STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225253	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam West Rehab and Nursing	61 Cooper Street Agawam, MA 01001

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on interview, record and policy review, the facility failed to ensure that Advance Directives (legal documents that provide instructions for medical care and only go into effect if you are unable to communicate your own wishes) were accurate for three Residents (#3, #62 and #39) out of a total sample of 24 residents. Specifically, the facility failed to: 1. For Resident's #3 and #62, ensure that the MOLST (Massachusetts Medical Order for Life-Sustaining Treatment) form was valid and reflected the signature of the Resident's invoked (made active by a Physician) Health Care Proxy (HCP- a legal document that allows you to appoint someone you trust to make medical decisions on your behalf if you are unable to do so). 2. For Resident #39, offer the opportunity to formulate an Advance Directive for the Resident after his/her HCP had been deactivated by the Physician. Findings include: Review of the facility policy for Advance Directives, initiated 10/16/23, indicated the following: -If utilizing a MOLST form, the order will take effect after signatures of the resident/resident representative and is signed by the Provider. -The Advance Directive shall be reviewed and updated upon resident request, with the comprehensive care plan, and with significant changes in condition. -If a resident is incapacitated at the time of admission and is unable to receive information (due to the incapacitating conditions or a mental disorder) or articulate whether or not he or she has executed an advance directive, then the facility may give advance directive information to the resident's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with the law. (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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	225253	A. Building B. Wing	07/16/2024

