STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225380	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Westfield LLC	60 East Silver Street Westfield, MA 01085

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews for one of four sampled residents (Resident #1), who had a change in condition requiring a transfer to the Hospital Emergency Department (ED), the facility failed to ensure they communicated pertinent clinical information to the ED when there was no clinical, medical, or contact information sent with the resident or communicated to the ED at the time of transfer. Findings include: Resident #1 was admitted to the facility in June 2025, diagnoses included Type 2 Diabetes Mellitus, osteomyelitis (a bone infection) to his/her left ankle and foot, as well as a diabetic ulcer on his/her left heel. During a telephone interview on 07/25/25 at 1:15 P.M., the Emergency Department (ED) Nurse said on the morning of 06/16/25, Resident #1 was transported to the ED via Ambulance from the Facility. The ED Nurse said when Resident #1 arrived, she received verbal and written report of his/her condition from the paramedics, however the only documentation she received from the Facility was a Face Sheet (which includes demographic information such as the Resident's name, date of birth , home address, admission date to the Facility, payor source, care providers, emergency contact information and a diagnosis list) and a medication list.The ED Nurse said the facility did not send a copy of Resident #1's Health Care Proxy Form or a copy of his/her Massachusetts Medical Orders for Life Sustaining Treatment (MOLST, a medical order form that relays instructions between health professionals about life-saving care), or a Nursing Home to Hospital Transfer Form.The ED Nurse further said the Facility nurse never called the ED to provide a nurse-to-nurse report on what had transpired prior to Resident #1 being sent to the ED and said that once she got Resident #1 situated, that almost two hours later after not hearing from the facility, that she had to call there to elicit additional pertinent medical information about him/her and his/her care needs.During an interview on 07/29/25 at 10:45 A.M., Nurse #1 said she was the nurse who sent Resident #1 to the ED on the morning of 06/16/25 and she said she provided clinical information verbally to the Emergency Medical Service (EMS). Nurse #1 said she thought she sent a copy of Resident #1's Face Sheet and Physician's Orders with the paramedics but was not certain. Nurse #1 said she did not send copies of Resident #1's MOLST, Health Care Proxy Form, and she said she did not complete the Hospital Transfer Form to send with EMS. Nurse #1 also said that she does not normally call the ED to provide nurse-to-nurse report.During an interview on 07/29/25 at 2:54 P.M., Nurse #3 said she was working the morning of 06/16/25 when Resident #1 was transferred to the ED but did not take part in his/her transfer. Nurse #3 said later in the morning she received a call from the ED Nurse who was looking for information about Resident #1's clinical status prior to his/her transfer.Nurse #3 said when a resident is transferred to the ED, it was the expectation that they would be sent with copies of their Face Sheet, MOLST, the Health Care Proxy Form, Physician's Orders and a completed Hospital Transfer Form. Nurse #3 said it is best practice to call the receiving hospital to provide nurse-to-nurse report, and she said if the Hospital Transfer Form cannot be completed prior to the resident's transfer, the expectation was to fax the form to the ED as soon as possible.During an interview on 07/29/25 at 11:16 A.M., Unit Manager #1 said she assisted Nurse #1 in transferring Resident #1 to the ED on 06/16/25, however she said she did not complete any of the transfer paperwork herself. Unit Manager #1 said when a resident is transferred to the hospital, it is the expectation that they are sent with copies of their Face Sheet, Health Care Proxy Form, MOLST, Physician's orders, and a Hospital Transfer Form.Unit Manager #1 said occasionally during emergency transfers, the nurse is unable to complete the Hospital Transfer Form, but the expectation is that the transferring nurse completes the form as soon as possible and fax the form to the receiving provider.Unit Manager #1 said if Nurse #1 completed a Hospital Transfer Form for Resident #1's hospital transfer on 06/16/25, it would be found under the Assessment tab in the Electronic Health Record (EHR). After reviewing Resident #1's EHR, Unit Manager #1 said there was no documentation in Resident #1's EHR to support that Nurse #1 completed the Hospital Transfer Form, as required.