADON) said Assessments were documented and filed under the Assessment tab in the Electronic Health Record (EHR), when a resident was admitted , the Nurse was required to complete a Nursing Admission Assessment. The ADON reviewed Resident #1's EHR and said a Nursing Admission Assessment, which contained a comprehensive skin assessment, was never completed for him/her. The ADON said during the time Resident #1 was admitted , there was an issue with the Unit Manager on the Resident's unit ensuring necessary paperwork was completed. During an in-person interview on 10/22/24 at 12:45 P.M., the Director of Nurses (DON) said Skin Assessments should be completed upon admission and weekly. The DON said the Assessments should be located under the Assessment tab in the Electronic Health Record (EHR). The DON reviewed Resident #1's EHR and said since Resident #1 had not been in the facility for a full seven days, she did not expect to see a weekly Skin Assessment, however she would expect a Nursing Admission Assessment, which included a Skin Assessment to have been completed. Upon reviewing Resident #1's EHR, the DON said the Nursing Admission Assessment was never completed, there was no documentation to support Resident #1's wounds were assessed by Nursing, and said she had no explanation other than there had been a series of Unit Managers on A-Wing (where Resident #1 resided) that did not work out. During a follow-up telephone interview on 10/25/24 at 1:25 P.M., the Director of Nurses (DON) and the surveyor reviewed Resident #1's Hospital Discharge/Transfer Note. The DON said the Nurse that admitted Resident #1 should have ensured there were orders in place for Nursing to monitor Resident #1's left lower leg surgical incision, when to apply the CAM boot to his/her left leg (a boot used to stabilize the foot and ankle after an injury or surgery), and when to apply the Ampushield to Resident #1's right leg. The DON said those orders were not in place and there was no documentation in Resident #1's Medical Record to support that Nursing staff were monitoring his/her left leg, applying the CAM boot appropriately and applying the Ampushield to his/her right leg.