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility is not relieved of its obligation to provide this information to the resident once he or she is no longer incapacitated or unable to receive such information. The facility shall implement and establish follow-up procedures to provide the information to the resident directly at the appropriate time. 1a. Resident #3 was admitted to the facility in July 2005, with a diagnosis of Schizophrenia (a mental illness that affects how a person thinks, feels and behaves). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #3 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of six out of a total score of 15. Review of the clinical record indicated a MOLST form dated 11/4/23, that had not been signed by the Resident, Resident Representative or Physician with the request for the following: -Do Not Resuscitate (DNR) -Do Not Intubate and Ventilate (DNI/ DNV) -Do Not Use Non-Invasive Ventilation (DNIV) -Do Not Transfer to Hospital (DNH) Further review of Resident #3's clinical record indicated: -A HCP Designation Form that appointed a HCP on 7/24/07 -The Physician had invoked the Resident's HCP on 10/6/15 During an interview on 7/15/24 at 3:11 P.M., Social Worker (SW) #1 said that she reviews MOLST forms quarterly. SW #1 said that Resident #3's MOLST form was not valid because it had not been signed by the HCP or the Physician and a new MOLST should have been completed but was not completed. 45429 1b. Resident #62 was admitted to the facility in December 2023 with a diagnosis of Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #62 was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of two out of a total score of 15. Review of the clinical record revealed a MOLST form dated 2/23/24 that had not been signed by the Resident, Resident Representative or Physician with the request for the following: -Do Not Resuscitate (DNR) (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Do Not Intubate and Ventilate (DNI) -Do Not Use Non-Invasive Ventilation (DNIV) -Do Not Transfer to Hospital (DNH) Further review of Resident #62's clinical record indicated: -A HCP Designation Form that appointed a HCP on 8/14/14. -The Physician had invoked the Resident's HCP on 4/14/23. During an interview on 7/15/24 at 12:07 P.M., SW #1 said that the MOLST form on file was not valid because it had not been signed by the HCP and the Physician. SW #1 also said that a new MOLST form should have been completed and it had not been. 2. Resident #39 was admitted to the facility in November 2016, with a diagnosis of spinal stenosis (a condition where the spinal column narrows and compresses the spinal cord and nerves and can cause pain). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #39 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of a total score of 15 points. Review of Resident #39's clinical record indicated: -The Resident's HCP had been activated on 11/18/16. -The Resident's MOLST had been signed by the HCP on 11/27/16, with the request for DNR and DNI. -The Resident's HCP was de-activated by the Physician on 5/11/23, and he/she was deemed to have capacity to make medical decisions on his/her own behalf. Review of the clinical record indicated no evidence that Resident #39 had been provided with the opportunity to formulate an Advance Directive after his/her HCP had been de-activated by the Physician. During an interview on 7/15/24 at 12:02 P.M., SW #1 said that a new MOLST should have been established once the Resident was determined to have capacity for informed medical decision making.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on interview, record and policy review, the facility failed to notify the Physician/Non-Physician Practitioner (NPP/ Nurse Practitioner [NP]) of a significant change in condition for two Residents (#62 and #86) out of a total sample of 24 residents. Specifically, the facility staff failed to notify the Physician/NPP: 1. For Resident #62, when the blood sugar reading was greater than 400 mg/dL. 2. For Resident #86, when the Resident experienced an unplanned, significant weight loss of -10.73% in one month. Findings include: 1. Resident #62 was admitted to the facility in December 2023 with a diagnosis of Diabetes Mellitus Type 2 (DM II- a chronic medical condition where the body cannot effectively use insulin [hormone that regulates blood glucose/sugar] or produce enough insulin, and has trouble controlling blood sugar levels). Review of the facility's policy for Hyperglycemic (high blood sugar) Protocol, last revised 11/5/2019, included: -Early signs and symptoms of hyperglycemia may include increased thirst, increased urination, appearing tired, restlessness. -Later signs and symptoms of hyperglycemia may include lethargy, dehydration, decreased awareness, loss of consciousness. -If an Accu-check (a blood glucose measuring system) reveals a blood glucose level above 300 mg/dL (milligrams per deciliter) or level identified per individual orders, hyperglycemia should be suspected. -If any of the above signs or symptoms are identified .report the resident's diabetic condition to the Physician immediately. -Follow the resident's individual hyperglycemic protocol, if ordered by the Physician. Review of Resident #62's care plan for Insulin Dependent Diabetes last revised 5/18/23, indicated: -an intervention to monitor for signs and symptoms of hyperglycemia . -and report abnormal findings to the Physician. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #62's care plan for Maintaining Blood Glucose Levels initiated on 7/2/24, indicated: -an intervention to monitor for a change in condition and . -notify the Physician. Review of the Resident's July 2024 Physician's orders included: -Insulin Glargine (long-acting insulin) - Subcutaneous Solution Pen- (injection between the skin and muscle for treatment of Diabetes) 100 UNIT/ML (units/milliliter); Inject 12 units subcutaneously at bedtime for Diabetes, initaited 7/2/24 -NovoLog FlexPen (fast acting insulin injection) Solution Pen-injector 100 UNIT/ML; Inject as per sliding scale: >if blood sugar is 200 - 249 mg/dL = give 2 units (u). >250 - 299 mg/dL = give 4u. >300 - 349 mg/dL = give 6u. >350 - 400 mg/dL = give 8u. >401 - 450 mg/dL = give 10u., call MD (Doctor of Medicine/ Physician) for FBS (fasting blood sugar) above 400 mg/dL, subcutaneously before meals for Preventative care, initiated 7/2/24 Review of the Resident's July 2024 Medication Administration Record (MAR) indicated the following blood sugar levels recorded at 4:30 P.M. on the following days: -7/5/24 = 404 mg/dL -7/6/24 = 425 mg/dL -7/7/24 = 416 mg/dL -7/8/24 = 411 mg/dL -7/11/24 = 442 mg/dL Review of the Resident's progress notes from 7/5/24 through 7/11/24 did not indicate any notification to the Physician related to a blood sugar result greater than 400 mg/dL. During an interview on 7/16/24 at 12:03 P.M., Unit Manager (UM) #2 said that the Physician should have been notified when Resident #62's blood sugar was over 400 mg/dL. UM #2 also said that it should have been documented in the Nurses progress notes and it had not been. 50138 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #86 was admitted to the facility in March 2024, with diagnoses including Diabetes (elevated levels of glucose in the blood), Anemia (condition that develops when the blood produces a lower than normal amount of red blood cells and/or hemoglobin [protein in red blood cells that carries oxygen from the lungs to other organs/tissues] to carry oxygen to the body's tissues), and Atrial Fibrillation (A-fib: irregular, rapid heartbeat that can lead to blood clots and other heart related complications). Review of facility policy titled Weight Assessment & Interventions dated 11/1/15, indicated: -It is the policy of this facility to prevent significant unplanned or unavoidable weight loss for our residents. -Criteria threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria: a. 1 month 5% weight loss is significant, greater than 5% is severe b. 3 months 7.7% weight loss is significant, greater than 7.5% is severe c. 6 months 10% weight loss is significant, greater than 10% is severe -Nursing staff will measure resident weights on admission, and then weekly for four weeks. If no weight concerns are noted at this point, weights will be measured monthly thereafter. -Weights will be recorded in the resident's medical record -Any weight change of 5 pounds or more within 30 days will be retaken for confirmation and if the weight is verified nursing will notify the Provider and the Dietary Manager/Dietician. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #86: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of seven out of a total score of 15. -had identified weight loss. -recieved nutrition via tube feeding. Review of Resident #86's comprehensive care plan for Nutritional Risk, last revised 3/22/24, indicated an intervention to monitor for weight changes and notify Physican and Registered Dietician (RD) as needed. Review of Resident #86's weight record indicated the following weights: -6/1/24: 123 pounds (lbs.) -7/1/24: 109.8 lbs. (a significant change of -10.73%) (continued on next page)