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on records reviewed and interviews for four of four sampled residents (Resident #1, Resident #2, Resident #3, and Resident #4), who all had a diagnosis of Diabetes (a condition when a hormone called insulin does not work properly or there is not enough of it which causes the level of glucose (sugar) in the blood to become too high), the facility failed to ensure they maintained a complete and accurate medical record when Certified Nurse Aide (CNA) Activity of Daily Living (ADL) Flow Sheets related to meal intake were not consistently completed and often left blank.Findings include:Review of the Facility Policy titled, Charting and Documentation, dated as last revised July 2017, included but was not limited to: -All services provided to the resident, progress toward care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. Review of the Facility Policy titled, Nursing Care of the Resident with Diabetes Mellitus, dated as last revised in 2015, included but was not limited to: -Documentation - percentage of meals consumed. 1) Resident #1 was admitted to the facility in June 2025, diagnoses included Type 2 Diabetes Mellitus, osteomyelitis (a bone infection) to his/her left ankle and foot, and a diabetic foot wound to his/her left heel.Review of Resident #1's Documentation Survey Report (ADL Flow Sheets) for 06/09/25 through 06/16/25 indicated for the following meals, documentation on the flow sheet was incomplete:- Breakfast Meal - 4 days (out of 6) were left blank.- Lunch Meal - 4 days (out of 6) were left blank.- Dinner Meal - 2 days (out of 7) were left blank. 2) Resident #2 was admitted to the facility in July 2025, diagnoses included Type 2 Diabetes and Diabetic Retinopathy (an eye disease caused by Diabetes that damages blood vessels in the tissue in the back of the eye).Review of Resident #2's ADL Flow Sheets for 06/01/25 through 06/30/25 indicated for the following meals, documentation on the flow sheet was incomplete:- Breakfast Meal - 7 days (out of 30) were left blank.- Lunch Meal - 10 days (out of 30) were left blank.- Dinner Meal - 1 day (out of 30) was left blank.Review of Resident #2's ADL Flow Sheets for 07/01/25 through 07/28/25 indicated for the following meals, documentation on the flow sheet was incomplete:- Breakfast Meal - 8 days (out of 28) were left blank.- Lunch Meal - 8 days (out of 28) were left blank.- Dinner Meal - 9 days (out of 28) were left blank. 3) Resident #3 was admitted to the facility in October 2020 with a diagnosis of Type 2 Diabetes.Review of Resident #3's ADL Flow Sheets for 07/01/25 through 07/28/25 indicated for the following meals, documentation on the flow sheet was incomplete:- Breakfast Meal - 8 days (out of 28) were left blank.- Lunch Meal - 8 days (out of 28) were left blank.- Dinner Meal - 7 days (out of 28) were left blank.4) Resident #4 was admitted to the facility in January 2022 with a diagnosis of Type 2 Diabetes.Review of Resident #4' s ADL Flow Sheets for 07/01/25 through 07/28/25 indicated for the following meals, documentation on the flow sheet was incomplete:- Breakfast Meal - 3 days (out of 28 days) were left blank.- Lunch Meal - 3 days (out of 28 days) were left blank.- Dinner Meal - 8 days (out of 28 days) were left blank.During an interview on 07/29/25 at 10:35 A.M., Certified Nurse Aide (CNA) #1 said that all CNA documentation is to be completed in the computer by the end of their shift. CNA #1 said if there are blank spaces on the CNA Flow Sheet, that means the documentation was not completed. During an interview on 07/29/25 at 4:25 P.M., CNA #2 said all CNA documentation should be entered in the computer by the end of their shift. CNA #2 said there should be no blank spaces on the CNA Flowsheet and if there were any, that meant the CNA did not document what they did.During an interview on 07/29/25 at 4:36 P.M., CNA #3 said it was important to document residents' meal intake on the CNA Flowsheet. CNA #3 said if a resident refused a meal, the CNA should document the refusal with a code RR (resident refused) so there should not be any blank spaces on the CNA Flowsheet and said if there were blank spaces that meant the CNA did not complete their documentation.During an interview on 07/29/25 at 4:45 P.M., CNA #4 said all meals and other ADL assistance CNAs provide for the residents, are supposed to be entered in the computer by the end of their shift and if there is no information on the CNA Flow Sheet, that meant the CNA did not input their documentation.During an interview on 07/29/25 at 10:45 A.M., Nurse #1 said CNAs will often write residents' meal intake on a sheet of paper which is kept on a clipboard at the nursing station and that documentation should also be entered into the computer for each resident by the end of the shift. Nurse #1 said that there should not be blank spaces on the CNA Flow Sheets and said if there were blank spaces, that meant the CNA did not document on those days or shifts.During an interview on 07/29/25 at 11:16 A.M., Unit Manager #1 said all CNAs should be documenting all ADL care they provide, including meal percentages in the computer. Unit Manager #1 said if the CNA Flow Sheet has blank spaces, that meant the documentation was not completed, as required.During an interview on 07/29/25 at 1:00 P.M., the Director of