STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225242	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westborough Healthcare	8 Colonial Drive Westborough, MA 01581

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37086 Based on records reviewed and interviews for one of three sampled residents (Resident #2), who had a legal guardianship in place, which was updated on [DATE] to include the right to make decisions regarding Advanced Directive with an elected code status of Do Not Resuscitate (DNR, medical order which instructs healthcare providers not to do cardiopulmonary resuscitation, in the event of cardiac or respiratory arrest) the Facility failed to ensure that new physician's orders were obtained, so in the event of cardiac or respiratory arrest, staff did not attempt to resuscitate him/her. Findings include: Review of the Facility's Policy titled Resident Rights, dated ,d+[DATE], indicated all residents would be treated with kindness, respect, and dignity. Review of the Facility's Policy titled Advanced Directives, dated ,d+[DATE], indicated the following: -Advanced Directive is a written instruction, recognized by State law, relating to the provisions of health care when the individual is incapacitated. -Advanced Directives will be respected in accordance with state law and facility policy. -Do Not Resuscitate indicates that, in the case of respiratory or cardiac failure, the resident, legal guardian, health care agent, or representative has directed that no cardiopulmonary resuscitation or other life sustaining treatments or methods are to be used. Review of the Facility's Policy titled Code Blue, dated ,d+[DATE], indicated CPR will not be initiated if there is a valid Do Not Resuscitate order or MOLST form indicating DNR. (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
	225242	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westborough Healthcare	8 Colonial Drive Westborough, MA 01581

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], at approximately 10:00 A.M., Resident #2 was found unresponsive, was assessed by nursing to be without pulse or respiration, nursing verified his/her code status by checking his/her Medical Order for Life Sustaining Treatment (MOLST), determined he/she was a full code (a medical directive to indicate full resuscitation in the absence of breathing or heartbeat), immediately intervened and initiated life saving measures including starting chest compressions for CPR and activating 911. CPR was unsuccessful, and Resident #2 was pronounced dead at the Facility. Immediately following Resident #2's code, nursing determined Resident #2's Guardianship (a legal role that gives someone the authority to make decisions for another person) had been expanded on [DATE] to include a Do Not Resuscitate directive, which was not reflected on his/her current MOLST form. Resident #2 was admitted to the Facility in February 2024, diagnoses included Alzheimer's Disease and depression. Review of Resident #2's Decree and Order of Appointment of Guardian for an Incapacitated Person, dated [DATE], indicated the court authorized treatment for the following treatment or action: -Do Not Resuscitate (DNR), Do Not Intubate (DNI), Care and Comfort Measures, Consent for hospice and/or palliative care. Review of Resident #2's Physician's Orders for the month of [DATE] indicated he/she was a Full Code status. Review of Resident #2's Advanced Directives Care Plan, reviewed with the previous Quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated his/her Advanced Directives were in effect and would be honored, and the Advanced Directive could be changed if the resident or the appointed health care representative changed their mind about medical care. Review of Resident #2's medical record included a blank MOLST form, placed inside of a red tinted plastic folder, with an attached index card which read Full Code-Guardian in Place. Review of Resident #2's Nurse Progress Note, dated [DATE], indicated Resident #2 was noted to have no pulse, CPR was initiated, code blue and 911 was called, when Emergency Medical Services (EMS) arrived, they took over CPR. Review of Nurse #1's Written Statement, undated, indicated she was alerted that Resident #2 was laying in bed unresponsive, with no respirations, no breath, no pulse via carotid (neck artery), and no signs of life, at which time Nurse #1 initiated CPR (administered chest compressions). During a telephone interview on [DATE] at 9:32 A.M., Nurse #1 said that on [DATE] around 10:00 A.M. she was alerted by a Certified Nurse Aide that Resident #2 was unresponsive. Nurse #1 said she worked at the Facility through a nurse staffing agency and was unfamiliar with Resident #2. Nurse #1 said she immediately went to Resident #2's room and brought his/her medical record with her. Nurse #1 said she found a blank MOLST form in Resident #2's medical record along with an index card that referenced Resident #2 had a guardian in place. Nurse #1 said that because the MOLST form was blank, she initiated CPR and was later assisted by the Assistant Director of Nurses and a (former) Director of Nurses until EMS arrived. Nurse #1 said it was her understanding that if a MOLST form was blank, CPR was to be initiated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225242	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westborough Healthcare	8 Colonial Drive Westborough, MA 01581

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:51 P.M., the Assistant Director of Nurses (ADON) said that on [DATE] around 10:05 A.M. she was asked to assess Resident #2. The ADON said she did not check Resident #2's code status herself. The ADON said she assisted nursing with CPR until EMS arrived. The ADON said that following the code blue, the staff found a Social Worker Progress Note in Resident #2's medical record which indicated the Guardian had an upcoming court date to change Resident #2's Advanced Directive from full code to DNR. During a telephone interview on [DATE] at 9:00 A.M., the (former) Director of Nurses (DON) said that she was in the Facility on [DATE] and was called to assist in Resident #2's code. The DON said that she and another nurse checked Resident #2's medical record and there was a blank MOLST form along with an index card which read Full Code, Guardian in Place. The DON said nursing continued CPR for Resident #2, but it was unsuccessful. The DON said there were many staffing changes, including in the Social Services Department, at the time of Resident #2's code. The DON said the multiple staffing changes contributed to the Facility not having the most up to date guardianship, which included the DNR order, for Resident #2 at the time of his/her code. During a telephone interview on [DATE] at 11:50 A.M., Social Worker #3 said she left her position at the Facility on [DATE]. Social Worker #3 said she was familiar with Resident #2 and was aware of the plan to expand his/her Guardianship. Social Worker #3 said Resident #2's expanded guardianship was not received by the Facility as of [DATE] and that it usually took one week from the court date. During an interview on [DATE] at 3:05 P.M., Social Worker #2 said her company was contracted by the Facility in [DATE] and she was familiar with Resident #2's incident on [DATE]. Social Worker #2 said the expanded guardianship which indicated to change Resident #2's Advanced Directives from full code to DNR had not been received by the Facility. Social Worker #2 said the Guardianships were tracked by the Social Services Department but due to the multiple staffing changes at the Facility, it was difficult to determine where in the system the problem occurred. During an interview on [DATE] at 3:23 P.M., the Director of Clinical Operations said she was notified that following Resident #2's code blue the staff discovered he/she was a DNR and he/she should not have received CPR. The Director said the Facility determined they never received a copy of the expanded guardianship that was done on [DATE], which indicated to change Resident #2's Advanced Directives from full code to DNR. The Director said if the Facility had received the information, the new order for the DNR would have been in place and honored.