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	225253	A. Building B. Wing	07/16/2024

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Dietary assessment dated [DATE], indicated that Resident #86: -Was below ideal body weight with gain desirable. -Had triggered for significant weight loss and recommended re-weight. -No changes in the Plan of Care made at this time. -Resident was at risk for malnutrition. Review of Resident's #86 Dietary Progress Note dated 7/2/24, indicated the following: -A weight warning triggered due to (significant/severe) weight loss (-10.73%) -The accuracy of documented weight from 7/1/24 was in question. -A re-weight was requested. Review of Resident #86's clinical record did not indicate that a re-weight had been obtained since the 7/1/24 weight indicating a significant weight loss. During an interview on 7/16/24 at 1:35 P.M., Nurse #1 said that he was not aware of a request for a re-weight on Resident #86. During an interview on 7/16/24 at 1:40 P.M., Unit Manager (UM) #1 said she was unaware of the request for a re-weight by the RD and a re-weight should have been done. UM #1 was unable to provide evidence at time of survey end that the Physican had been notified of the significant weight loss for Resident #86.

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	225253	A. Building B. Wing	07/16/2024

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 48206 Based on record review and interview, the facility failed to ensure the timely completion and transmission of the Minimum Data Set (MDS) Assessments as required for four Residents (#65, #33, #92, #72) out of five applicable residents. Specifically, the facility staff failed to ensure that the components of the MDS Assessments were completed and transmitted within the required timeframes when: 1. For Resident #65, the Assessment was transmitted 28 days after the MDS completion date. 2. For Resident #33, the MDS Assessment was completed 17 days after the ARD (Assessment Reference Date). 3. For Resident #92, A Quarterly MDS assessment with an ARD of 5/28/24, completed 6/11/24, was not yet transmitted as required. 4. For Resident #72, the MDS Assessment was completed 22 days after the ARD, and was not yet transmitted as required. Findings include: Review of the CMS Resident Assessment Instrument (RAI) Version 1.18.11 Manual dated October 2023, included the following: -Assessment Reference Date (ARD) refers to the specific endpoint for the observation (or look-back) periods in the MDS assessment process. -The facility is required to set the ARD on the MDS or in the facility software within the required timeframe of the assessment type being completed. -The Quarterly MDS Assessment completion date must be no later than 14 days after the ARD. -The Annual MDS assessment completion date must be no later than 14 days after the ARD. -Assessment Transmission must be within 14 days of the MDS Completion Date. 1. Resident #65 was admitted to the facility in April 2021. Review of the clinical record indicated: -A Quarterly MDS assessment with an ARD of 6/6/24, was completed 6/18/24, and transmitted 7/16/24. -Quarterly MDS assessment transmission occurred 28 days after the MDS completion date of 6/18/24. (continued on next page)

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	225253	A. Building B. Wing	07/16/2024

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #33 was admitted to the facility in January 2024. Review of the clinical record indicated: -An Admission MDS assessment with an ARD of 1/15/24, was completed 2/1/24, and transmitted 2/8/24. -MDS completion occurred 17 days after the ARD. 3. Resident #92 was admitted to the facility in June 2021. Review of the clinical record indicated: -A Quarterly MDS assessment with an ARD of 5/28/24, was completed 6/11/24, and had not yet been transmitted. 4. Resident #72 was admitted to the facility in July 2018. Review of the clinical record indicated: -An Annual MDS assessment with an ARD of 6/4/24, was completed 6/26/24, and had not yet been transmitted. -MDS completion occurred 22 days after the ARD. During an interview on 7/16/24 at 8:58 A.M., with MDS Nurse #1 and MDS Nurse #2, MDS Nurse #1 said that the process is for her and MDS Nurse #2 to complete the MDS assessments and then the facility's Corporate MDS staff review and transmit the MDS assessments. MDS Nurse #1 said she and MDS Nurse #2 do not have access or permission to transmit the MDS assessments. MDS Nurse #1 said that the completion date for the MDS assessment would be 14 days from the ARD. The surveyor and MDS Nurse #1 reviewed the MDS assessment documentation. MDS Nurse #1 said that the MDS assessment for Resident #33 was completed late. MDS Nurse #1 also said that Resident #65 and Resident #92 MDS assessments were late to be transmitted. MDS Nurse #1 further said that Resident #72's MDS assessment was late to be completed and late to be transmitted.

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	225253	A. Building B. Wing	07/16/2024

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. 48206 Based on interview, record and policy review, the facility failed to notify the State Mental Health Authority for a resident review after a significant change in mental condition occurred for one Resident (#2) out of a total sample of 24 residents. Specifically, the facility failed to request a Preadmission Screening and Resident Review Level II screen (PASRR- an evaluation done to determine if a resident has an intellectual or developmental disability and/or serious mental illness[SMI] and if a Resident is in need of additional specialized support services at the facility) after Resident #2 received emergency mental health interventions and experienced limitations in major life activities due to mental illness. Findings include: Review of the facility policy titled Social Services - Coordination with PASRR Program, initiated 2/2/24, indicated the following: -Any resident who exhibits newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the State Mental Health or intellectual authority for a Level II resident review. Resident #2 was admitted to the facility in May 2024, and had diagnoses including Bipolar Disorder (a chronic mood disorder that causes intense shifts in mood, energy levels, and behavior), Major Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Suicidal Ideation (verbal expressions of thoughts of harming oneself that may or may not lack specific intent). Review of the PASRR Level I form dated 5/9/24, indicated the following: -Resident #2 had a documented mood disorder (bipolar disorder/major depression). -Resident did not have any treatments due to mental illness. -Resident did not have a history of emergency mental health interventions. -Resident did not have any functional life impairments due to mental illness. -Negative screen result and Level II PASRR evaluation was not needed. Review of Resident #2's Clinical Record indicated the following Nursing Progress Notes: -On 5/13/24, Resident #2 reported intermittent suicidal ideation. The Resident was evaluated by the Nurse Practitioner (NP) and deemed not currently/actively suicidal. Resident did not need to be transferred to the emergency room (ER) at that time. (continued on next page)

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	225253	A. Building B. Wing	07/16/2024

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 5/14/24, Resident #2 was transferred to the Hospital for suicidal ideation and returned after crisis evaluation in the ER. -On 6/17/24, Resident #2 said to the Nurse that he/she would rather die than eat and had not eaten in 2 days. The NP was made aware and Resident #2 was transferred to the hospital. During an interview on 7/12/24 at 2:38 P.M., the SW (Social Worker) said the Social Service department was responsible for completing the PASRR form and that she reviews the PASRR form prior to the initial social service assessment. The SW said if new information is identified during the assessment process indicating a change from the initial PASRR, she will submit a new PASRR form indicating a request for Level II evaluation. The surveyor and the SW reviewed Resident #2's PASRR Level I evaluation and the SW said that the Resident did not trigger for a Level II on 5/9/24. The SW further said that Resident #2's suicidal ideation would be considered a change and that a PASRR Level II should have been requested, but had not been.

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	225253	A. Building B. Wing	07/16/2024

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on observation, interview, and record review, the facility failed to provide care and services to address a hearing problem for one Resident (#57), out of a total sample of 24 residents. Specifically, the facility staff failed to provide care and services that would maintain or improve Resident #57's hearing and communication when there was a decline in hearing ability, and the Resident/ Resident Representative had consented to be seen for audiology (the science of hearing, balance and related disorders) services. Findings include: Review of the facility policy for Physician Services, initiated 10/16/23, indicated: -Each resident shall be under the care of a licensed Physician. -Physician's services include but are not limited to . ancillary services (Health Care Providers that support Primary Care Providers) of additional Providers based upon the individual need. -Provision for and coordination with the attending provider. Resident #57 was admitted to the facility in November of 2023, with a diagnosis of hearing loss. Review of the Physician's orders indicated an order dated 2/29/24, for ancillary and specialty care as needed. Review of Resident #57's clinical record indicated a Request for Service Form signed by the Resident's Representative requesting Audiology services on 3/7/24. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident had moderate hearing loss but was able to understand others without hearing aids. Review of the MDS assessment dated [DATE], indicated the Resident had moderate hearing loss, no hearing aids, and only sometimes understood others. Review of Resident #57's care plan for Communication Deficit initiated on 12/19/23, last revised 6/12/24, indicated that the Resident had a hearing deficit. During an interview on 7/11/24 at 9:44 A.M., Resident #57 said he/she was very deaf, could not understand what the surveyor was asking and could not read lips. The Resident also said that he/she did not have hearing aids and had recently lost his/her hearing. Review of the clinical record did not indicate that Resident #57 had been provided with audiology services as requested on 3/7/24. (continued on next page)

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	225253	A. Building B. Wing	07/16/2024

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/15/24 at 10:15 A.M., the Director of Nursing (DON) said Resident #57 had never been referred to an Audiologist and should have been referred, because the family (Resident's Representative) had consented to audiology services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225253	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam West Rehab and Nursing	61 Cooper Street Agawam, MA 01001

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on observation, interview, policy and record review, the facility failed to ensure that the administration of enteral (also referred to as tube feeding) nutrition was consistent with and followed the Physician's orders for one Resident (#76) out of a total sample of 24 residents. Specifically, the facility staff failed to administer the Physician ordered volume (quantity) of tube feeding for Resident #76, whose sole source of nutrition are enteral feeds thus placing the Resident at risk for altered nutritional status. Findings include: Resident #76 was admitted to the facility in September 2020, with diagnoses including Subarachnoid Hemorrhage (SAH - bleeding in the space between the brain and the tissue covering the brain) and Respiratory Failure (a serious condition that makes it difficult to breathe on your own that develops when the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #76: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of zero out of a total score of 15. -and received nutrition via feeding tube. Review of facility policy titled Tube Feeding, dated 11/28/23, indicated: -It is the purpose of this policy to ensure safe and effective use of the tube and maintain the integrity of the tube per the Provider's orders. -Enteral feeding orders will be written to ensure consistent volume infusion. The following information will be included to ensure that any necessary interruptions of feeding will not decrease volume infused: >Bolus Feeding (a method of tube feeding that involves administering a limited volume of enteral formula or liquid food through a feeding tube in several doses over brief periods of time throughout the day) procedure includes: -Verify Physician order for enteral feeding via bolus method. -Gather necessary equipment. -Identify resident. (continued on next page)

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	225253	A. Building B. Wing	07/16/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pour prescribed amount of feeding into syringe. -Refill the syringe until the feeding is complete. -Clamp (close) tube and detach syringe. Review of Resident #76's July 2024 Physician's orders included the following: -NPO (nothing by mouth). -Gastrostomy tube (G-tube: a soft, flexible tube that passes through the abdominal wall and into the stomach) 18 French (6 millimeter [mm] diameter tube) for diet. -Enteral feed order: Osmolite 1.5 CAL (a therapeutic nutrition solution for tube fed residents) bolus 356 milliliters (ml) four times a day. -Flush tube with 150 ml of water every six hours. -Flush tube with 60 ml of water before each medication pass every shift. Review of Resident #76's comprehensive care plan last revised 5/22/24, indicated the Resident: -was at a Nutritional Risk given weight loss -was NPO -had enteral feeding as the sole source of nutrition, and included the following interventions: >Provide enteral feedings and flushes as ordered by Physician to maximize nutritional intake and monitor tolerance. >NPO On 7/15/24 at 11:57 A.M., the surveyor observed Nurse #1 administer 60 milliliters (ml) of water flush to Resident #76 though the G-tube followed by four 60 ml syringes of Osmolite 1.5 CAL tube feeds for a total dose of 240 ml. The surveyor observed Nurse #1 administering an additional 60 ml of water flush after the tube feeds and then closed the G-tube port. During an interview on 7/15/24 at 12:15 P.M., Nurse #1 said the total dose of Osmolite 1.5 CAL that was given to the Resident was about 237 ml. Nurse #1 said that the correct dose that should have been given was 356 ml (with a deficit of 119 ml tube feeds that was not administered) and that he had not given the correct volume as ordered by the Physician. Nurse #1 said it is important for Resident #76 to get the proper volume (tube feeds) because that is Resident #76's only food and nutrition available.

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	225253	A. Building B. Wing	07/16/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on observation, interview, policy and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for one Resident (#15), out of a total sample of 24 residents. Specifically, the facility failed to maintain an oxygen concentrator (a device used to deliver supplemental oxygen) filter for Resident #15 in a clean, safe and functional manner in accordance with Physician orders, placing Resident #15 at risk for impaired oxygen delivery and equipment malfunction. Findings include: Review of the facility policy titled Oxygen Administration and Storage, dated 10/16/23, indicated the following; -It is the purpose of the policy to ensure staff follow safety guidelines and regulation for storage and use of Oxygen. -Filters should be removed and cleaned by rinsing with clear, cool water as needed to maximize flow rate of clean air. Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf indicates in part: -All oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Undesirable results or events may result from noncompliance with Physicians' orders or inadequate instruction for oxygen therapy. -Equipment maintenance and supervision: *All oxygen delivery equipment should be checked at least once daily *Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply. Resident #15 was admitted to the Facility in November 2023, with diagnoses including Asthma (a condition in which airways narrow and swell [inflammation] making it difficult to breathe) and Acute Respiratory Failure (an inability to maintain adequate oxygenation for tissues within the body or remove enough carbon dioxide from the body). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #15 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of a total score of 15. (continued on next page)

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	225253	A. Building B. Wing	07/16/2024

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Agawam West Rehab and Nursing	61 Cooper Street Agawam, MA 01001

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #15's Physician's orders for July 2024 included: -Oxygen: one liter per minute (LPM) via nasal cannula (a device that delivers supplemental oxygen through a tube and into the nose) continuous (non-stop around the clock) for shortness of breath. -Clean filter on oxygen concentrator weekly every night shift (11:00 P.M. - 7:00 A.M.), every Friday for supplemental O2 (Oxygen). Review of Resident #15's comprehensive care plan, last revised 6/11/24, indicated the Resident: -had an alteration to his/her respiratory system. -an intervention to administer medications and treatments as ordered by MD. On the following dates and times, the surveyor observed the Oxygen flow rate for Resident #15 was set at 1 LPM via nasal cannula and a thick coating of gray dust on the oxygen concentrator filter: -7/11/24 at 8:53 A.M. -7/12/24 at 11:15 A.M. -7/15/24 at 4:12 P.M. During an observation and interview on 7/15/24 at 4:12 P.M the Unit Manager (UM) said the Physician's orders were that Resident #15's oxygen concentrator filter was to be cleaned weekly on Fridays. The UM said filter cleaning had been signed off as complete on 7/5/24 and 7/12/24. The surveyor and the UM observed the oxygen concentrator filter that was still coated in dust. The UM said the filter cleaning did not appear to have been done as ordered. During a follow-up interview on 7/16/24 at 1:27 P.M., the UM said it is important for the oxygen concentrator filters to be cleaned as ordered to prevent equipment malfunction, allergens, and germs, putting a resident with respiratory diagnosis like Asthma at risk for breathing trouble.

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	225253	A. Building B. Wing	07/16/2024

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on observation, interview, and record review, the facility failed to provide dental care and services as required for one Resident (#39) out of a total sample of 24 residents. Specifically, the facility staff failed to refer Resident #39 for dental services, when the Resident had consents for dental care and services. Findings include: Resident #39 was admitted to the facility in November 2016, with diagnoses including Quadriplegia (condition where all four limbs and body from the neck down are paralyzed. Can be caused by spinal cord injury or medical conditions). Review of Resident #39's clinical record indicated a Request For Service Form signed by the Resident's Representative on 12/3/19 for dental services. Review of the facility policy for Physician Services, initiated 10/16/23, indicated: -Each resident shall be under the care of a licensed Physician. -Physician's services include but are not limited to . ancillary services (Health Care Providers that support Primary Care Providers) of additional Providers based upon the individual need including but not limited to . dental. -Provision for and coordination with the attending Provider. Review of Resident #39's care plans initiated 2/7/21, and last revised 5/30/24, indicated that the Resident was at risk for oral health and dental care problems. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #39 was cognitively intact as evidenced by Brief Interview for Mental Status (BIMS) score of 12 out of a total 15 points. Further review of the MDS indicated that the Resident was dependent on staff for assistance with oral hygiene. Review of the July 2024 Physician's orders indicated: -an order to obtain a Dental Consult and treatment for patient health and comfort as needed, dated 12/8/20. During an interview on 7/11/24 at 8:06 A.M., Resident #39 said that he/she has never been seen by the Dentist and would like to be seen. Resident #39 also said that his/her brother helps him/her to clean his/her teeth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225253	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam West Rehab and Nursing	61 Cooper Street Agawam, MA 01001

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #39's medical record failed to indicate whether Resident #39 was ever seen by the Dentist. During an interview on 7/15/24 at 10:17 A.M., the Director of Nursing (DON) said that Resident #39 had not been seen by the Dentist. The DON said the Resident should have been seen because the dental services consent had been signed by the Resident's Representative.

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	225253	A. Building B. Wing	07/16/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44337 Based on observation, interview, and policy review, the facility failed to maintain safe and sanitary conditions in accordance with professional standards for food service safety on three unit kitchenettes (F Wing, C Wing, and A Wing) out of four applicable unit kitchenettes, to prevent contamination and food borne infections. Specifically, 1) The facility failed to maintain clean and sanitary conditions for the unit kitchenette refrigerators on the F Wing, C Wing and A Wing unit. 2) The facility failed to maintain clean and sanitary conditions for a unit microwave on the F Wing unit. 3) The facility failed to store food safely in the refrigerator in the kitchenette on the A Wing unit. Findings include: Review of the facility policy titled Food Storage Areas last revised June 2023, indicated the following: -Food storage areas will be maintained in a clean, safe and sanitary manner. -Prepared food stored in the refrigerator until service shall be dated. Such food will be tightly sealed with plastic wrap, foil or a lid. On 7/16/24 at 8:34 A.M., the surveyor and Unit Manager (UM) #2 observed a sticky red and brown substance splattered on the inside of the refrigerator door on the upper and lower shelves of the refrigerator located in the F Wing kitchenette. The surveyor and UM #2 also observed food debris splattered inside the microwave located in the F Wing unit kitchenette. During an interview at the time, UM #2 said she thought that housekeeping and/or dietary staff were responsible for cleaning the refrigerator and microwave in the kitchenette. UM #2 said that the refrigerator and the microwave were dirty and should have been cleaned as soon as possible. UM #2 said she would find out who to notify to clean the refrigerator and microwave in the kitchenette. On 7/16/24 at 8:45 A.M., the surveyor and Certified Nurses Aide (CNA) #2 observed a sticky red brown substance splattered on the inside of the refrigerator door on the upper and lower shelves and on the bottom floor inside the refrigerator located in the C Wing kitchenette. During an interview at the time CNA #2 said that the refrigerator was dirty. CNA #2 also said that the refrigerator is always dirty and should have have been cleaned by housekeeping staff. (continued on next page)

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	225253	A. Building B. Wing	07/16/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 8:56 A.M., the surveyor and Nurse #2 observed a sticky red substance on the inside refrigerator door on the upper shelf and in the freezer located in the A Wing kitchenette. The surveyor and Nurse #2 also observed three plastic containers of food in the refrigerator that were unlabeled and undated. During an interview at the time, Nurse #2 said that the refrigerator and freezer were dirty, and he was unsure who was responsible for cleaning the refrigerator and freezer. Nurse #2 also said that he did not know how long the unlabeled and undated food had been in the refrigerator but that the food should have been labeled, dated, and discarded after 72 hours. During an interview on 7/16/24 at 11:55 A.M., the Food Service Director (FSD) said that the Dietary department was responsible for the maintenance and cleaning of the appliances located in the unit kitchenettes. The FSD said that there should not have been any liquid or food splatter left in any of the kitchenette appliances. The FSD also said that dietary staff try to clean up spills when they stock the kitchenettes each day and that no routine maintenance and cleaning schedule had been developed or implemented for cleaning the refrigerators and microwaves in the kitchenettes, but there should have been a maintenance and cleaning schedule in place.

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	225253	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on interview, policy and record review, the facility failed to maintain complete and accurate medical records, including provision of support services for one Resident (#2) out of a total sample of 24 residents. Specifically, the facility failed to document social service supportive visits for Resident #2 after the Resident required multiple hospital evaluations for suicidal ideation (verbal expressions of thoughts of harming oneself that may or may not lack specific intent). Findings include: Review of the facility policy titled Responding to Intent to Self-harm, revised 3/13/23, indicated the following: -Staff should document behaviors in accordance with the behavior management policy. -Documentation should be ongoing. -Said documentation should include all plans, goals, interventions, behavior tracking, and care plan updates when available. -Always document efforts, situations, observations, date and times, location, witnesses, staff members present, outcomes, who was contacted and who made the contact as well as future plans for safety. Review of the facility policy titled Behavior Management, revised 11/5/19, indicated the following: -Document evaluation of the presence of behavioral symptoms or the potential for behavioral symptoms in the residents' medical record and care plan. -Document the initiation of the behavioral interventions and mental health professional visits (if applicable) in the resident's medical record and care plan. -Document non-pharmacological (without use of medication) interventions attempted and resident response. Review of the facility policy titled Social Services-Behavioral Health, revised 11/15/21, indicated the following: -The identified need, assessment, plan, and outcomes will be documented through the care planning process and in nursing/social service progress notes. (continued on next page)

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	225253	A. Building B. Wing	07/16/2024

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Agawam West Rehab and Nursing	61 Cooper Street Agawam, MA 01001

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 was admitted to the facility in May 2024, with diagnoses including Bipolar Disorder (a chronic mood disorder that causes intense shifts in mood, energy levels and behavior), Major Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Suicidal Ideation. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #2: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of a total of 15. -and reported feeling depressed daily in the past two weeks. During an interview on 7/11/24 at 12:01 P.M., Resident #2 said that he/she was admitted to the facility for short-term rehabilitation services but was unable to return to his/her home. The Resident further said that he/she had a history of suicidal ideation, was frustrated with his/her situation, and had been sent out to the hospital for mental health evaluation. Review of the Resident #2's Clinical Record indicated the following Nursing Progress Notes: -On 5/13/24: Resident #2 reported intermittent suicidal ideation. The Resident was evaluated by the Nurse Practitioner (NP) and deemed not currently/actively suicidal. Resident did not need to be transferred to the ER at that time. -On 5/14/24: Resident #2 was transferred to the Hospital for suicidal ideation and returned after crisis evaluation in the ER. -On 6/17/24: Resident #2 said to the Nurse that he/she would rather die than eat and had not eaten in 2 days. The NP was made aware and Resident #2 was transferred to the hospital. Review of the Resident's Plan of Care initiated 5/14/24, indicated Resident #2 was at risk for alteration in mood status due to suicidal ideation and included the following interventions: -Encourage Resident to express feelings. -Monitor/record/report to MD (Physican) as needed mood patterns, sign or symptoms of Depression, anxiety, sad mood as per facility behavior monitoring protocols. Further review of Resident #2's Clinical Record did not indicate that any social service supportive visits occurred after Resident #2 expressed suicidal ideation on the following dates: -5/13/24 -5/14/24 -6/17/24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225253	A. Building B. Wing	07/16/2024

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Agawam West Rehab and Nursing	61 Cooper Street Agawam, MA 01001

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/12/24 at 1:19 P.M., the Social Worker (SW) said her process is to check in with Resident #2 daily for support and that she documents those visits in a progress note. The surveyor and the SW reviewed the clinical record and there were no documentation of social service supportive visits.The SW said that she was unable to recall if she met with Resident #2 after 5/13/24 or 5/14/24. The SW said when Resident #2 returned from the hospital on 6/17/24, she met with the Resident for a supportive visit and have provided other visits since then. The SW said that she did not document the supportive visits and should have.

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	225253	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. 44337 Based on observation, interview, and record review, the facility failed to implement appropriate infection control measures to prevent the transmission of communicable diseases and infections for one Resident (#266), out of a total sample of 24 residents. Specifically, the facility staff failed to implement the use of appropriate Personal Protective Equipment (PPE) as indicated for Resident #266 when the Resident had been identified as having a COVID-19 infection. Findings include: Review of the facility policy titled Infection Prevention and Control Program, revised September 2021, indicated policies and procedures reflected the current infection prevention and control standards of practice. Review of the Infection Prevention and Control Standards of Practice, provided by the facility, indicated the following: -If a resident is suspected and symptomatic or confirmed to have COVID-19, the health care provider must wear an N95 or other respirator, eye protection, gown, and gloves for the care of that resident. Resident #266 was admitted to the facility in July 2024. Review of the facility Respiratory Surveillance Line List indicated that Resident #266 had tested positive for a COVID-19 infection on 7/12/24. On 7/16/24 at 8:49 A.M., the surveyor observed a clear plastic bin that contained PPE, and an isolation sign posted outside Resident #266's room that indicated staff and providers must clean hands, and don (put on) a gown, N95 respirator, eye protection, and gloves before entering Resident #266's room. The surveyor observed Certified Nurses Aide (CNA) #1 enter Resident #266's room without donning a gown, N95 respirator, eye protection or gloves. During an interview at the time, after CNA #1 exited Resident 266's room, she said she should have paid attention to the isolation sign and put on the required PPE to enter Resident 266's room. During an interview on 7/16/24 at 9:44 A.M., the Infection Preventionist (IP) said there was an isolation sign posted outside Resident 266's room because the Resident had tested positive for COVID-19 and had been placed on isolation precautions. The IP said that anyone who entered the isolation room should have read and followed the directions on the posted isolation sign. The IP also said CNA #1 should have worn a gown, N95 respirator, eye protection, and gloves to enter Resident #266's room.